South London
Academic Health Science Network

Part One - The Model

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Foreword
By Dr Chris Streather, Managing Director

By design, and from the outset, the AHSN in South London will be different from previous initiatives to drive and diffuse innovation in the local NHS. This will be demonstrated by a step change in ambition, and in the breadth of our remit. We will focus on delivery, with an unprecedented level of involvement from partners in the NHS, universities, local government, industry, the third sector and patients and public.

We will develop lasting, strategic partnerships with industry which bring in expertise, transferrable skills and resource, helping us to avoid past failures of strategic implementation at scale. We are fortunate in our geography, having strong existing links through our academic centres and as a result of the concentration of commerce in the South East and the Capital. We will better co-ordinate these assets, moving from isolated examples of good practice to a comprehensive and consistent approach to innovation.

Patients, the public, and the third sector will be central at every tier of decision making, from Board to disease-based themes. This has been a successful model, transforming the quality of Stroke care in London since 2008, and will be reproduced by drawing on the experience of our network leadership. We have already drawn on the work that John Grumitt the VP of Diabetes UK has done in user design of improved diabetic services in Bexley, and are firmly committed to diffusing this excellent practice and methodology. We have also discussed using the on-line forum Patient Opinion to shorten the NHS response time to feedback, and widen the user involvement in service redesign in a novel way, and will benefit from the development of "myhealthlondon" as a mechanism to publicise transparent information about healthcare services.

The cultural change required to ensure that this initiative bears fruit is not underestimated. We will invest time, resource and the energy of leaders from across South London in developing new partnership working, supported by professional expertise including a relationship with Ashridge.

The practical delivery of these aims is best summarised using our key objectives:

1. To bring academic & scientific rigour to service improvement (evidence based care, evaluation and education)
2. To focus on key Public Health issues for the South London population, where all member organisations have a role and a network approach adds value
3. To create effective mechanisms for delivering change at scale, and a culture which supports continual improvement
4. To support the wealth creation agenda locally, and increase value in healthcare provision by generating improved patient outcomes from the same or reduced investment

1. To bring academic & scientific rigour to service improvement (evidence based care, evaluation and education)

We will evaluate progress against all our priorities and objectives using academic rigour. We have tremendous advantages in terms of local expertise, both in research and health service education and training, with a successful Academic Health Science Centre (AHSC), seven higher Education Institutions including two established Medical Schools. However, we consider evaluation in its broadest sense. The development of plans will use the best available scientific and clinical evidence, all our redesigned pathways will be clinically evaluated, delivering both research translation and participation for the benefit of patients. In addition, and this is a critical component of the added value of the network, we will use local academic expertise, including improvement science and health economics to evaluate the cost effectiveness of interventions and how they are implemented, not just the clinical impact.

When pathways have been redesigned we can only expect commissioners to sign up to the new pathways if we can evidence the economic as well as the clinical benefit, but in many cases this needs to be considered in the context of longer term health benefits and returns, moving away from an annual cycle which can drive perverse incentives. There is an excellent local worked example of this approach in London, where the stroke pathway has been evaluated and it has been demonstrated that there is a substantial return on investment from the new pathway after just three months, mainly delivered through a reduction in length of stay, but also indirectly in the long term to the economy via a reduction in adult disability. We will appoint "improvement fellows" to work with each theme, who will support organisational and professional behaviour change through the use of improvement science methods. Their work will contribute to an evaluative and learning culture in South London, providing a key linkage between our research and education priorities, which are different aspects of the same philosophy of academic rigour.

2. To focus on key Public Health issues for the South London population, where all member organisations have a role and a network approach adds value

We have chosen four illustrative clinical themes, which are significant local public health issues, based on a review of the Joint Strategic Needs Assessments (JSNA) of our 12 boroughs. The themes are Diabetes, Dementia, the Musculoskeletal pathway and Alcohol, and although diverse, they have a number of common features. These themes have been deliberately chosen to reflect evidence-based local need, but also to draw on existing local good practice and specific expertise. These will be refreshed regularly in partnership with the Health and Well Being Boards (HWB) and Members Council.

We have considerable experience of collaborative working on which to build. For example, the Health Innovation and Education Cluster (HIEC) has done a great deal of development work in both Dementia and Diabetes. We have quite deliberately picked themes that are specific, for the network to be successfully established it will be important to deliver meaningful changes to patient outcomes

rapidly, allowing us to develop longer term gains when confidence and trust in the network has grown. We aim to shorten the time to deliver real change to patients, and of measurable wealth creation by this active choice.

We are also establishing mechanisms for the network to support smaller themes and other clinical areas in a timely and nimble way, and this will be important to spread innovation and increase involvement, thereby supporting widespread culture change. There is compelling evidence that physical activity improves health outcomes. This is therefore a core aspect of our themes, particularly Diabetes and Musculoskeletal, and is important as the population ages and obesity increases, but also highlights a link to childhood obesity, which is a common theme in the JSNA data. There is an important advantage of timing in London after the Olympic and Paralympic Summers and we will draw on this with some novel public health interventions.

This will include working with experts in health service evaluation and commercial partners, e.g. working with Optima to customise exercise interventions which have been successfully developed and tested with elite athletes in Finland, for use with our diabetic population. The impact will be measured in terms of health improvement and economic outcomes.

It is important also to recognise the importance of Cancer as a hugely significant national and local health priority, and one where we have a great deal of local clinical and academic expertise. This must clearly be a strategic priority for South London, but we recognise that the primary responsibility sits with the London Cancer Alliance (LCA), and therefore we have not specifically named Cancer as a clinical theme. We will use our shared membership to ensure that this clinical theme is given due prominence, and expect the two networks to collaborate closely, with the AHSN supporting the LCA as necessary. Indeed we have borrowed heavily from the LCAs governance and performance management arrangements as we have confidence in their fitness for the task.

Our themes have been chosen to address health issues where all members have a stake. Alcohol and dementia affect local government (the former law enforcement), primary care, the third sector, the ambulance service, acute care, both secondary and tertiary and the mental health providers. Our strength in mental health research through the Institute of Psychiatry is unrivalled and gives us a significant head start, and a body of existing good practice to build from.

In the bid we address the six key functions described in the guidance in turn, however, we take a holistic view of health improvement, and have attempted to show the interdependency between each of these functions, using our model for Service Improvement as a framework.

We have very strong links between academia and improvement science, including, but not exclusively, the King's Improvement Science (KIS) development. Our local Comprehensive Local Research Network (CLRN) is highly successful and provides a platform from which to grow research further still and provide the benefits to wider population base. There have also been important achievements of the AHSC, the HIEC and the SW London Health and Social Care System. These

existing successful networks provide a culture of cross organisational working that will be a rich resource and a platform to take the AHSN to the next level.

The Members Council will be the driving force of the network, generating priorities for the Executive to manage under the guidance of the Board. We are seeking an experienced leader from outside the public sector as non-executive chair to add discipline and credibility to our wealth creation mission. We have already agreed to share this membership with the Local Education and Training Board (LETB), recognising the complementary functions of the two bodies, and the need to use our decision makers' time wisely.

The collective voice of our members will be more powerful than that of individual organisations, making us a more effective partner in collaborations with industry. We have heard this very clearly from the Trade Organisations in preparing the bid. We also plan to work closely with other AHSNs, particularly our London neighbours, drawing on our combined strengths as partners, the diverse population resource, and on the concentration of wealth in the Capital. There is existing work across the three London AHSCs in life sciences that we will build on. The three London AHSNs have committed to collaborate, and we also have an important relationship with Kent, Surrey and Sussex (KSS) based on historic academic, education and tertiary service links.

3. **To create effective mechanisms for delivering change at scale, and a culture which supports continual improvement**

In the past attempts to innovate top down have not often delivered, and bottom up schemes have struggled to diffuse beyond disease based or geographical boundaries. The AHSN will use peer relationships to break this cycle, as well as creative partnerships outwith the NHS - both industry and the not for profit sector, and include active patient participation in design.

However, we will use robust and transparent outcomes measurement, and apply academic rigour both to the methodology of change management but also to its evaluation, so that we can reproduce the methodology in other settings.

The NHS can make significant change at scale. The transformation of Health Care Associated Infection over the last 5 years with simple interventions, priority, hand washing, wise use of antibiotics and cleanliness has reduced MRSA by 95%.

In London, and involving a significant number of leaders involved in our AHSN, stroke care was transformed using a consistent and rigorous methodology. Some of the key elements of this, patient and third sector involvement in design, a powerful case for change, evidence base, clinical leadership, rigorous project management, and priority from the NHS leadership in London are entirely reproducible in other settings. The South London Cardiovascular and Stroke Network played a key role in the implementation strategy, and there are clear methodological lessons from this to transfer to other pathways.

Drawing on this positive experience our themes will have a decision making senior figure from the membership of the AHSN, an academically literate clinical leader, and professional project management. The Board and the membership will provide priority and the executive some programme managerial and performance discipline.

Each theme, and the functional work streams such as research participation will develop hard edged metrics and support will be dependent on delivery (see detailed sections below). We will develop a limited number of metrics in the first year so that the interventions we choose per theme will be evidence-based, have impact and be measurable.

Information is a key to delivery, it allows different elements of the network to share patient data, allows peer pressure to drive up performance, and supports evaluation and the further development of an evidence-base. Information is also a very powerful tool for patients and the public, we intend to promote transparency of data to promote both choice and drive up quality, for example building on myhealthlondon. Our potential links with fora such as Patient Opinion can be developed further to this end, and we have exciting potential to develop telemedicine with some local expertise and entrepreneurism, improving the patient experience, saving money and possibly developing products to take beyond our geography.

Finally we will invest in leadership, with a full time Director and senior team, and we will spend focused time on bringing the membership together to develop effective ways of working. We will also invest in the development of the core team for each clinical theme, so that academia, industry and the NHS work together to deliver better outcomes for patients. We have already made positive steps towards leadership development by working with Ashridge, who have a strong existing track record in London and with the National Institute for Health Research (NIHR).

4. **To support the wealth creation agenda locally, and increase value in healthcare provision by generating improved patient outcomes from the same or reduced investment**

The theme of developing strong new strategic partnerships with a wide range of commercial companies runs throughout our approach to managing and disseminating innovation.
Indeed, there are many creative and novel partnership arrangements with industry already in place across the sector. However, our clear ambition is to move from these as isolated examples to achieve a culture where expertise from outwith the public sector is embraced, and the success of associated private companies is seen as a success by public sector colleagues.

As indicated above, the importance of economic benefits from new service models is equally critical, as without demonstrable value, commissioning plans will not reflect innovative practice, inhibiting dissemination.

1. Vision for the health of the South London population

1.1 Our Vision

Our ambition is for all South London residents to be actively encouraged and empowered to remain healthy. This will be achieved by timely access to practical advice on adopting healthly lifestyle choices, and by facilitated access to bespoke and evidence-based treatment pathways. A core aims will be to facilitate self-management of the local population's health issues where appropriate. When residents do need professional healthcare advice and facilities, they should be able to access services which are appropriate for their needs, evidence-based and that meet agreed standards and patient requirements.

These prevention and treatment pathways will be informed by expert clinicians, academics and most importantly will be co-created with patients themselves, and will encompass health promotion and prevention as well as healthcare services, and will span all care delivery organisations and care settings, across primary and community care, hospitals, and social care. Where it adds value to do so, pathways of care will be designed and/or delivered in collaboration with commercial partners.

Implementation of new prevention and treatment pathways will be supported by responsive commissioning systems which incentivise good practice, and are flexible enough to adapt rapidly to new innovations, emerging research evidence and changing national guidance and policy. The goal of research participation for every patient will be explicit in all models of care, and made possible by revolutionising access to and the delivery of healthcare research. All health professionals will have the necessary skills and expertise to ensure safe delivery of care, and will work collaboratively with colleagues across the network, within a common values and outcomes framework, supported by aligned information systems and standards.

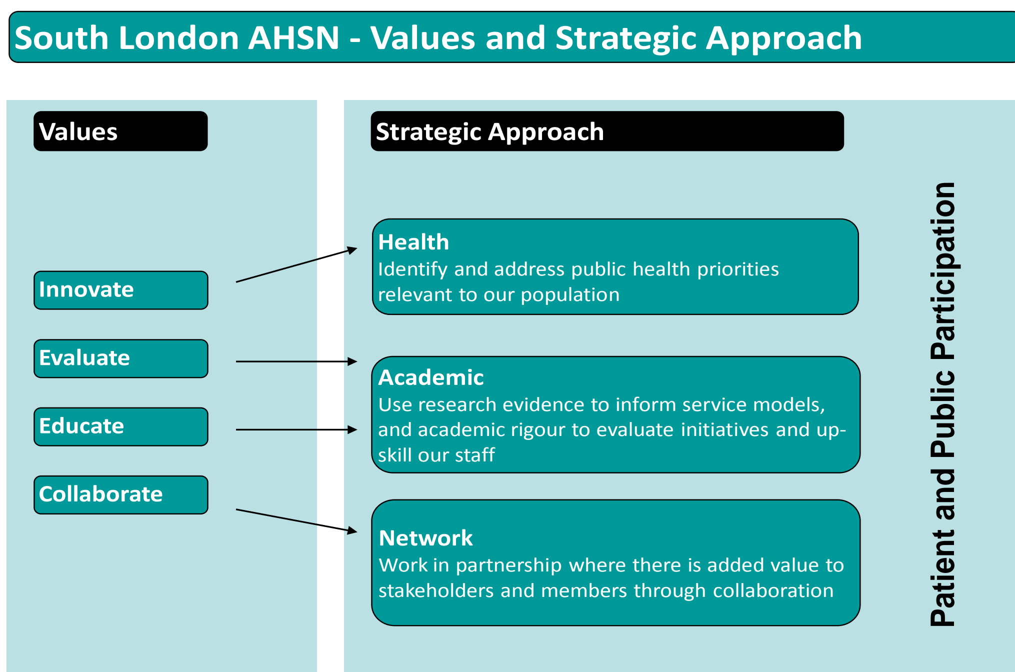
Key objectives for the South London Academic Health Science Network

1. To bring academic & scientific rigour to service improvement (evidence based care, evaluation and education)
2. To focus on key Public Health issues for the South London population, where all member organisations have a role and a network approach adds value
3. To create effective mechanisms for delivering change at scale, and a culture which supports continual improvement
4. To support the wealth creation agenda locally, and increase value in healthcare provision by generating improved patient outcomes from the same or reduced investment

1.2 Our Approach and Values

Previous attempts have been made across the NHS to deliver this vision, through implementation of innovative and evidence-based care. These initiatives have had varying degrees of success, but it is rare to achieve sustainable change across entire health systems. The ambition of the Academic Health Science Networks is bold, aiming to deliver lasting change across all healthcare and related organisations within a geographic catchment.

We believe that there are certain characteristics of an AHSN that will enable success, in particular strong patient and public participation in all aspects of the AHSN and a focus on innovative strategic partnerships with industry and the third sector, stimulating the local economy and driving value. These factors need to be underpinned by the commitment of leaders, the enthusiasm of clinicians, managers and academics, and supported by a robust delivery system, transparent use of information and shared values and culture.



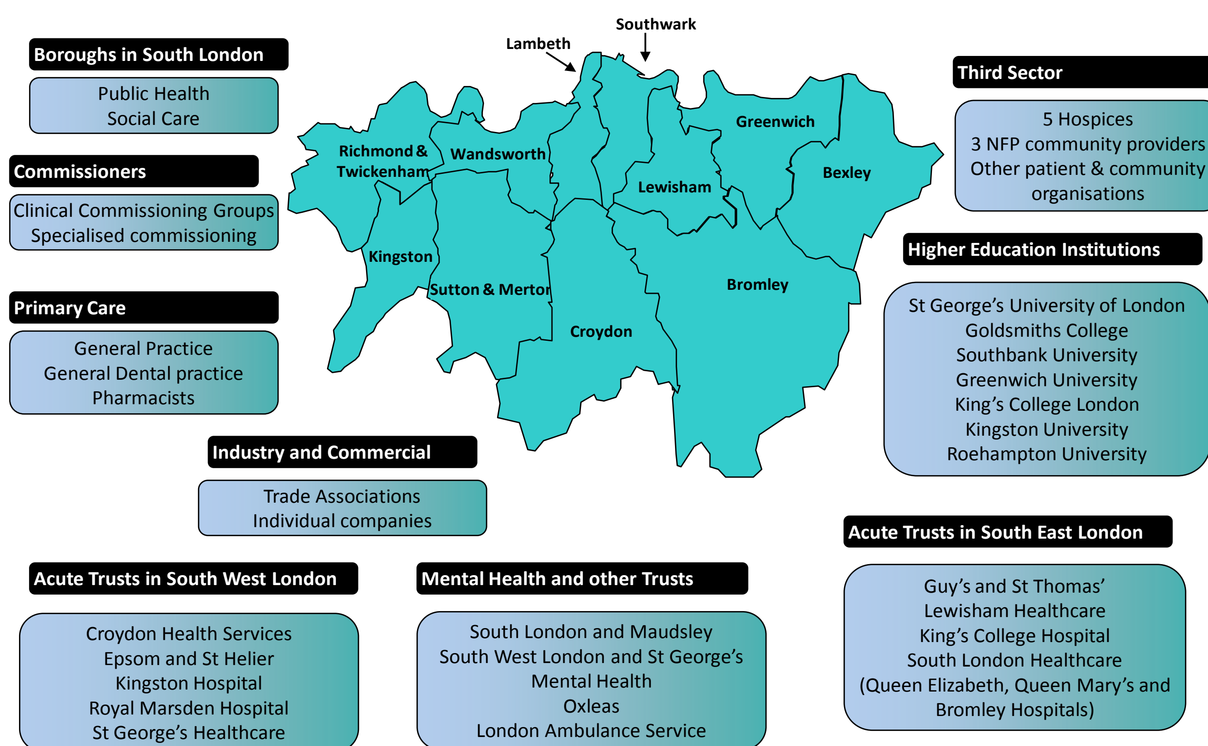
In order to make demonstrable progress we will focus on a small number of priority clinical themes (initially Diabetes, Dementia, Musculoskeletal and Alcohol) where there is real public heath need and shared purpose. However, we expect an evolving culture of continuous improvement to be a lever for change across all areas of health more broadly. We recognise the central role that improving cancer care has in the health of our local populations, and will work closely with the London Cancer Alliance.

We also aim to capitalise on the Olympic Legacy, as the current interest in sports activities can positively contribute to healthy lifestyles, helping to reduce the future burden of disease in our populations.

2. South London Profile

2.1 Geographic Footprint

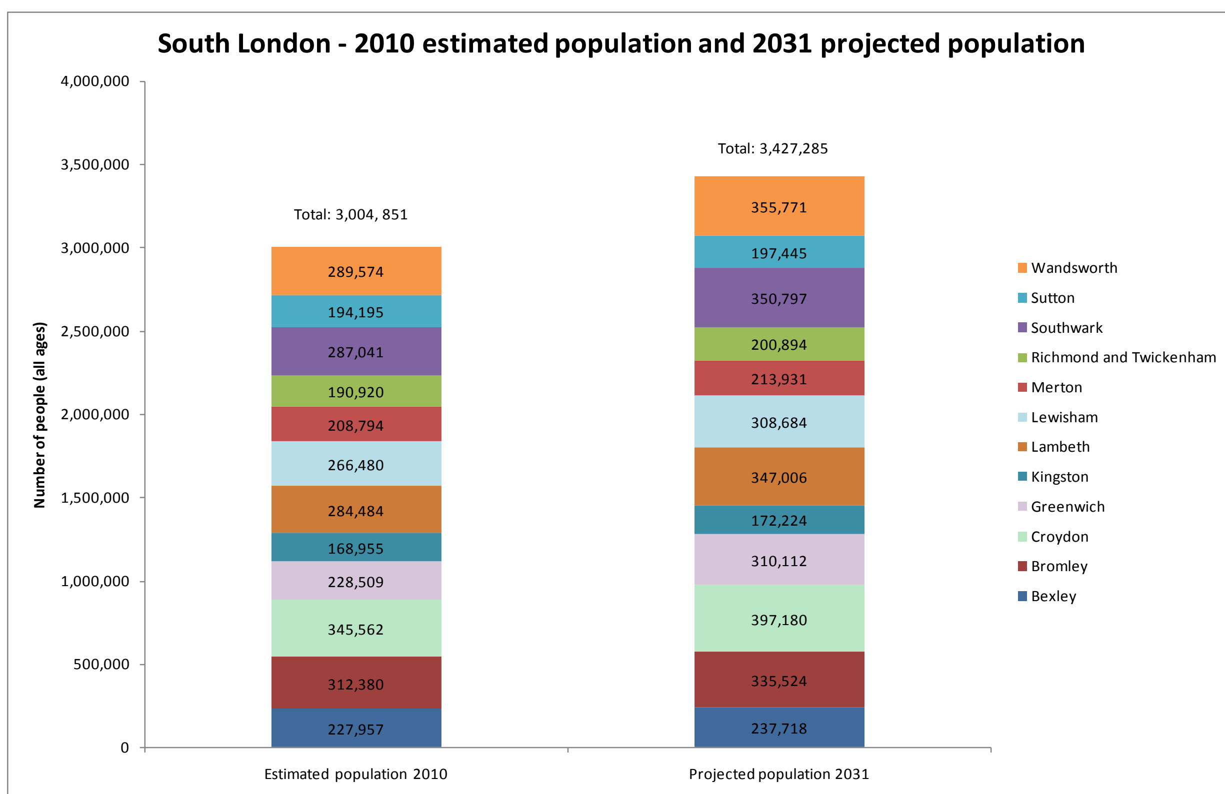
We have obtained commitment from a large number of stakeholders in the South London Academic Health Science Network, and the diagram below outlines the groups of members, and the geography of the 12 boroughs across South London.



2.2 Population Characteristics

Total Population and Population growth

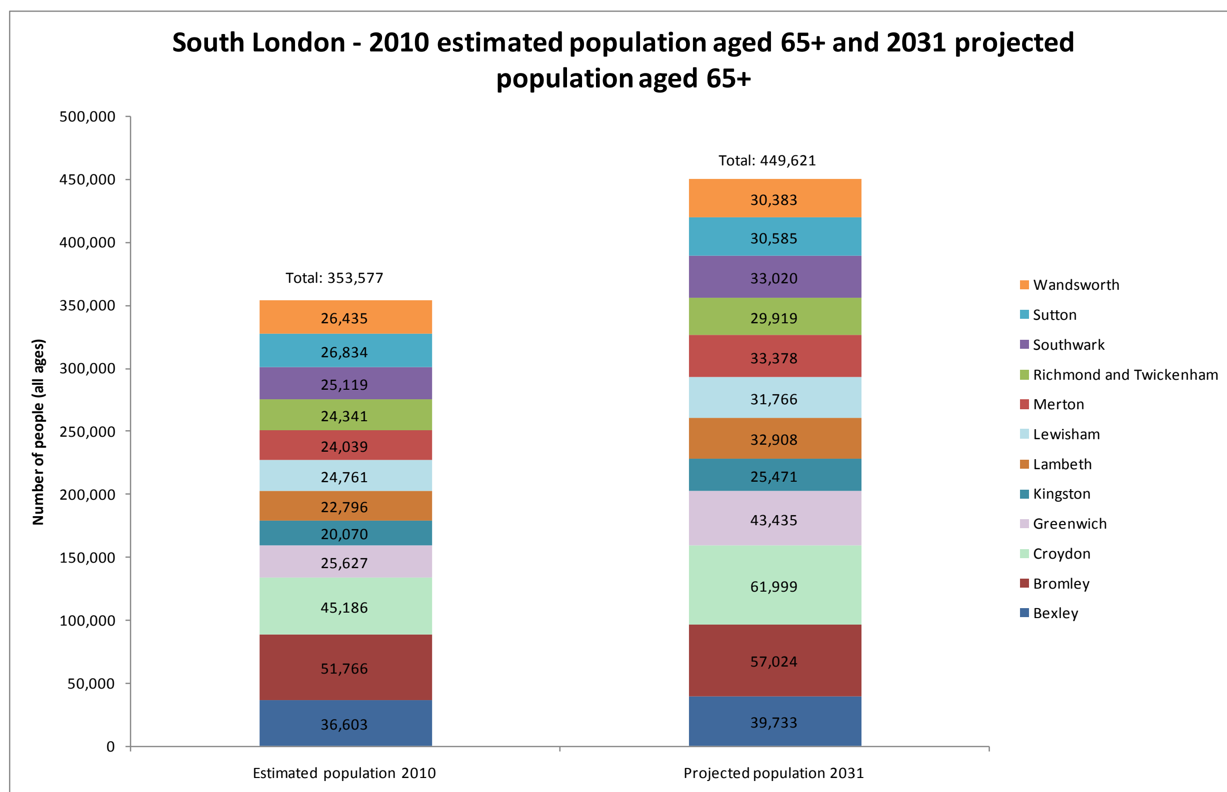
South London spans a large population totalling approximately three million people[1]. The health needs of such a large population will inevitably differ in their totality, and the priorities for improving outcomes will vary across the sector. The table below shows 2010 population estimates, and also the Greater London Authority population projections for 2031 by borough. If these projections are accurate, the South London population will grow 14.1% between 2010 and 2031. With such a large expected increase in population over the next twenty years, our vision to deliver change is even more important, if healthcare provision is to keep pace with demand.



[1] 2010 Mid year ONS Population Estimates

Ageing population

Using 2010 population estimates, currently 11.8% of the South London population is aged 65 or over, and current predictions suggest that this will have risen to 13.1% by 2031. Additionally there will be a growth in the numbers of those aged 65 plus of 27.2% between now and 2031. This is of significant importance when considering the public health challenges that an ageing population presents. The graph below shows this visually.



Clinical Priority areas across South London – Review of Joint Strategic Needs Assessments (JSNAs)

A review of the Joint Strategic Needs Assessments across South London was undertaken to identify key public health and clinical priorities across the sector. Different local authorities present the information in different ways, however summary chapters provide an overview of the key priorities identified in each JSNA. The aim of the AHSN is to focus efforts in specific areas of the *most mutual benefit* across South London to improve patient and population health outcomes, and these areas are summarised below.

Key common public health priorities identified across South West London are circulatory diseases (CHD, Stroke and COPD) as well as diabetes. Additionally priorities relating to long term conditions in general are priorities across all boroughs.

There is also a clear focus throughout South West London on the prevention of risky behaviours e.g. smoking, drinking, poor dietary choices, and substance misuse. Staying healthy is another theme across several boroughs in the South West London sector, with Kingston identifying this a priority service area, and Sutton & Merton highlighting obesity as an issue.

South East London comprises a more diverse population than South West London in terms of deprivation, ethnicity and health inequalities although Bexley and Bromley have similar priorities to those identified in South West London. Obesity and the impact of long term conditions is a recurring priority across all boroughs with a particular need to consider how to avoid emergency admissions and instead promote self-management and healthy lifestyles.
The projected increase in the older population was highlighted across all boroughs although in inner South East London boroughs the consideration was more around the increased ethnic diversity of this older population rather than significant absolute increases.
In addition to the JSNAs we will also capture relevant data from other sources, such as utlitising the "Atlas of Variation" to assist in identifying unhelpful variations, and acting to reduce these.

2.3 Local Strengths and Expertise

There is a wealth of local talent across South London, including excellent clinical services, strong academic expertise (in both research and education, within 7 university partners including 2 medical schools), existing academic networks embracing the NHS and Local Authorities (e.g. the HIEC) and knowledge and experience in many associated areas, such as patient involvement, building effective partnerships with the third sector and industry, service improvement and whole system working, and informatics.

The following table is in no way exhaustive, and is for illustrative purposes only. These examples serve to highlight the wealth of local expertise, and the insights that this experience affords us, thereby helping to equip us collectively with the skills and abilities necessary to deliver on the challenging agenda of the AHSN.

Research participation	• Substantial research portfolio from early to late phase clinical research, major research hubs at King's Health Partners and St George's • CLRN activities, including detailed understanding of current and future clinical and translational research potential, clinical specialty groups in all major specialties, and successful use of targeted strategic funding to incentivise research collaborations • SLAM's consent to consent (for patient participation in research studies) supported by CRIS system to analyse anonymised clinical data

<table>
<tr><td></td><td>Active patient and public involvement in research group, as part of King’s Improvement Science</td></tr>
<tr><td>Research translation</td><td>KHP’s Clinical Academic Groups (CAGs) – bringing together KCL’s academic departments with GST/KCH/SLAM clinical services into strategic groupings
Collaborations drawing on third sector expertise (e.g. Charity models for research dissemination)
King’s Improvement Science (expertise in health economics and evaluation)
Research Design Service London hosted at KHP</td></tr>
<tr><td>Education and training</td><td>HIEC examples of multi-professional training (e.g. community pharmacists) and patient education in Diabetes
SGH multi-professional education strengths
KHP Education Academy, specific strengths such as simulation and blended learning approaches
Modernising clinical/academic careers for nurses, midwives and allied health professionals – South London has successfully won two of the prestigious NIHR funded MRes programmes</td></tr>
<tr><td>Service improvement</td><td>Trust and system-wide Transformation & Organisational Development teams
SWL academic health and social care system
GST Charity Modernisation Initiative (e.g. Sexual Health award winning service in Denmark Hill, and Diabetes in South London)
Evidence-based co-design delivering patient driven changes in cancer</td></tr>
<tr><td>Informatics</td><td>Breadth of electronically-held clinical and research information (in hospitals and primary care)
System integration, e.g. ICP work bringing together hospital, social care and primary care health records
Local Tele-health initiatives (e.g. Hurley group)</td></tr>
</table>

	• Research informatics expertise, e.g. CRIS system at SLAM using anonymised clinical data (NIHR supported project to roll out in additional mental health trusts) • Primary Care research informatics platform development (lead for PCRN is a senior KCL academic)
Wealth creation	• There are 178 industry clinical research studies currently recruiting under the auspices of London South CLRN • Commercial partnerships, such as between KHP and Quintiles • Joint venture with Industry Partners to improve Diabetes care in Bexley • KHP – clinical trials office to support commercial research • Kingston University's innovation voucher scheme that incentivises enterprise activities with SMEs • London as a strong financial capital city is home to a number of major global commercial companies • Numerous international health partnerships (high and low income countries)

2.4 Track Record of Collaborative Working

Although the AHSN may be the most ambitious partnership (in terms of scope and membership) yet to be established in South London, there are many existing examples of effective networks and collaborative projects which we can draw on.

South London Networks

- South West London Academic Health and Social Care System
- South London Health Innovation and Education Cluster
- London South CLRN & Topic Specific research networks
- London Cancer Alliance
- Stroke and Cardiovascular Clinical Network
- Numerous informal clinical networks (including sexual health, diabetes)

Broader Relationships and Alliances

- Improvement Science London
- London AHSCs Executive
- Numerous clinical networks – e.g. solid organ transplant, sickle cell disease

Collaborative Working with the Public, Patients and Advocacy Groups
Many of the members of the South London AHSN, and a number of our close partner organisations have considerable expertise when it comes to effective working with Patients and Patient Groups.

Examples of existing good practice include :

- South London Cardiovascular and Stroke Network has a panel of over 100 patients who they draw on to be involved in service redesign projects and other aspects of their work
- Involvement of key individuals in South London in the NHS London Stroke services reconfiguration which used central patient involvement
- SLAM has a long established Service User Research Enterprise group, which benefits from the research knowledge, skills and experience of patients to shape research proposals and priorities.
- KCH Rheumatology dept has a strong track record and academic publications on PPI
- A number of senior leaders and academics in South London played leading roles in the Healthcare for London Stroke reconfiguration, which benefited from strong patient engagement
- Cancer Programme (part-funded by GST Charity) has a patient involvement as an integral part of its approach
- The London South CLRN has a prominent PPI strand in its work
- The Centre for Patient and Public Involvement in the Joint Faculty of Health and Social Care Sciences (Kingston University and St George's, University of London)
- The Diabetes Modernisation Initiative has a well established patient forum, over 350 local patients engaged in their work, along with user leads that champion service improvements alongside clinicians The DMI has an active capability building programme in place to skill up users in engaging, and the parent support group for paediatric diabetes services are active co-producers in developing local services

Transformation of acute stroke care in London provides an excellent example of how patient participation can play a powerful role in transformation of services. The process involved centralising hyper-acute care to provide easy access to the whole population, with stroke units providing ongoing rehabilitation closer to home. The new model of care was subject to wide consultation and agreed by commissioners, clinicians and user groups. Stroke networks across London led implementation with oversight from the pan-London cardiac and stroke network board. Robust assessments of all units were undertaken to ensure the correct workforce, staffing and infrastructure was in place.

London patients are now accessing specialist care more quickly. London Ambulance conveys patients to a HASU within an hour of a 999 call, length of stay is reducing, thrombolysis rates are among the best nationally and internationally, the majority of patients are seen in stroke units and as a result, outcomes are improving and mortality is down.

Patient and family feedback on the model is positive. Economic analysis has demonstrated that the new London stroke model represents good value for money when costs and benefits beyond 30 days are accounted for.

The NHS in London won the Improvement in Patient Safety Award BMJ Group Improving Health Awards 2012 and received the 2010 Health Service Journal award for Clinical Service Redesign.

2.5 The Potential to develop an effective AHSN in South London

Although there is an impressive track record and expertise across the sector, lasting change of this nature has rarely been achieved historically. We can draw on the lessons from previous initiatives, but apply these:

- At scale, making changes and disseminating good practice across much larger geographical areas than has hitherto been possible
- Through more rigorous evaluation of new interventions and innovative service models
- In collaboration with commercial partners who are neighbours and stakeholders in our local geography
- By harnessing a broader public health approach, including building on the Olympic legacy to encourage health lifestyles

3. Process for the Development of Proposals to Date

Following publication of the initial guidance, King's Health Partners and St George's took a lead role in the co-ordination of an open meeting for all prospective members on 14 June, and subsequently in developing the Expression of Interest for South London. At the open meeting in June considerable enthusiasm was generated for the concept of an AHSN across South London, and many individuals from diverse backgrounds and organisations volunteered to contribute to its development. We have therefore been able to establish very rapidly over the Summer months an effective and representative working group which has met on a weekly basis from July to September. This has facilitated a genuinely inclusive and multiprofessional approach, where the voices of Patients, the Third Sector, General Practitioners, Clinical Commissioners, Local Authorities, Higher Education, Teaching Hospitals and DGHs are equally valued, and new relationships and alliances are being formed.

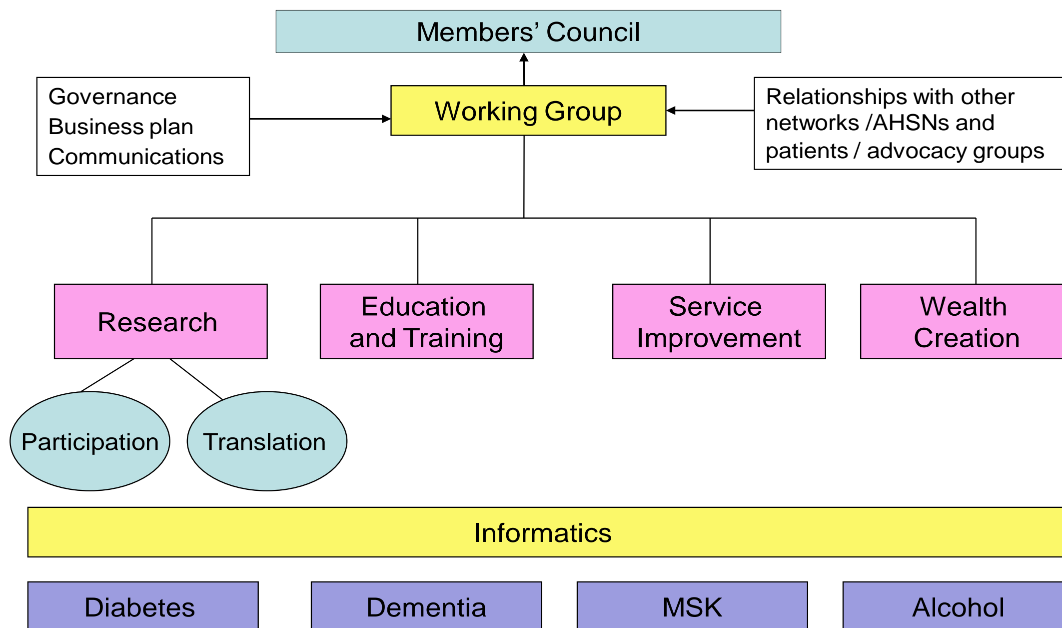
In addition to those who could commit to regular input to the process, members of the Working Group have made contact with a large number of individuals and organisations who have helped to shape our plans, and who have expressed enthusiasm for being part of an active network across South London in the future. These contacts have been captured in a log to inform future developments.

Of particular note are the patient representatives and third sector patient advocacy organisations, who are helping us to think through how we can grow and sustain patient involvement in our network to ensure it is meaningful and effective. These organisations include:

- Diabetes UK
- Stroke Association
- Alzheimer's Society
- Macmillan
- St Christopher's Hospice
- LINkS
- Thomas Pocklington Trust

The working group has also overseen a broader process of engagement, structured around the 6 key functions of the AHSN, each having separate theme meetings, chaired by one of the working group members. One of the early tasks of the Working Group was to commission a high level analysis of the Joint Strategic Needs Assessments (JSNAs) for all boroughs across South London (see earlier section). This informed the selection of 4 provisional clinical themes (Diabetes, Dementia, Musculoskeletal and Alcohol), each of which has generated a small, clinically-led working group to consider what a new approach may look like, facilitated by an effective South London AHSN.

The structure of the bid development process is shown visually below



4. Approach to the 6 Key Functions of the AHSN

For each of the six key functions of the AHSN identified in the early guidance, we have developed initial proposals for our approach, incorporating the aims of each theme, and initial proposals for actions and milestones. The business plan document provides more detail on objectives and actions, as well as the associated risks and challenges.

We have sought to integrate these 6 themes in a number of ways

- Through the use of a service improvement model (see 4.1) which acts as an overarching framework for developing all elements of AHSN activity
- By working up proposals for how the AHSN would add value against each of these areas, in a number of our early clinical themes (see section 6. below)
- With a clear focus on the culture change necessary to deliver sustainable success

4.1 Service Improvement

Innovation and service improvement are inseparable, making service improvement a core component of the AHSN. By using rigorous improvement science methodologies, and with the involvement of patients and key stakeholders across the network, we will work towards improving pathways of care for patients in key priority clinical themes, whilst improving value for money of service provision.

The service improvement theme has many stakeholders that need to be fully engaged:

- *The South London population, patients, service users and their carers:* we need user input to make sure that we meet requirements and address priorities, co-designing models for the provision of high quality services and excellent patient care
- *Commissioners*- new innovative models of care will only be adopted if they are appropriately supported by flexible commissioning models and aligned incentives, such as CQUINs and other mechanisms. Commissioning input is needed at all stages of the process to be effective – from determining the priorities to design and delivery
- *Staff involved in delivery of care:* we need to take a whole system networked approach to service improvement, working closely across the acute sector, community providers and - crossing organisational boundaries to create a shared culture of continuous improvement, encouraging, motivating and disseminating good practice
- *Staff involved in health promotion and public health* – prevention of ill health and promotion of health and wellbeing need to be central to models of care, and there needs to be close alignment and integration right along patient pathways
- *Academics* – in order to achieve a new degree of academic rigour, we need the input of all our higher educational institutes – engaging clinical academics as well as those from other disciplines such as social scientists and economists.

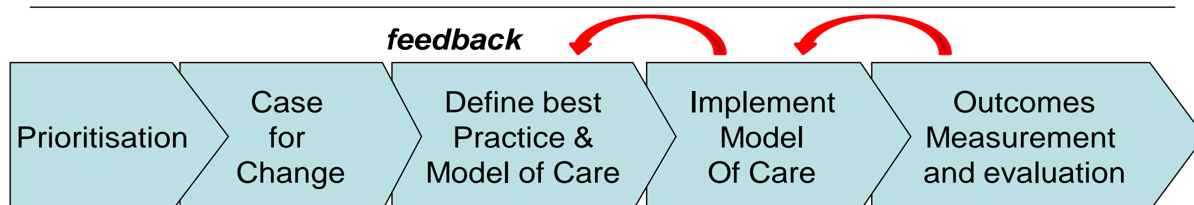
- *Industry and Commercial partners:* we will establish commercial partnerships where these can support service improvement in patient care, with economic benefits. We will use technological advances to enable and underpin new service models and inform future improvements

Building on existing change models, such as that used very effectively by NHS London for the Stroke and Trauma reconfigurations, we are proposing a 5 stage process as an overarching model for the South London AHSN's approach to service improvement. This flows right through from identifying a health need and outlining the case for change, to defining and implementing a model of care, implementing the new model, and measuring impact of the change.

Stage 1 : Determining relative priority of clinical themes
Stage 2 : Developing a case for change
Stage 3 : Creating a best-practice model of care
Stage 4 : Implementation
Stage 5 : Evaluation and outcomes measurement

Feedback at all stages of the process is essential to ensure continued improvement both related to the clinical changes themselves, and for the design of future improvement projects.

Service Improvement – Proposed Process



- Is it a Public Health priority for our local population ? (i.e. from JSNA analysis)
- Do we have specific expertise in the area? (clinical and / or academic)
- Is there other rationale?

- Are there variable clinical outcomes?
- Are there variations in clinical models?
- Is there robust evidence to support best practice?

- Research evidence (what is the field telling us?)
- What local initiatives are in place & are they evaluated?
- National guidance (e.g. Royal Colleges; NICE) and health policy
- What do patients and carers require?
- What are costs / benefits of models?
- Underpinned by new ways of working and strong network relationships

- What project support required to deliver at pace?
- Use Improvement Science expertise implementation
- Providers to work together as effective partners
- Meaningful engagement of patients and carers
- Commercial partnerships to support delivery
- commissioning plans and incentives aligned

- Have outcomes improved (rapidly?) from baseline as a result of new model of care?
- Does the model add value /reduce costs?
- how do patients evaluate the change?
- What can we learn from the process of design and implementation?
- How will we continually update and adapt the model to ensure sustainability?

South London Academic Health Science Network
'in partnership for better health'

Objectives of the Service Improvement Function

This theme will apply key principles of service improvement to drive the adoption and spread of innovations leading to improved patient and population health outcomes, and more cost-effective services.

1. To deliver demonstrable improvements in outcomes in a focused number of clinical themes
   - Launch 1-2 major programmes of work in priority clinical themes, including appointing to key roles (leadership, academic fellowships), reviewing current practice and research evidence base, establishing project plans and milestones, ensuring patient participation
   - Construct a phased implementation plan for future clinical themes (including structured process for determining future priority themes)
   - Develop outcomes framework to support clinical themes / work programmes

2. To ensure that commissioning priorities, decision-making and incentives (e.g. CQUINs) are appropriately informed by the findings from the AHSNs – in terms of baseline assessments of outcomes measures and evaluation of innovative new, economically viable models of care
   - GP commissioners to have key involvement in the choice and design of prioritized clinical themes and programmes of work

3. To align education and training to each phase of the service improvement model that will encompass diagnostic analysis of the organizational and training needs, implementing change in professional behaviour through a range of workplace learning approaches e.g. peer review, coaching and multi-professional learning
   - Work closely with LETB to ensure that major service changes with impact on workforce adequately inform education commissioning plans across South London
   - Work closely with education providers who may propose brief programmes tailored to the specific needs of staff supporting innovation and service change (see model under education and training function, section 4.4)

4. To create a “small grants fund” for any stakeholder who needs resources for small scale project – where this encompasses evaluation and dissemination of existing good practice, economic assessment, patient and public participation or supporting novel industry partnerships
   - Establish a structured bidding process and selection criteria for projects
   - Monitoring system to oversee delivery

5. To establish a virtual community of enthusiastic clinicians, professionals, academics and managers who can share service improvement experience and learning as part of a Service Improvement Forum and drive the spread and adoption of new innovations and knowledge

- Create steering group to design structures and agree initial activities, and to engage all potential interested groups

6. To draw on wide range of expertise, experience and skills through partnerships and collaborations in service improvement and clinical themes
   - Use contacts from Industry Advisory Board, third sector and patient groups to inform the design of change programmes

7. To increase the pace of spread / uptake of innovation across South London sector
   - Develop communications strategy for SL-ASHNs activities
   - Learn from successful examples involving industry and third sector
   - Robust informatics and outcomes measurement, with transparent and publically available data to drive behaviour change

Approach

1. To ensure that a strong patient and public voice leads to patient-centred improvements, through a philosophy of co-production of healthcare management models between patients / users / carers and professionals
2. To ensure integrated care delivery along the entire clinical pathway from community through to tertiary care, across organizational boundaries - minimising barriers patients face navigating their care, and delivering care closer to home whenever safe to do so (build on existing Integrated Care Programmes to deliver)
3. To apply academic rigour to drive evidence based change and improvements, by (a) taking into account research evidence and national best practice guidelines, (b) ensuring all service improvement innovations are adequately evaluated, taking into account outcome, patient experience and economic impact (such as the formal evaluation of SLAM's Mood, Anxiety and Personality service changes, carried out by IoP academics) (c) ensuring best practice models of care are supported by training and educational programmes, and related activities such as clinical effectiveness and audit programmes
4. To look outside the NHS, particularly to industry, for expertise in delivering change, to harness entrepreneurial spirit or for investment to add momentum. A good example of this is the **Sidekick Studios and SLaM mobile technology project**. Sidekick Studios is a UK start-up company based in London and Buddy is a digital tool to support therapy services. Clients use SMS to keep a daily diary of what they are doing and how they are feeling, in order to reinforce positive behaviours. To complete the diary service users simply use SMS, making it highly accessible. Buddy was developed with the Community Mental Health Team at SLaM in 2010, and then rolled out to the Psychosis Early Intervention service in 2011.

The theme is very closely aligned with the work being developed in the 4 clinical themes, and the overall service improvement approach will be tested in detail against each of these areas and refined as necessary.

4.2 Research Translation

Research is a central imperative to the modern NHS and a core component of the Health and Wealth National Agenda. A research active NHS organization is typically one where clinical standards and patient outcomes are above average. The translation of up to date clinical research findings into clinical practice delivery through appropriate service redesign is a key element of the service improvement process, in particular at the following stages of our Service Improvement Model:

Stage 3 – designing new models of care, which must be explicitly informed by research (basic science, clinical research and health services research (HSR) as appropriate. This must incorporate locally initiated research projects, in addition to the international body of published research.

Stages 4 & 5 – implementation and evaluation – should draw on the academic expertise we have in health services research, health economics and improvement science.

Collaboration with Industry is already strong in this theme. For example, **St George's University of London and eSTI2** is partnership between Industry, Academia and NHS to build translational capacity in micro-diagnostic technologies to reduce the clinical burden of sexually transmitted infections in the UK, and to create a diagnostic evaluation pipeline to enable industry easy access to clinical trials.

Objectives of Research Translation Function

1. To work with patients, carers and user groups to look at "pull through" of innovation and research evidence-based clinical practice (i.e. by patients requesting care based on latest findings) – including learning from Charities which have structured processes in this areas
2. To develop the role of the CLRN Specialty Groups (building on a successful existing model, rather than setting up additional parallel structure) to expand this to include oversight of non-portfolio research and a dissemination function – and potentially over time, to be developed as a local "expert panel" in each specialty, which works closely in collaboration with local commissioners. Pilot this model in one or more of the key clinical priority areas (e.g. MSK) & ultimately apply to the wider system, e.g. care homes /private sector
3. To achieve alignment of the various systems, processes and organisations which contribute to research translation (for example, clinical effectiveness and audit processes, CQUINs and commissioning, trust performance management, research centres, KHP's Clinical Academic Groups, education and training programmes) – first step to map the various functions and activities
4. To use a "small grants fund" as described above, to support proposals to implement / roll out research findings more broadly, e.g. demonstrating cost effectiveness, or the

feasibility of implementation & sustainability in other healthcare setting and / or geographic locations (consider the potential to establish a funding mechanism jointly with charities and or commercial partners) or to develop patient participation approaches

5. To work closely with King's Improvement Science (KIS) and other academic resources in local HEIs, to ensure that we fully utilize academic expertise in this area (e.g. sharing of academic posts, accessing the KIS international advisory board), and linking as appropriate to the pan-London Improvement Science initiative

4.3 Research Participation

There are two primary ways in which research participation will be enhanced as a result of the ASHN's Service Improvement Model:

Stage 3 – the model of care should include research participation as an integral element of the clinical service model, and the dialogue with patients about their care options and management should include relevant research studies in which they might participate

Stages 4 & 5 – the number of health services research projects, involving evidence-based interventions and robust evaluation of outcomes, will necessarily increase as the ASHN becomes successful, and patients will be active participate in such research projects, for example through the provision of patient-reported outcomes measures.

There are also a number of specific actions which can be taken by the AHSN (jointly with R&D leaders in member organisations and the CLRN as appropriate) in order to increase research participation across South London, which are included in the objectives below.

Our AHSN is fortunate to have as an integral and close partner the London South CLRN which is now amongst the top CLRNs nationally in respect of overall patient recruitment to research studies, with a 300% increase in such recruitment over the last 4 years. The participation with industry in research programmes in London South is also one of the most impressive in the National Portfolio. This is an excellent base from which to build, in addition to a number of high performing, research active trusts within the sector.

Recognising that the London South CLRN's specific remit and objectives in this regard, we have therefore developed the proposed actions detailed below in close consultation with the leadership team of the CLRN. It will be essential to ensure that there is not duplication of effort or conflicting initiatives being carried out by the AHSN and the CLRN (or its successor, which is likely be an "integrated research network" subsuming current topic-specific networks). How the two networks work together in the future will require more detailed planning, but we would anticipate closely aligned governance arrangements (i.e. as are being proposed with the LETB and the AHSN).

Objectives of Research Participation Function

1. To increase participation in research studies (portfolio) from approx 2.5% of patients across South London to 5% (as achieved in higher performing networks) over the 5 year license period (learning from successful groups, e.g. cancer, and using CLRN specialty groups and strategic funding to drive progress)
2. To increase patient awareness of research & the benefits of participation. For example, through developing common information to be included in patient communications, and rolling out a "consent to consent" approach, as introduced at SLAM (this links to the "pull through" approach described above, where patients request care based on the latest research evidence)
3. To work with CCG members to find effective ways of using commissioning as a lever to stimulate research participation
4. To speed up the approvals processes & streamline these across South London, to avoid duplication and delays, by working towards a "single sign-off" process. This could be achieved in steps, moving to "hubs" for R&D approvals at KHP and St George's to support smaller organisations (e.g. learning from PCTs who worked as consortia to accept sign-off in by one PCT across the entire consortia). It could also be piloted in our priority clinical themes for the AHSN.
5. To create effective networks and collaboration between key research support services such as research pharmacy, radiology and pathology (building on current CLRN initiatives)
6. To explore the extension of the "research passports" scheme to primary care and to universities
7. To develop specific plans to grow research activity in areas where this is low at present, in particular in primary and community care, non-statutory settings (i.e. care homes) and research led by non-medical staff (e.g. mechanisms to support research nurses working in general practice, supporting practice nurses to consent patients for research, also by using tele-health more imaginatively
8. To build and support cadre of PIs working in smaller DGHs who obtain support from larger centres or via specialty groups (or potentially supported by commercial partners)
9. To improve the uptake of the Research Design Service (RDS) (an NIHR funded, pan-London service, hosted by KCL) more widely across the patch (as measurable outcome) supporting less experienced researchers and improving the quality of grant applications
10. To agree a central mechanism across South London to address treatment costs not funded within research studies (through engaging CCGs and NHS provider members and agreeing a funding mechanism, such as top-slice, which could be administered, using explicit criteria, through the CLRN)
11. To increase commercial-sponsored research across South London. By streamlining of research governance approvals, reducing the time between study design, resource allocation and then first patient recruitment we can provide an extremely attractive model which will draw in many industrial partners to provide a viable long-term research partnership. Coupled with access to larger patient populations, this should make South London the place where Industry will look to as a research partner.

12. Increase early phase trials and industry collaborations (this objective will be led by the AHSC and its BRCs. However, the AHSN can and should provide a useful "pipeline" allowing proof of concept to be tested on larger populations). A good example of this is the **Quintiles and Experimental Medicine Hub at Guy's Hospital**; Quintiles has delivered more 'first in human' studies than any other commercial research organisation and has helped to develop all of the top 30 bestselling drugs in the world

4.4 Education and Training

The goal of the education and training theme is to support and expedite the spread of evidence based innovations and health improvements from the "bench to bedside and bus stop" in order to deliver better population health outcomes.

Overarching Goals

We will work strategically with the South London LETB to develop the workforce with the skills:

- To identify, appraise, translate and implement evidence into clinical practice
- To understand the importance of organisational culture and how to manage change effectively
- To implement and evaluate change and escalate the spread of effective innovation

We will develop AHSN leaders who will:

- Work successfully in teams, across boundaries
- Enable and inspire the development of new organisational and professional cultures within which innovation flourishes
- Implement and evaluate service improvement across care pathways

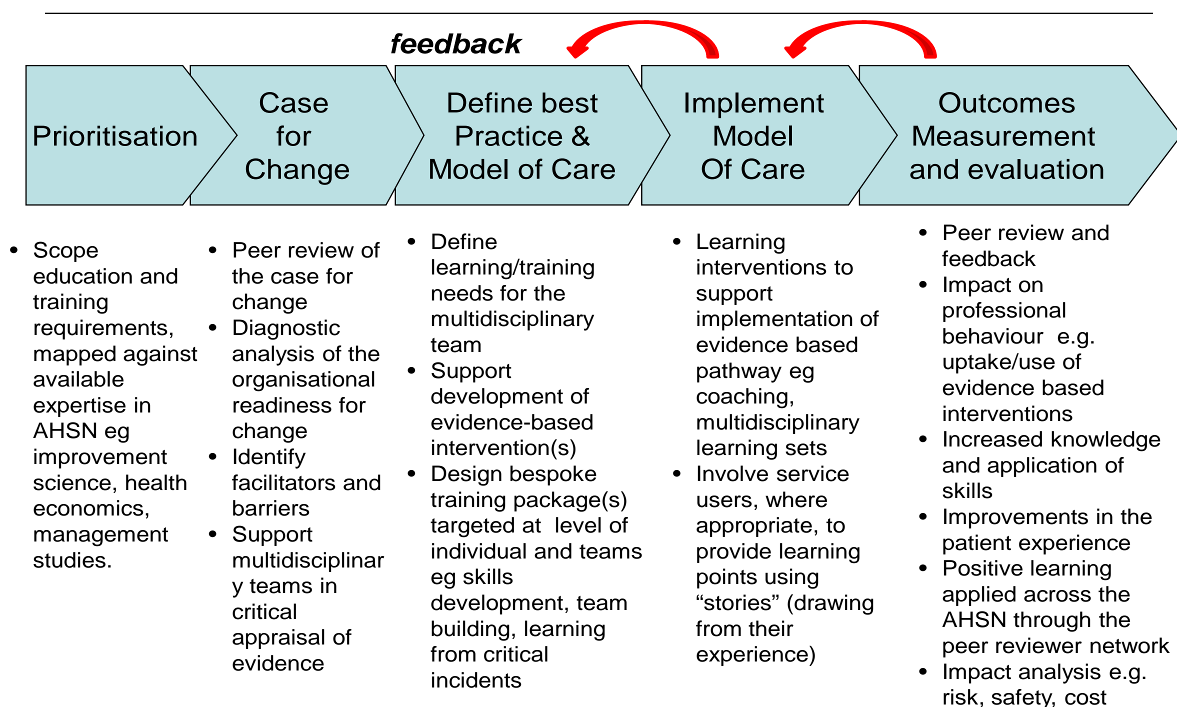
The South London AHSN is fortunate to have 7 universities (Greenwich University, London South Bank University, King's College London, Kingston University, St George's University of London, Goldsmiths and Roehampton University) within its geographic boundary providing a variety of research and education expertise from which to draw. We will build on this expertise using partnership and co-production approaches with the NHS, Local Authorities, Independent, Third Sector and Industry to develop bespoke packages appropriate to foster professional and organisational change in the workplace.

We have approached the exercise of agreeing initial objectives and scope of this theme through a process of stakeholder engagement including the LETB, the 7 universities in South London, the Deanery, HIEC, the South West London Academic Health and Social Care System and the AHSN working group. The shared membership council with the LETB will aid and promote this joint working.

We believe that the following objectives (supported by more detailed proposals) will achieve cultural change and promote innovation through mediating professional behaviours and workforce development.

This will require multidisciplinary approaches, organisational learning, leadership development and collaboration with service users to ensure that innovation is relevant and improves the patient experience. The following diagram helps to demonstrate the relationship between the Education and Training approach and the Service Improvement Framework.

Linking Education and Training to Service Improvement



Objectives of the Education and Training Function

1. To develop an evidence-based education model that is multi-professional, and supports population health, working across care pathways (using the framework of the service improvement model described above).
2. To influence pre and post qualification programmes in medicine, nursing and the allied health professions to achieve improved health outcomes (e.g. ensure programmes include a focus on values, patient safety, critical appraisal and research utilisation and consent training, building on the work of KHP Education Academy)
3. To identify, build on and scale up good practice in education and training wherever it is found (review mapping undertaken by the HIEC to ensure we are comprehensive and inclusive in building relationships outside of the health sector)

4. To stimulate (and peer review) training and development programmes (from multiple potential providers, including non-public sector) which will increase the workforce capability in scholarship, leadership, innovation and improvement, with reference to the AHSN's clinical priorities
5. To support and develop a community of local champions to lead innovation in South London including Innovation and Improvement Fellows (similar to Darzi Fellows in concept, but with a greater focus on care pathways, improvement science and evaluation) who will support the delivery of innovation and change in the priority areas across the AHSN. These fellowships may be part funded by Industry to pump-prime innovation and encourage the cross fertilisation of ideas between industry and the NHS. For example, **Knowledge Transfer Partnerships: University of Greenwich and SMEs** supports local businesses wanting to improve their competitiveness, productivity and performance by accessing the knowledge and expertise available within UK Universities and Colleges. Projects have facilitated the transfer of knowledge by high calibre recently qualified people under joint supervision from the SME and St.George's.

4.5 Informatics

Development of Informatics capability is essential to support each of the individual AHSN themes with their information needs, and in developing the outcomes measurement framework.
The collection, analysis and use of information are key to identification of variations of practice and standards / outcomes, and in demonstrating the impact of best practice within identified clinical priority areas (e.g. Diabetes, Dementia, Alcohol and Musculoskeletal). The sharing of data related to the entire patient pathway (i.e. spanning organizational boundaries) will be crucial as the AHSN works towards improving health outcomes, and also vital to support health research locally and nationally.

The ability to share data between providers across the patient pathway is a critical factor to gain the full advantage of the successful local Integrated Care Programmes. However, we must ensure that we co-create our plans and protocols for data sharing directly with patients, and that we give due regard to privacy, data security, confidentiality and better informed patients. In this regard We can build on the eMPOWERMENT project – a joint venture between SLAM, Institute of Psychiatry and primary care practices in Lambeth, a first of its kind in the UK. In line with the Department of Health's information strategy to improve access to service user health information, the programme has led the development of an electronic Personal Health Records (ePHR) system known as 'myhealthlocker™' which allows service users to gather, store and share health information.

This aspect of sharing patient information more broadly will require particular attention as we develop more productive partnerships with commercial companies.

Innovative information technologies may also be beneficial interventions in themselves, enabling service delivery to be transformed. This will facilitate improved patient care, and also improved productivity over time. Examples include telemedicine initiatives being introduced by the Hurley

Group, and the use of social networking and fora such as "Patient Opinion" for gathering real-time patient feedback on services. Another example is the **KHP and MedSciNet collaboration** to develop bespoke software for an in-house clinical trials portfolio management system and an internet deployed electronic CRF designer and database.

Crucially, we will need to use information intelligently to determine whether and how our AHSN is successful, and build on this knowledge to continue to improve our performance and effectiveness in the future.

Objectives of the Informatics Function

Data, information and performance outcomes framework

1. To assess the data and information currently available, in support of the main themes of the AHSN (research, education and training, wealth creation and service improvement) and work with leaders in these areas determine the information needs, and how best to support these
2. To develop an outcomes framework to evaluate the success of individual change programmes and of the AHSN itself
3. To inform intelligent commissioning and ensure a health economic focus to inform incentives and change in financial flows
4. To generate transparent and meaningful information for patients, to help inform their choices and behaviours
5. To use transparent data to mobilize peer pressure to improve the quality of care, reproducing the success of sharing outcome data in cardiac surgery post Bristol- building on the myhealthlondon development to make healthcare data transparent and publically available

Digital technology

6. To facilitate innovation within the arena of information technology, providing a fast track network approach to rolling out new technologies, where appropriate in collaboration with Industry partners (e.g. building on Hurley Group's innovative work)
7. To facilitate dissemination of information and dialogue throughout the AHSN – for example through the provision of intelligent social networking and secure area networks

Integration of IT systems, data

8. To facilitate the integration of data between organisations along pathways of care, to determine impact of whole system changes (e.g. drawing on ICP experience)
9. To capitalize on the opportunities provided by integrated clinical data in terms of research utilization, for example with SLAM's CRIS system accessing anonymised clinical data for research purposes
10. To make patients central to the dialogue regarding data integration, informing our plans and practices with regard to data security, data sharing and privacy

11. To make appropriate linkages with existing IT and informatics groups and networks, including the ICT professional network for NHS organisations, and London Connect

In order to deliver effective informatics support to significant improvement programmes in the AHSN, there would need to be rapid access to those responsible in member organisations for both the IT function and the informatics or "business intelligence" function. It is proposed that that is facilitated by the creation of an Informatics Reference Group – comprising leads for both function from each of the major organizational groups included as members. These individuals will access their own networks and contacts to ensure communications channels are optimized.

4.6 Wealth Creation

Strong and strategic collaborative relationships with Industry are vital if the South London Academic Health Network is to meet the objectives of speeding up the identification, adoption and spread of innovation in order to improve the health of the population in South London, and to support wealth creation for UK companies and local economic growth.

Although areas of good practice have been identified within our partner organisations, considerable development work is required in order for this approach to be adopted systematically and comprehensively across the sector and for the culture of the public sector to support and embrace new collaborations. The importance of this lever and element of the strategy is reinforced by relevance and inclusion as a key component of the other five functions of the AHSN. This is a significant, mutually beneficial opportunity for both Industry and Health and Social Care.

Four Key Wealth Creation Programmes and Opportunities for South London

We have identified four key overarching objectives and programmes for the AHSN that encompass all eight of the wealth creation components in the DH guidance of: run transparent procurements, creation of measurable economic impact on UK companies, exploitation of industry resources, expert advice on the benefits of innovation, membership and involvement of trade associations, contribution to SBRI, commercialisation of innovation and working with local economic development partnerships**.** These objectives are:

1. To develop and sustain strategic relationships with Industry
2. To support Industry's innovation process
3. To generate revenue and increase value for the NHS and Social Care System
4. To develop strategic procurement in order to improve population health and reduce system costs

Objective 1: Strategic Relationship Management with Industry

If Industry and the Health and Social Care System are to move away from a combative, short term and transactional set of relationships, both sides will need to start with the mutual understanding of the need for being long term and strategic partners.

This then can be underpinned by the use of Strategic Relationship models, which have been in wide use in non-health segments of the economy.

(i) Working with the Trade Associations to identify industry innovators

For Small and Medium Size companies (SMEs), we will work with SEEHTA and EGMI to identify industrial companies that have an interest in our four disease areas of Diabetes, Dementia, Musculo-Skeletal pathway and Alcohol. Initially, we will use the Trade Association to help manage the AHSN relationship with them. When specific opportunities for collaborative working arise, these can then be transitioned to 1:1 relationship management in the AHSN. We will also adopt this approach for the larger international enterprises by working with the ABPI and ABHI to help identify potential partners for our four disease areas. As the ABPI develop its regional infrastructure, we will link in with any South London office established.

Specific programmes and KPIs: We will co-sponsor at least one event each year, with each of the 4 trade associations, to describe the work of the AHSN in our four disease areas. In these events, we will co- organise Knowledge Exchange Sessions to address the procedural and cultural differences between the two sector in order to begin bridging the cultural divide and to build mutual trust and respect. We will measure our success through structured feedback from the Trade Associations on the relationship of their members with the NHS

(ii) Direct relationship management to support the uptake of innovation

As specific opportunities arise to work collaboratively with SMEs, we will adopt a direct (1:1) relationship model. For larger enterprises, we recognise that they will expect and value a single point of entry into the NHS, and we would expect the South London AHSN to take a national role in the relationship management of a select number of organisations.

Specific examples of best practice:

- **KHP Partnership and Quintiles**

First in human (FIH) trial capacity as part of an experimental medicine hub at Guys Hospital. The new suite houses a pharmacy for trial materials, labs for stem cell and genetic research and a study information centre and is designed to encourage patient participation and foster closer links between scientists and health professionals. Quintiles, the largest CRO in the world, operates the 30 bed phase 1 unit for FIH and proof of concept drug research.

- **Cell Therapy Catapult Centre at Guys**

The Catapult will bridge the gap between academic invention and real life commercial products. It laboratories will be able to address technical issues relating to the quality, safety and efficacy of cell therapies in pre-clinical studies and carry out clinical trials as well as develop effective manufacturing processes for these novel products. The Catapult will also focus on the regulatory and commercial challenges surrounding cell therapies and address the economics of new products and services emerging from research, ensuring they are cost effective and market ready. Cell

therapy offers a great promise for many unmet clinical needs and the Catapult will be in the vanguard of translating the science into real benefits for patients and growing UK businesses

Specific programmes and KPIs: We will establish a simple relationship management system, available to all AHSN partner organisations, to make our interactions transparent across the system. We will measure our success in developing longer, strategic relationships with a few key partners by the use of a simple, low cost, web-based tool to measure ‘partner satisfaction each year. We will build on the relationship management knowledge already within our network, in organisations such as Joint Clinical Trials Office (JCTO). The South London ASHN Industry Advisory Board (see (iv) below) will provide advice on the establishment of effective and transparent collaborations.

(iii) Linking with other NHS Networks for Working with Industry to align programmes and reduce duplication of effort

We recognise that there are other South London, pan London and national networks that also have the remit to manage Industry relationships. We will work to keep others informed of our activities and to link with them when there are common programmes and goals in order to reduce duplication of effort. These networks include the National Clinical Research Infrastructure, and we will link in specifically with the Translational Research Partnership for joint and inflammatory diseases and the Dementia translational research collaboration (under the leadership of Professor Simon Lovestone, SLAM). They will also include the Global Medical Excellence Cluster and its office at Kings and the BRC/BRU at Kings and SLAM. We have already met with these organisations to inform them of our work.

We will continue to support the work of the NHS Confederation on Wealth Creation, and hosted an event on this topic for London and the South East regions to inform the development of the AHSN prospectuses.

(iv) Establishing an Industry Advisory Board

As part of the AHSN governance structure we will be establishing an Industry Advisory Board, which will have a direct relationship to the AHSN Board, but for good governance (i.e. avoidance of conflicts of interest) will have a degree of separation. We anticipate the membership of this Board being wide-ranging, including Trade Associations (e.g. ABPI, ABHI) some individual large companies (possibly by rotation) including potentially other related industries, such as IT suppliers, private healthcare providers, etc. We would also be looking to public sector colleagues with particular expertise in managing the interface, for example Local Authorities (who have significant contracts with local private providers) and local expertise in Intellectual Property (KHP) and local GPs who are successful business entrepreneurs.

Discussions have been held with Imperial and UCLP AHSNs, and agreement has been reached that we will develop a collaborative approach to working with Industry. This requires further discussion in order to develop detailed plans, but for example we may run pan-London industry engagement meetings on a regular basis.

Objective 2- Supporting Industry's innovation process; revenue for the NHS and wealth creation for Industry

(i) The NHS value proposition; service design, business case development and proof of concept

The population of South London is hugely diverse and provides a very attractive testing and development ground for Industry that can then internationalise successful developments. For example, research involving the BME population in South London may inform the development of products and services for Africa.

The AHSN is a valuable source of patient information and expertise in its analysis that, if accessed appropriately, provides Industry with information to design appropriate products and services. Also, there is the opportunity to provide Industry with the opportunity for proof of concept testing. Both facilitate the design of services that reflect the delivery models of healthcare within the health and social care system. This moves the relationship process with Industry to a strategic rather than a transactional level. We will use the framework developed for the Changing Diabetes Project (see below), and the expertise within the BRCs, to inform the development of guidance for network members in developing needs based solutions to our health and social care priorities in diabetes, dementia, alcohol and the MSK pathway. Large research driven organisations understand the value of our BRC/BRU at Kings and SLAM in accessing basic research and discovery expertise and knowledge to inform their own work. Our objective is to make South London a preferred location for Industry Research and Development

Specific examples of best practice:

- **Changing Diabetes Project at KHP with Norvonordisk**

This project has created a framework agreement for the development of clinical interventions in diabetes to reflect the move of focus from secondary to primary care in the management of this long term condition.

- **South London NIHR CRN**

The South London NIHR CRN is committed to helping the life sciences industry deliver high quality research to time and target in a well managed, efficient and cost effective environment. This is facilitated through a dedicated industry manager within each Local Research Network who works to ensure that the NHS can meet the health research needs of industry

- **KHP Clinical Trials Office**

King's Health Partners member institutions have long history of collaboration in the conduct of clinical trials. NHS and academic clinicians have recruited NHS patients and volunteers into a variety of local and international trials on behalf of pharmaceutical and biotechnology companies and have conducted or contributed to investigator-led and academic trials. Together, the member institutions present a strong interface between academic and NHS researchers, world class clinical

and research facilities and a large patient base across the one mental health two acute and NHS foundation trusts.

- **St George's University of London and Equipment and Reagent Manufacturers' new product testing**

St George's is trialling new analytical equipment for Randox (UK), Beckman-Coulter and GE, gaining access to early innovations and working with Industry to establish protocols for use in UK Health.

Specific programmes and KPIs:
For all strategic partners identified in the relationship management analysis we will facilitate the development of framework agreements to encourage product and service developments that are tailored to the needs of our health and social care system. Key KPIs will include number of framework agreements reached, number of co-created programmes and number of proofs of concept established. In each of our key Disease Areas, we will identify at least one project for trialling innovative products and services for Industry within the AHSN, looking to establish a new revenue stream and/or in-kind donations.

(ii) Supporting the Small Business Research Initiative (SBRI).
For early stage small to medium size companies to develop and demonstrate technology
SBRI is a programme that brings innovative solutions to specific public sector needs, by engaging a broad range of companies in competitions for ideas that result in development contracts. The Technology Strategy Board runs a number of innovation support programmes and competitions for SMEs, including national Innovation Voucher scheme, Smart proof of market, concept or prototype development grants, and we will work with them to identify areas of common interest in our key clinical theme areas.

Specific programmes and KPIs:
We will work with the SBRI, Technology Strategy Board and the Trade Associations to identify a pool of candidates with interest in our Disease focus areas. The AHSN will work with its members to identify current areas of unmet need in our research, education and service delivery portfolios and with the input of the SBRI develop appropriate specifications for a bid process. We will then work with the SBRI to run the bid programmes. KPIs will include at least one SBRI initiative each year.

Objective 3 - Revenue generation for the NHS

The AHSN provides an overarching structure to bring in new funding into the health and social care system in South London by facilitating the commercialisation of its own innovative product and services as well as providing services to Industry to support its innovation processes.

(i) Better management of Intellectual Property and Licensing.

By utilising the expertise of KHP and the HEIs within our network, we will facilitate the development of intellectual property for all members of the network so as to commercialise opportunities with Industry and internationally.

Specific examples of good practice:

- **KHP agreement with Sigma Life Science**

King's researchers in the Division of Cancer Studies have developed new technology for the identification and validation of microRNA (miRNA) targets in research, resulting in an exclusive license agreement with Sigma Life Science.

- **St Georges and Kingston University Bridges initiative:** self-management after stroke, and project to launch in New Zealand.

(ii) Encouragement of spin-out companies

Specific examples of good practice:

- **Centron Diagnostics**

A spin-out company from King's College London, Centron Diagnostics Ltd, has created a revolutionary new device that measures central blood pressure easily, speedily and non-invasively.

Specific programmes and KPIs:

We will organise workshops for all members of the network, bringing expertise from Industry as well as our own network in order to encourage a more systematic approach to intellectual property development, licencing and company spin-outs. We will measure the number of new licence agreements and spin-outs, and the commercialisation of our own innovations outside the UK (with or without industry partners) with a particular focus on our key clinical areas. Where this results in increased local employment, we will also track this, as well as new revenue that comes into the NHS and Social Care system.

Objective 4 - Strategic procurement; adoption of innovation for the NHS, wealth creation for industry and local economic development

(i) Needs/solution based procurement

Strategic procurement ties in with our strategic relationship management programme. In order to speed up the identification and adoption of innovation, we will encourage development of a needs/solutions based procurement process that builds on the SBRI process for research. The aim will be to complement existing transactional and spot purchases of commodity products and services from Industry and develop a more solution/needs based purchasing process that will encourage Industry to tailor its development programmes to the needs of our population. We will work with commissioning bodies and take account of guidance on co-operation and competition to inform this development.

We will work with Industry to take expert advice on the benefits of innovation so as to help our partner organisations make the business case for specific procurements.

(ii) Large scale procurements – producing a business case for the NHS

For large scale procurements from Industry, where the business case for procurement will spans many providers, the AHSN provides a vehicle for facilitating the business case. Where very large sale procurement is required in order to justify investment, a pan London AHSN or even a Network of Networks approach may be necessary. Investments in this area may include, for example, telecare and telemedicine systems.

(iii) Supporting iTAPP, where partner organisations are from Industry

The Network partners will match the areas of clinical focus with the inventory of iTAPP innovations to identify potential areas of collaboration. The initial focus will be on those innovations with an existing good evidence base that have already been launched and tested. The second priority will be to evaluate supporting those that have the potential to improve health outcomes and lower the system delivery cost.

	Priority		
	Low	**Medium**	**High**
Benefitting population	<250 k	>250k	>2.5m
Net financial savings	<£250k	>£250k	> £2.5m
Deployment timescale	3 years	2 years	1 year

(iv) Working with local economic development partnerships

We will align our priority areas with the opportunities for local economic development through our health and social care partner organisations.

Specific examples of best practice:

- **Guys and St Thomas' Caesarean Section Simulator partnership with Adam Rouilly**

Developed an emergency cesarean simulator to help train doctors to perform complex C-sections. During emergency cesareans in advanced stages of labor, the baby's head can get stuck in the mother's pelvis – a potentially life-threatening situation for both mothers and babies. Designed by the Guys and Thomas's Team and produced and manufactured by Adam Rouilly Company.

Specific programmes and KPIs: We will facilitate at least one co-created procurement programme each year. We will support the launch of at least two new SMEs over the 5 year period of our licence. We will measure the increase in employment numbers in the organisations with which we will have a strategic relationship. We will support at least 2 iTAPP technology procurements. Supporting at least one UK SME/start up in each year of the programme. Early discussions have taken place with a number of small to medium size enterprises. For example, Optima-life provides an objective and personalised understanding of human wellbeing, resilience and performance and centres on a technology that maps physiological response (autonomic activity) against behaviour. It is has been used in multiple areas ranging from cancer survivorship, to workforce to elite sport.

5. High Impact Innovations, NICE Guidance and iTAPP

5.1 Six High Impact Innovations for Healthcare

Background
Innovation Health and Wealth identifies the rapid acceleration of the use of high impact innovations as a key objective. To reinforce this, from April 2013, compliance with these will become a pre-qualification requirement for CQUIN.

The six high impact innovations

3 million lives initiative	Aim is to spread the use of telecare and telehealth across the country to improve at least 3 million lives over the next five years.
Oesophageal Doppler monitoring ODM	A minimally invasive technology used by anaesthetists during surgery to assess the fluid status of the patient and guide the safe administration of fluid and drugs.
Child in a chair in a day	Ambition is to get disabled children into a wheelchair appropriate for their needs within one day (for example, the Whizz Kidz model)
Digital by default	Currently face to face contact accounts for nearly 90% of all healthcare interactions; every 1% reduction in face to face contact saves up to £200m. Reduction in inappropriate face to face contacts utilising email and internet technologies is identified as a priority
Carers for people with dementia	Carers save the public £6 billion every year. NHS must commission services to support people with dementia, in line with NICE guidelines.
International and Commercial Activity	Exploration of opportunities to increase national and international healthcare activity

Snapshot of status of implementation within South London

CCGs across South London have been active in supporting the adoption of the six high impact innovations. The following table gives examples which indicate approach and progress across the sector.

High Impact Innovation	South West London	South East London
3 million lives	60 telehealth kits are deployed by community service providers in Wandsworth for patients with heart failure and patients at risk of an immediate admission. Merton has approved a business case for the 100 Telehealth kits for patients with COPD or Heart Failure	Telephone coaching to support self-management of LTCs being piloted in Southwark and Lambeth. Lewisham NHS Trust has 92 patients with COPD or Heart Failure on telehealth kits. Video consultation equipment for recording blood pressure and blood glucose and then engaging with clinicians through a videoconference link. GSTT Paediatric ENT Nurse specialist telephone clinics to reduce ENT follow ups. KCH has pioneered the use of home telemetry monitoring for epilepsy patients
Oesophageal Doppler Monitoring	Commissioners to review progress at next Hospital Clinical Quality review Group	South London Healthcare has met the ERAS target for colorectal surgery. Lewisham NHS Trust; colorectal, major gynaecology and orthopaedics surgery (in Enhanced Recovery Programme). GSTT has already implemented this in colorectal surgery with eight machines in use
Child in a Chair in a Day	Commissioners to establish a plan of action across SWL with the service provider	A review of wheelchair services in Lambeth, Lewisham and Southwark has been completed.
International activity	Kingston CCG sponsored the treatment of 50 Libyans in the UK following the recent conflict	KHP and Tropical Health and Education Trust partnership formed in 2010 to support international partnerships for global health. UCSF in US emerging as a strategic partner. Global Health is a strategic initiative for KHP. Global Child Dental Fund has helped around 20 million children. GSTT - primary care services contract for the British Forces in Germany and secondary care back in the UK.
Digital by default	Wandsworth CCG has developed a portfolio of electronic services to aid GPs in reducing out-patient	Health Vault initiative between Microsoft and SLAM. Lewisham NHS Trust; SMS messaging to remind patients of

	attendances. Kingston Hospital working with primary care on electronic consultations in gynaecology. Merton has implemented an ECG service in general practice hubs to reduce unnecessary cardiology outpatient appointments	appointment and surgery. Digital Clinical Correspondence implemented in inpatient areas. DocMan document management system implemented in GP practices.
Carers for people with Dementia	Sutton and Merton have increased investment for carers to £1mm, with NICE guidelines compliance being a contract requirement	Memory Services being rolled out across the region in collaboration with SLAM. Lewisham received a Care Integration Award in 2012. Includes RemPod pop up 1950's living room. GSTT; all carers who present to the Southwark & Lambeth memory Service are assessed for carer stress

Future initiatives for the AHSN:

- We will work with the lead commissioning groups to identify existing initiatives in our clinical focus areas, and to encourage the wider adoption across South London
- We will work with the DoH, Institute for Innovation and Improvement and other AHSNs to identify initiatives outside South London from which our network can benefit, and support the adoption of these
- We will work with the Shaftesbury Partnership and FranchisingWorks to evaluate an innovative business model for replicating high impact innovation, referenced by David Cameron in his launch of the Big Society Capital in April 2012.
- We will work with the Hurley Group to evaluate telehealth initiatives specifically for video consultation, protocols for consulting on line platform and for the primary and secondary care interface to reduce hospital admissions.

KPIs for success:

We will measure the progress of each of the high impact innovations across all 12 South London boroughs to identify year on year progress.

5.2 Supporting the Innovative Technology Adoption Procurement Programme (iTAPP)

Background

Established by the DoH, The aim of this programme is to help the NHS to adopt innovative medical technology to improve quality and raise productivity and specifically to raise over £1bn in efficiency savings across the NHS by 2015.

Current Status of The South London AHSN and iTAPP initiative
South London has been represented by the SL HIEC on the London iTAPP board, chaired by Fiona Carragher and there has been some progress in the identification of appropriate iTAPP technologies. Two groups of technologies were identified and clear linkages made to pan-London priorities such that those chosen would support innovative working and service redesign leading to improved patient outcomes.

- Doppler guided intra-operative fluid management system; embedded in the London Enhanced Recovery Programme
- Community Diagnostic technologies: NT Pro-BNP, Finger prick HbA1c, Urine microalbumin.

Specific future initiatives:

- The AHSN will work with NICE (which will take over the responsibility for iTAPP from NTAC) to match its areas of clinical focus with the inventory of iTAPP innovations to identify potential further areas of collaboration. The initial focus will be on those innovations with an existing good evidence base that have already been launched and tested (Level 3). The second priority will be to look at the Level 2 technologies and identify any that may be of value in our clinical focus areas, and the opportunity of collaboration to establish a robust evidence base for wider adoption.
- Work with The London Scientific and Diagnostic Network to support rapid adoption of the national chosen technologies.

KPI measures:
During the first 100 days of the operation of the AHSN, we will work with NICE to identify technologies that have relevance to our clinical priority areas. Where appropriate, we will identify at least one technology per annum to commercialise further within the Network.

5.3 Status of NICE Guidance

Status in London
NHS London's Medical Director has written to all London's hospital chief pharmacists to remind them of their responsibilities and to ask about their processes for automatic inclusion of NICE Technology Appraisal (TAs) guidance in hospital formularies and, specifically about the inclusion of ticagrelor. Of the 17 Trusts responding to date, all reported that processes are already in place for automatic inclusion of NICE TAs or that they are actively amending their processes to make this the case. 10 trusts confirmed that ticagrelor was included in their formulary, with others reporting that it was not relevant (i.e. they did not undertake percutaneous coronary intervention (PCI), or they are a mental health or a children's trust).

All trusts have a formal governance process for NICE guidance, including a formal system for follow up of NICE recommendations to ensure implementation. This is reported and reviewed at the Trust Risk, Audit and Quality Committees and reports are submitted CCGs and, where appropriate, to the CQC

Specific Future Initiatives for the AHSN

- Support the incorporation of NICE technology appraisal recommendations into relevant NHS formularies in a planned way and the NICE Implementation Collaborative (NIC) when formed, to encourage the local implementation of NICE guidance.
- Leverage **the Memorandum of Understanding** between King's College London (and KHP) and the National Institute for Health and Clinical Excellence (NICE) to build upon the research, teaching, service development and capacity building activities currently undertaken by both organisations with the emphasis on new research that will benefit local, national and international populations
- Leverage **A**ppraising **G**uidelines **Re**view and **E**valuation **(AGREE)** expertise at KCL (Professor Peter Littlejohns)
  This is an on-going international research collaboration seeking to improve the impact of clinical guidelines in translating research in to practice. There is an active website (now run from Canada) which encourages the use of the AGREE instrument.

6. Clinical Themes

South London Academic Health Science Network has identified 4 initial priority themes for development and improvement work.

1. Diabetes
2. Dementia
3. Musculoskeletal
4. Alcohol

The choice of clinical themes has been informed by a number of factors, including :

- The Public Health needs of the 12 boroughs (based on Joint Strategic Needs Assessment analysis
- Commissioning priorities as included in Commissioning Strategy Plans across South London.
- The priorities put forward by South London stakeholders at our engagement events
- A range of clinical areas at very different stages in the journey of innovative new models of care (for example, Diabetes has an impressive selection of well evaluated initiatives to draw on, whereas MSK has a much less developed evidence base).

In addition to the four identified areas we recognize the importance of Cancer as a significant public health issue. However, improvement programmes in this area will be led by newly formed London Cancer Alliance, and the AHSN will need to develop strong collaborative links with the LCA and support its work as appropriate.

The illustrative examples given below give some of the further rationale, and set out existing good practice and innovative care, as well as emerging approaches to dissemination and spread. As each of these areas develops more concrete plans and proposals we would expect them to focus on a small number of objectives, with measurable outcomes, which are :

- High impact
- Evidence based
- With clear and available outcomes measures

A good illustration of this approach is the London Respiratory Team's work on COPD (in which key South London clinical leaders have been involved). The focus of this team is on achieving improvements in:

1. access to pulmonary rehabilitation
2. use of inhalers
3. use of oxygen
4. smoking cessation

6.1 Diabetes

Stages 1– Prioritisation

Clinical case

- Diabetes in South London has a higher prevalence than the national average (100,000 have been diagnosed with Type 2 diabetes) and is rapidly increasing (2.4% p.a. growth forecast) because of rising obesity, unhealthy lifestyles and local ethnicity. Childhood obesity and paediatric diabetes rates are amongst the highest in the country.
- Joint Strategic Needs Assessments across the region have identified diabetes and childhood obesity as priority areas for population health improvement (e.g. in Wandsworth 20.9% and in Croydon 23.3% of year 6 children are classified as obese).
- There is unacceptable variation across South London with regard to access to services for people with diabetes (e.g. in detection rates, self-management, access to structured education and complication rates) and also considerable variation in childhood obesity rates.
- It is estimated that 1 in 4 people with diabetes (i.e. 45,000 people in South London) do not know that they have the condition and these people are at significant risk of developing long term complications.
- Undiagnosed or poorly managed diabetes can lead to long term complications affecting the kidneys, eyes and feet, and can lead to mental health problems. Early intervention with newly diagnosed patients significantly improves outcomes and reduces complications.

Economic case

- Spending on diabetes accounts for approx 10% of the NHS budget (and will grow unless treatment of this long term condition is improved).
- Across South London, it is estimated that direct spend is over £100m, majority of costs being in preventable treatments for the complications arising from diabetes.
- People with diabetes occupy 15-20% of hospital beds and the cost of IP care for someone with diabetes can be up to five times more than for a person without the disease.
- An incentive for GPs to reduce HbA1c (3 month blood glucose) can provide significant savings. (Research shows a 1% reduction in HbA1c leads to a 37% reduction in micro-vascular complications, i.e. as kidney disease and blindness, a 43% reduction in numbers of amputations and 14% reduction in heart attacks. It also cuts the number of overall deaths related to diabetes by more than 20%)

The SE Boroughs in London in particular have a very high ethnic population and the incidence and morbidity and mortality related to Diabetes is high. This makes it an ideal national testing ground for innovation in diabetes care, from a population health and social cost perspective. Additionally, it is an attractive testing ground too for Industry for designing their products and services – access to relevant population data to help design appropriate services and access to the population to test the effectiveness of products and services

Stage 2 - Case for Change

There are existing innovative and cutting edge projects relating to Diabetes care across South London, but these at present only represent pockets of good practice. It is our ambition to take the best of these innovations and scale them to allow access to the best care for all of our population..

Good practice examples

(i) NHS Bexley

"This is the most impressive application of QIPP I have seen anywhere in the country"
David Colin Thome, National Clinical Director for Primary Care

This approach to care planning co-created with Diabetes UK puts people with diabetes firmly in the driving seat of their care, and supports them to self-manage. This is delivered through annual review consultations which focus on joint decision making utilising shared data, as well a comprehensive patient education programme for people with type 2 diabetes. In addition, training for professionals increased awareness and confidence in managing this group of patients, such that insulin regimes – previously only initiated in hospital – are being started by GP practices.

Outcomes

The programme achieved its target of reaching 50 percent of people with Type 2 diabetes who are in the first year of diagnosis Average HbA1c reduced from 8.4% to 7.1% 6 months post X-Pert, twice as good as the national average improvement. Average cholesterol reduced from 5mmol/l to 4.3 , three times better than the national average. Bexley has seen the biggest reduction in HbA1c in the UK, hundreds of patients transferred to primary care and the introduction of care planning at eight out of ten GP practices. Around 10% of patients have become expert patients to provide further support for uptake of structured education.

(ii) Diabetes Modernisation Initiative in Lambeth and Southwark

The Modernisation Programme brings together acute, community and public health services in an integrated care initiative funded by the Guys and St Thomas' Charity. The overall aim is to support patients to 'live well with diabetes', and the approach is characterised by a strong patient voice, patient education and peer support (particularly for ethnic minority groups).

Goals include:

- To increase early detection rates from 60% to 80%
- To achieve a 70% uptake of self-management training for every newly diagnosed diabetic
- To attain 78% of all diabetic patients achieving controlled HbA1 (blood sugar) and blood pressure control.
- To increase care provided in GP practices by 50% and reduce hospital out-patients by 50%
- To reduce avoidable emergency admissions by 20%.

Specialist diabetes clinics have been established in the two boroughs to support GPs (agreed with Clinical Commissioning Boards) and nearly 800 patients have had their care transferred from acute care.

(iii) 3 Dimensions of Care for Diabetes (3DFD) by King's College Hospital NHS Foundation Trust

Many people with persistent, poorly controlled diabetes also have psychological and social problems that impinge on their ability to manage their diabetes care effectively. 3DFD is a service that fully integrates medical, psychological and social care for them. The overall aim is to improve diabetes control, quality of life and quality in care with associated cost efficiencies.

Objectives of this study

- To improve glycaemic control and unscheduled care in the short-term
- To reduce complications in the long term for people with complex diabetes (persistent poor glycaemic control and multiple social and psychological problems) over 12 months.
- To improve psychological functioning and social welfare for this group with complex diabetes over 12 months

(iv) NHS Greenwich

Second place QiC award: Systematically Improving the Outcomes of Prevention in Primary Care by Greenwich Public Health NHS South East London

In 2008 people living with diabetes in Greenwich had some of the poorest outcomes in the country as measured through QOF. The Goal 2 programme was launched to develop a systematic approach to prevention in primary care, including structured cardio-metabolic risk management and continuing professional development. Estimated savings since the programme was commissioned for all Greenwich practices are £731,688.

(v) - Wealth Creation and Partnering with industry - King's Health Partners Changing Diabetes Project in Partnership with Novonordisk UK

The ambition of this project is to co-create a world-recognised centre for diabetes care, research and education: developing and delivering the most cost effective, highest quality care, ensuring optimal outcomes to patients.

Expected outcomes and benefits to patients are:

- To develop, design and deliver integrated diabetes care across the KHP area, for optimal cost-effectiveness and outcomes
- To establish clear, costed, evidence based, quality controlled pathways for all diabetes patients, with medicines used appropriately to deliver optimal outcomes
- To create an infrastructure for supporting innovation and expanding research portfolio & patient participation in clinical trials

Expected outcomes and benefits to Novo Nordisk are:

- To articulate an integrated model of care to maintain high quality diabetes care, research and education, which can be adapted and implemented in other markets
- To generate end-to-end patient and cost data
- To position Novo Nordisk as a partner of choice in developing diabetes solutions
- To develop a diabetes care model that facilitates set-up and recruitment for clinical trials, for both the benefit of patients and Novo Nordisk business

We will use this agreement as a basis for developing framework agreements for collaborations between Industry and the Network.

Stage 3 – Designing the Model of Care

The local examples of good practice described above provide a really strong foundation upon which to develop evidence based models of care for Diabetes across South London.

The Model of Diabetes Care for South London builds on the Healthcare for London recommendations and has six strategic principles:

1. The 'voice of the patient' shapes our programmes, particularly as hard-to reach and high-risk populations are targeted (building on work of the HIEC)
2. Early detection and identification of people with diabetes is essential, as is the early detection of complications arising from diabetes
3. Individualised care plans with patients at the centre supported by education programmes for clinicians and healthcare workers
4. Effective self-management of diabetes is vital, supported by structured patient education
5. Integrated care across all organisational boundaries, with care managed away from hospital setting wherever possible
6. Service model underpinned by effective quality assurance, evaluation and performance monitoring

In addition to effective diagnosis and treatment, we will also focus resources on prevention, and for example, childhood obesity is also an area of focus in this clinical theme.

In this Model of Diabetes Care education and training activities are already integrated, and there are good best practice examples within the network that can be leveraged and spread more widely. Additionally, we will plan for further alignment with research activities with the network.

Examples of Education and Training Expertise

- **Depression in Diabetes**, South London HIEC; Diagnostic E-Learning package for clinicians in all settings (to improve the treatment and referral of depression in diabetes, identified as a significant factor in poor diabetes control).
- **Self-Management** for people with type 2 diabetes, south London HIEC; course and e-learning module (to train people to manage their own condition).

Basic and Translational Research Experience

- NIHR funded study on the impact of psychological and social factors on diabetes outcomes, recruiting nearly 2500 people
- Working with the Health Foundation, in developing ways of helping people with diabetes achieve better health, making use of the segmentation models
- Obesity is a major risk factor for Type 2 Diabetes. Working with colleagues in neuroimaging Professor Amiel's group have suggested how insulin resistance may alter appetite control. A new project funded by the Diabetes Foundation investigates how successful obesity surgery alters the brain's response to eating. The ultimate aim is successful, non-surgical obesity prevention and treatment.
- New methods of treating type 1 diabetes are being developed. KHP has been working on the pioneering technique of islet transplantation.
- Kings College London is also home to one of the three UK centres funded by the Juvenile Diabetes Research Foundation to investigate the causes of Type 1 diabetes.

The model of care also requires a supporting **Informatics** plan, and, for example, NHS Bexley has developed the Vision VE form for extraction of patient data from GP practices.

Stage 4 – Implementation

The first focus for our implementation programme is the wider geographic spread of existing best practice with a good evidence base across South London

- The NHS Bexley self-management programme
- The Diabetes Modernisation initiative

This supports the building of primary and community care capacity and capability for the early identification of and treatment of diabetes and the complications of diabetes and a delivery system that supports self-management.

The second area of focus will be on the adoption of existing innovations in the network and the collection of an evidence base to support their spread

- The Depression in Diabetes E-learning module for GPs, clinicians and healthcare workers
- The Self Management E-learning module for patients with type 2 diabetes.
- The Diabetic Retinopathy Screening E-learning package for GPs and practice nurses

The third area of focus will be on translational research and the identification and development of appropriate innovations from Industry ; aligning activity with population health needs and bringing the fruits of this research into our service models

- The 3 dimensions of Care for Diabetes
- Framework agreements for collaboration with key industry players, building on the KHP Norvonordisk agreement.

Stage 5 – Outcomes measurement

Reducing variability of outcomes across South London is a key aim of the future work programmes. There are already well established outcome measures for diabetes, and one of the first tasks of the network will be to identify a core set for tracking across South London so that reduction variation can be measured over a 5 year period. These will reference the Outcomes Framework for the NHS, Public Health and Social Care and are likely to include:

- Number of newly diagnosed patients
- Rates of retinal screening
- Average HbA1c blood glucose levels in diabetic patients
- Uptake of structured education programmes for self-management
- Uptake of minimum standards for care planning
- NICE guidance data set measurement in primary care
- Patients initiated on insulin regimes in primary care
- Rate of emergency hospital admissions for people with diabetes

6.2 Dementia

Definition and approach

Dementia is one of the biggest challenges facing health and social care today. Research in dementia has advanced significantly in the last 15 years; however it is significantly underfunded when compared to research in cancer and cardiac care. People with dementia, and their carers, still face a lack of understanding about their condition and the challenges they face across public services, businesses and society as a whole. The AHSN has identified the dementia pathway as a key health and social care priority and the approach to this is outlined below. It is clear that the following roles will also be needed to ensure success:

- Strategic vision to deliver change
- Strong programme and project management
- Clinical leadership
- Senior buy-in
- Strong governance structure

Service Improvement model

Stage 1 - Prioritisation

Dementia is most common in older people with the age related prevalence at 1 in 100 65-69 year olds 1 in 25 70 –79 year olds and 1 in 6 80 years + (Alzheimer's Society 2012). In England in 2012, 670,000 people have dementia and this number will double in the next 40 years (Alzheimer's Society 2012). [2]It is estimated that 36% of people living with dementia are placed in care homes with the proportion in care rising with age (Alzheimer's Society 2012). In addition approximately two thirds of people in acute hospital beds are over 65 years with around 30% of them suffering with dementia (Alzheimer's Society 2012). Among the over-55s, dementia is feared more than any other illness. The Prime Minister's challenge from 2012 which builds upon "Living well with dementia: a National Dementia Strategy" from 2009, outlines that there is not only a moral imperative to improve dementia care – there is a strong financial one too. It is estimated there is a cost of £19 billion a year related to dementia; therefore the cost to our economy at large is huge. It is estimated that this is higher than the costs of cancer, heart disease or stroke combined.
The analysis of the Joint Strategic Needs Assessments demonstrates that dementia is already widely identified as a key health and social care priority across South London. Equally, the impact of an ageing population in South London also referred to earlier, cements the need for the AHSN to continue to build upon work started within the field of dementia care.

Expertise

There is considerable expertise across the health, social care, voluntary and educational organisations within South London. A number of work programmes including the South London HIEC have made progress in disseminating best practice in relation to dementia treatment and care.

[2] Prime Minister's challenge on dementia, 2012.

There is however, still work to be done in strengthening collaborative relationship with key stakeholder and strengthening uniformity. The range of Dementia expertise includes:

- **Institute of Psychiatry (IoP),** King's College London– the IoP is Europe's largest centre for research and post-graduate education in psychiatry, psychology, basic and clinical neuroscience. The Biomedical Research Centre (BRC) and Old Age Psychiatry Department work hard to advance research on dementia internationally as well as providing clinical and academic leadership across South London. The portfolio of current research includes investigation of the basic cellular and molecular biology of dementia, discovery of novel biomarkers to aid diagnosis and prediction of disease course, investigation of the underlying brain changes that accompany cognitive and non-cognitive symptoms and clinical trials to evaluate efficacy and effectiveness of therapeutic interventions.
- **King's Health Partners –** The Academic Health Science Centre (AHSC) in collaboration with GSST, KCH. SLaM and KCL has set a central mission of linking physical and mental healthcare in an integrated way. Dementia is identified as a key condition that will benefit from this approach.
- **Mental Health Trusts** – South London has three mental health trusts:
    - Oxleas NHS Foundation Trust
    - South London and Maudsley NHS Foundation Trust (SLAM)
    - South West London and St George's Mental Health Trust (SWLStG)

  These trusts run many services across South East and South West London such as:
    - Memory services – the first service set up in Croydon was a national beacon site. These services are integral to the delivery of the National Dementia Strategy. The role of such services is to ensure early detection and diagnosis of dementia whilst supporting people to live well with the disease, enhance coping strategies and make choices about future care plan needs.
    - Acute hospital Dementia & Delirium teams and mental health liaison psychiatry teams which provide rapid assessment and consultation for older people with mental health problems and/or dementia.
    - Challenging behaviour service – this is run by SWLStG in Sutton and Merton offering offer alternative treatments to help people with dementia and behavioural problems. In the specialist Challenging Behaviour Service in Sutton and Merton, less than one third of its patients with dementia living in care homes are on antipsychotics despite the service helping those with the most severe of difficulties. Other service provision includes inpatients specialist care units that are located in the community.
    - Home Treatment Models of Care across all mental health providers. SWLStG are the most experienced provider and are sharing their knowledge with SLaM who has recently developed a service. These services manage mental health crisis at home and prevent admission. Research suggests that keeping people with dementia in their own homes for as long as possible can prevent reductions in global functioning.
- **Primary care** – is integral to providing better screening detection and proactively managing long term conditions. Lead GP for dementia and old age mental health have been identified

for local Borough's in preparation for GP commissioning and there are shared care protocols across all SLAM boroughs for example.

- **South London Health Innovation and Education Cluster (HIEC) –** the sunset review of the HIEC identified that their dementia work stream had focused on reducing the inappropriate prescription of anti-psychotic drugs and achieving an earlier diagnosis of dementia. The Dementia Training Centre will play a vital role in the improvement of workforce capabilities across dementia care providers at whatever stage of the disease. The HIEC has also developed a strong collaborative network of practitioners across South London, which can be built upon for future developments. The HIEC has focussed its attention on raising awareness about dementia, through mediums such as its website.
- **NHS London –** Has funding from DH from March 2011 until March 2013, for a Dementia Programme which is led by a Dementia Programme Manager, working across the whole of London focussing specifically on decreasing antipsychotic drug prescribing, and facilitating training programmes for staff in acute hospitals, community/mental health trusts and for GPs.

Rationale

It is clear that the SL AHSN has the potential to disseminate best practice and provide high level impact on the person with dementia experience of treatment and care across the care pathway continuum which will be underpinned by the across the tripartite mission. The work done so far can form the foundations to provide some quick wins initially, and as the network structure is further developed, provide a long term capability to look at larger scale change in the future. This crucially will include models of care that will release money spent on high cost acute and mental health hospital care can be reinvested in:

- building on the current models of early intervention
- crisis resolution interventions delivered where the person lives
- evidenced based model for that educated care home staff that bring direct benefits to patients
- Supporting primary care with the safe and effective management of dementia
- Supporting with dementia to live in their homes for as long as possible
- Evidence based dementia training for acute care

<u>Stage 2 - Case for change</u>

Variable clinical models

The case for change requires considerable co-ordination work to take place across the AHSN related to dementia, as the impact of dementia care is felt at many points along the patient pathway e.g. acute care, primary care, community care etc. The key organisations involved specifically in dementia care are outlined above, yet there is some variation in the type, level and geography of service provided by each of these institutions (for e.g. memory services are run by all but some are longer established and more embedded).

Also, there is variance in the management of dementia in acute hospitals across South London and the training that staff receives. The RCP national audit of general hospital care for people with dementia provides a clear case for consistent approaches to care delivery, governance structures and staff training that ensures that patients experience person centred care.

Additionally we need to improve care for patients living with dementia at home so that they can stay in their own environment for as long as possible. With care homes also there is a need to improve the management of non cognitive symptoms of dementia (psychosis, mood disorders and behavioural problems). We also need to ensure that care home staff fully understands what a diagnosis of dementia means to the person, their experience of care and the challenges communicating their needs. This would include building on the best practice of the Sutton and Merton model across South London and ensuring that prescribing practice reflects the current evidence base

The AHSN will audit current good practice and innovation to ensure the current dementia pathway and dementia service provision is mapped for the whole of South London, whilst being clear about the care pathway itself. A consensus about what constitutes the pathway (building upon the NHS London guidance from 2010) will be determined across the network so that service users and carers are clear about what to expect and experience.

Robust evidence of good practice

Our researchers have developed and evaluated the impact of services that improve outcomes for people with dementia. For example, the Croydon Memory Service has served as an exemplar service in the delivery of accessible high quality dementia diagnoses. Our work to identify the risks associated with the prescribing of antipsychotic medication for people with dementia and the development and evaluation of drug and non-drug interventions to manage behavioural symptoms has had international impact and has influenced DoH and NICE guidelines. We are currently engaged in leading multi-centre clinical trials of the effectiveness and cost-effectiveness of assistive technology in the domiciliary care of people with dementia and potential disease-course modifying drugs for Alzheimer's disease.

Therefore, one of the key objectives for this clinical priority area is to ensure that work already started on decreasing the use of antipsychotics, raising awareness and levels of training, and focussing on improving the management of dementia in peoples' own homes and within care homes, is built upon.

The network will build on the developments around interfaces with physical health and dementia to ensure that acute hospitals deliver high quality dementia care and work effectively with mental health trusts to manage co-morbidity. The work in relation to the KHP integrated care pathway for people who are elderly and frail provides an excellent platform to conduct research for developing evidence based practice for this complex issue. This interface is also very important when considering emergency care.

Whilst there is a role for safer prescribing for non cognitive symptoms of dementia for some patients, the network needs to develop an improved body of knowledge in relation to psychological interventions and models of direct care delivery for people with dementia. The Merton and Sutton challenging behaviour service, which is based on the Newcastle model is a basis for further investigation to provide academic rigour.

Further research is required to develop frameworks of care that builds on the work about person and relationship centred dementia care and recent examinations of relationship centred care – the current subject of an NIHR Programme submitted from KHP.

Finally, the development of future training models for dementia care must be evidenced based and move beyond participant satisfaction to measurable patient outcomes. Currently there is a very limited evidence base about what training interventions directly improve dementia care.

Stage 3 - Define best practice & model of care

The Scope of the model of care is extensive including:

- Increase public awareness of dementia
- Ensure early intervention and diagnosis – working on the interface with primary care
- Reduce the prescribing of anti-psychotic drugs
- Ensure person centred acute care
- Improve the management of non cognitive symptoms of dementia – working on the interface with care homes
- Training – training needs to extend to enable those working in the field to provide person centred care – potential to extend to community organisations and faith groups to raise public awareness

All the above factors will ensure an integrated care pathway that provides effective mental health, physical health and social care – supporting self management and well-being for as long as possible. As dementia progresses in the majority of cases the person requires a higher level of treatment and care due to dependency and the stress placed on carers. All services must provide safe and effective person centred care that values the person and is respectful and dignified. End of life care will be seamless and supported by primary care, social services, acute care, mental health trusts, charities, the independent sector, and community based pharmacists

This scope for the “model of care” encompasses the best practice and models of care already outlined in:

Living well with dementia: a National Dementia Strategy (2009)

- Improving services and support for people with dementia – Audit from the National Audit Office 2008
- The PM challenge on dementia – creating dementia friendly communities, and improving dementia research (2012)

- NICE clinical guidelines – Dementia: Supporting people with dementia and their carers in health and social care, Royal College of Psychiatrists (2012) National Audit of Dementia
- DH (2010) Personalisation through Person Centred Care Planning
- Royal College of Psychiatrists (2012) - National Audit of Dementia

Multi agency involvement for example with the Alzheimer's Society, Age UK, GPs as commissioners, social services and others is required to improve dementia care and ensure that cities are dementia friendly, screening and detection improves, and Relationship Centred care is provided for dementia patients, particularly in care homes. The AHSN will set up a patient and carer panel to link in with dementia healthcare professionals to help achieve the work of treatment and care pathways within the AHSN.

Stage 4 - Implement model of care

Implementing the model of care outlined above would require taking advantage of some quick wins, for example:

- Ensure all member organisations are aware of training programmes developed by NHS London and South London HIEC (acute, community, GP development), and that these training modules are rolled out across the AHSN
- Incentivise trusts and primary care to continue work on dementia by encouraging the uptake of CQUINs (both in mental health trusts and acute trusts) around antipsychotic drug prescribing and training

There are also a number of medium term work streams that need to be delivered to ensure the network model of care is sustained:

- **Partnerships** – some of the issues around implementing better practice in dementia are boundary issues, around discharge and referral information and communication – working across organisational boundaries is essential. This can be achieved by linking to the Integrated Care Programmes work for the frail and elderly in south London.
- **Raising public awareness** – by partnering with private marketing experts we will launch a whole programme of marketing and campaigning to raise awareness and secure patient, carer and public involvement for the long term future of the AHSN.
- **Evaluation** – this will be implicit within each work stream to ensure that changes in dementia care demonstrate better patient and carer reported clinical outcomes.
- **Joint commissioning –** across health and social care to enable improvement for e.g. integrated memory services in every borough of south London such as currently found in Lewisham
- **Network approach** – we will build leadership skills; improve training and implementing dementia champions. This will be more than just training - we will build leadership skills and the inclination for people to continue to improve dementia care. The AHSN will facilitate a network, and "train the trainers", meeting regularly bringing together acute and community champions, having seminars on specific areas of dementia care for e.g. nutrition, SLT, end of life care, managing challenging behaviour.

- **Building on the NHS London GP development programme** – we will develop GPs with special interest with linked development programmes to academic institutions. This approach is supported by the Royal College of General Practice and mental health trusts. Future developments will include building the capability of GPs to manage challenging behaviour in dementia and effective prescribing potentially.
- **Liaison** – evaluate new ways of commissioning physical and mental health liaison services that are sustainable.
- **Informatics** – Ensure joined up thinking around Information for e.g. NHS London's dementia project will be developing a dementia template this year to include in the Marsden's "Co-ordinate my Care" system. There is potential to link with this and support implementation throughout the network to tackling this issue of information sharing between organisations.

The key aim of the AHSN is to ensure that dementia care is provided within a comprehensive, cost effective and sustainable network. Additionally the AHSN will ensure work already done on dementia care is sustained, and used as a basis for further improvement.

Stage 5 - Outcomes measurement and evaluation

There will be a detailed outcomes framework of clinical and patient reported outcome measures, and economic and efficiency measures to monitor/evaluate progress. These will include measures such as those outlined below, which are currently indicative examples:

- 40% increase in GP's using the mini mental state on patients reporting memory problems to support onward referral to a memory clinic
  Quantified from GP's reporting mini mental state score in their referral to specialist services
- 35% reduction in the number of people with dementia living in care homes being presented to A&E due to behavioural and psychological symptoms of dementia
  Quantified by referral data from liaison services using a brief audit tool
- 40% reduction in the prescribing of anti-psychotics to people with dementia living in care homes
  Quantified from GP consortia prescribing data
- 45% reduction in people with behavioural and psychological symptoms of dementia who live independently or in care homes being referred for inpatient psychiatric assessment by their GP
  Quantified by data reports from relevant organisational data systems on where patients came from before admission and referred by whom
- 50% increase in the number of people with dementia living in care homes who have a life story document and person centred care plan completed
  Quantified from self reporting survey data competed by care homes

6.3 Musculoskeletal

Definition & Approach

There are many conditions that make up MSK, however, for the purposes of this bid we have chosen to focus on four key areas:-

- Elective orthopedic surgery - because 25% of surgical interventions within NHS are for the treatment of MSK, demand is rising, there is still variation in outcomes and some procedures need to be reviewed for effectiveness.
- Regional pain syndrome - because 30% of GP appointments are for general benign MSK conditions and the current triage models designed to manage demand have not been formally evaluated.
- Inflammatory disease (including Rheumatoid Arthritis) - because early diagnosis and compliance with treatment regimes are critical to improved outcomes.
- Falls (fractured neck of femur) - because best practice in fractured neck of femur pathways and falls prevention is still not consistently applied across South London.

Service Improvement Model

Stage 1 – Prioritisation

Main rationale for the choice of MSK is:-
a) Expenditure within local health economy
b) Impact on overall economy due to pain and disability in working-age population
c) Encompasses priorities within the NHS Outcomes Framework (Domains 2 – 5)

This is supported by the following facts:

- MSK has the third largest budget in the NHS after mental health and cardiac health and is the leading cause of disability and time off work for sickness worldwide.
- 25% of surgical interventions within NHS are for treatment of MSK
- In 2010 there was a 300% increase in TKR compared to 6 years ago with a 92% rise in revisions.
- 30% of GP appointments are for MSK and yet a trainee GP might only have 5 weeks of specialist orthopedic teaching.
- Increased public demand arising from expectations of an active retirement, increase BMI and people generally living longer (23% of the population will be over 65 by 2035).
- Demand for joint surgery is rising (demographic and lifestyle changes); longer implant survival rates, more surgery at younger age; variation in outcomes (infection rates and revisions).

This is set in a context of an economic downturn in which the NHS is faced with making savings of over £20 billion over the next five years.

In addition, there are established PROMs in hip and knee replacements in the UK. This work programme aims to understand better understand and maximise their value as well as understanding their limitations and building on them alongside other methods with transferrable learning to benefit other clinical specialties.

Activity-related pain reduces mobility and physics function, which are risk factors for the development and exacerbation of many chronic physical (diabetes, cardiovascular disease) and mental (depression) ill-health, and obesity and may also reduce pharmaceutical spend.

Stage 2 – Case for Change

Variable Clinical/Service Models

Whilst there is an established evidence for clinical outcomes in some areas of MSK, these are not consistently applied across South London (for example early diagnosis, waiting times for surgery and fractured neck of femur pathways) there is, however, no systematic evidence base for service models, for example the use of Musculoskeletal Community Assessment Triage (MCAT) and other triages services designed primarily to manage demand. MSK is a diverse set of conditions often not afforded the same status or systematic approaches that are applied to other Long Term Conditions (LTCs) such as diabetes. This bid aims to test the hypothesis that treating MSK as a LTC and front-loading appropriate clinical diagnosis, interventions and self management techniques at an early stage may reap clinical, social and financial benefits later down the line. The AHSN provides a unique opportunity to apply robust analysis and modelling (working in partnership with industry, local authorities, education and employers/ government) to produce the solid data and sophisticated modelling required as the basis for informing commissioning decisions with an aim to produce sustainable impacts over a 3-5 year period. This is in contrast to some of the non-evidenced based quick fixes that have perhaps simply applied a ‘sticking plaster’ to the problem.

High level Description of Current Services

South West London

- There is a range of MCATs/ triage and MSK services, mostly outside of the acute contracts that are locally commissioned.
- All trusts in SW London have orthopaedic and rheumatology services and a falls service integrated to varying degrees with community.
- South West London is facing a major service review (Better Care, Better Value), looking at appropriate future service provision. Any proposed changes in MSK services will need to take account of the implications of this wider reconfiguration.
- The South West London Elective Orthopaedic Centre (SWLEOC) is a dedicated treatment centre for elective hips, knees, and some shoulder and other joint replacement work. It is based at Epsom, which moves Ashford & St Peter’s from April 2013 but is subject to the

overall review of Epsom and St Helier. A review of the effectiveness of the EOC will be part of this work.

- The MSK pathway developments will need to align with changes emerging from the *Better Care, better Value* programme which includes planned care and Long Term Conditions.

South East London

- There is a range of locally commissioned MCATs/ triage and MSK services, mostly outside of the acute contracts.
- All trusts in SE London have orthopaedic and rheumatology services and a falls service integrated to varying degrees with community.
- South East London is facing a major service reconfiguration as part of the of NHS Unsustainable Providers Regime which recognises that changes cannot be made to South London Hospitals without taking into account implications for the rest of that health economy. The Secretary of State is expected to make a decision in February 2013. Any proposed changes to MSK services will need to take account of the implications of this wider reconfiguration.

If this clinical priority is developed into a full work programme of the ASHN more detailed mapping of all existing services would be required to create a baseline, including criteria, outcomes, resource, workforce, compliance with clinical standards, expenditure and current good practice.

The emphasis of this bid is on:-

- Improving patient outcomes
- Wealth creation for the economy – generation of income through joint ventures with industry and innovation
- Cost reduction in areas of limited clinical effectiveness – procedures and models of care
- Diffusion of best practice, aligned to commissioning intentions

Variable Clinical outcomes

There is considerable data to support this analysis, such as the track record of collecting PROMS, and other recognised NICE standards / measures, including waiting times, infection rates, fractured neck of femur standards and falls prevention etc that can be taken into consideration in creating a baseline picture of performance across South London.

Robust evidence of good practice

For a number of the conditions identified there is an established and internationally recognised body of evidence, as well as best practice standards and outcomes defined by NICE and the Royal Colleges.

A thorough horizon scanning review would need to be conducted a into MSK evidence based practice, including standards, outcomes and programme budgets – both nationally and internationally, across public and private sectors. This work could be supported by hospitals' Clinical

Effectiveness departments working collaboratively to share responsibilities (e.g. to lead this work in different clinical priority areas).
Given the body of evidence, the primary objective for this Clinical Priority Area is to ensure that the evidence based standards and outcomes that do exist for MSK are consistently implemented across South London, through a clear framework that is financially sustainable.

Stage 3 – Design of Service Model

Local Initiatives
There are a number of examples of existing good practice in London which can be used to support the cross cutting themes of informatics and communication that will any delivery model Informatics.

Service Models

- The Major Trauma Network for London is nationally recognised, dealing with the relatively small but important severe end of MSK disease. The fact the aspect has been dealt provides valuable learning and enables attention to now focus on the larger areas of MSK business. Two of the four major trauma centres are based in South London – Kings and St George's.
- Musculoskeletal Community Assessment Triage (MCAT) Services and similar triage models are in existence across SW and SE London and require evaluation.
- The Department of Rheumatology at Kings College London (Professor David Scott) has just won a NIHR programme grant to examine further service models for treating inflammatory arthritis taking into account evidence and patient views. This would align to the AHSN.
- The ESCAPE-knee pain research study conducted by Academic physiotherapists in the Faculty of Health and Social Care, St George's University of London, uses exercise to facilitate self management and has sustained health benefits, behavior change and is more cost-effective than usual GP management and outpatient physiotherapy. The programme is currently being assessed by the national QIPP team. This programme is also being applied across a broad range of benign chronic regional pain syndromes, and adapted for delivery via a website. In addition, a bid is being submitted to the NHIR Health Services and Delivery Research Programme to implement and evaluate the model in partnership with NHS providers in South London. This aligns well with AHSN approach.
- The London Health Improvement Board (Mayor of London) has a key priority to tackle the problem of childhood obesity through its Healthy Schools programme. Increase in BMI and lack of activity has a significant impact on the prevalence of MSK.
- The Transformation of Primary Care Programme led by NHS London and acknowledged by the NHS Commissioning Board can be a vehicle for driving improvements to the primary care aspects of the MSK business.
- The London Quality and Safety Programme (London Health Programmes) is leading work to improve compliance with the evidence based guidance on fractured neck of femur pathway.

Academic
King's Health Partners is internationally renowned for its work on Rheumatology, it now benefits from an NIHR accredited Clinical Trials Unit, and leads on PPI in research.

Academic physiotherapists in the Faculty of Health and Social Care, St George's University of London, who developed and implemented the ESCAPE-pain programme run an MSc "Exercise for Health" which takes a broad look at the place of exercise in Public Health, health promotion and policy, and have taught on the MSc in Rheumatology, KCL. They are currently looking at developing new pathways of care for MSK in primary care, and will contribute to research, teaching and training across South London.

Informatics

- Joint Angel, developed by Imperial College London is a free online community for patients to monitor their orthopaedic outcomes post operatively.
- The Hurley Group has developed a Tele Health package which includes webcam and online consultations for common conditions. They also have an online clinical community to support knowledge transfer between clinicians which could be applied to MSK clinical Network.
- The Allied Health Professions MSK Toolkit developed by NHS London.
- The NHS, GLA, London Councils and Londonwide LMCs are joint partners in myhealthlondon (www.myhealth.london.nhs.uk) – a regional online public information service. This is supported by the National Director for Patient and Information as a vehicle for providing transparency about outcome data and enabling patients to be partners in their care through access to self management tools. A citizen engagement platform (November 2012) is available to all 32 London CCGs.

Communication

- London has a history of successful clinical networks, for example the cardiac, stroke, major trauma and cancer and also an established Clinical Senate which will be developed as part of the London Office of the NHS Commissioning Board to support clinical networks.
- The Olympic legacy has a range of initiatives to promote health and fitness including training tools for primary care.

Each of these initiatives can be woven into an overarching framework for MSK in London as key enablers.

Scope of service model
We would anticipate the service model covering the following elements:

Prevention- to develop a cohesive and joined up approach to prevention, e.g.

- Develop a South London public awareness campaign designed to help prevent the onset of MSK conditions and trigger early detection, using the Olympic legacy and London Healthy Schools programmes as a stimulator for increasing participation at an early age in fitness and activity (reducing obesity) – this can be done in collaboration with commercial sector

expertise, e.g. in social marketing to develop simple but effective messing similar to the hand washing campaign and the FAST campaign for stroke.

- Implement support for NHS staff with MSK disorder (Boorman Report).
- To produce a framework for adherence to best practice standards on falls prevention involving potential partnerships with industry, the GLA, Education and the third sector.

Improve early diagnosis and rapid access to the right care first time

Improve rates of early and accurate diagnosis of the MSK conditions defined in this bid and expedite access to the right care/ definite treatment, first time. Evidence shows that early diagnosis and time to definitive treatment, improves outcomes, keeps people motivated to take control of their own disease, reduces complications and enables people to stay for as long as possible in employment and living independent lives.
This could be achieved by:

- The acquisition of musculoskeletal clinical skills by generalists such as GPs and physician through education and training.
- Improved communications - campaigns to drive public awareness of signs and symptoms and the importance of presenting to healthcare professionals early.
- Working with industry to utilize technology to support clinical decision making and improve access to diagnostics tests.

In order to produce accurate modelling and forecasting, the baseline data (prevalence, patient flows, costs etc) needs to be robust. The first 12 months will focus on this activity together with horizon scanning/ market research and engagement with potential industry partners.

Outputs for first 12 months

- To have produced robust data gathering and validation with a comprehensive baseline assessment of how each part of South London currently performs against known best practice standards - key issues/hotspots.
- Commenced formal evaluation of the current MCAT / triage models.
- Established a framework, governance model and formal MSK Network.
- Provide early outputs to inform the Sept 2013 commissioning intentions.
- Commissioned modelling expertise.
- To have mapped existing training/ education, assessed effectiveness and conducted a Knowledge and skills needs assessment.
- Work with the Academic Physiotherapists at SGUL to develop new models of primary care for people with MSK.

Patient requirements

To ensure patients and the public are engaged throughout, using up to date communications and digital solutions in partnership with industry and third sector, the AHSN will.

- Provide accessible information about what patients can expect at each stage of the pathway, including opportunity for patients to be partners in their own disease management through access to online information, shared decision- making tools, patient reported outcomes, Telehealth, and online records aswell as encouraging the participation in research.
- Use digital technology to gather valuable insights and feedback e.g. to have established a public reporting platform/ online health community for MSK building on existing provision i.e. myhealthlondon.
- Work with industry to find effective technology solutions that can be developed at scale to provide more cost effective solutions that complement face to face care.
- Develop a strategic approach to patient and public engagement, including establishing a patient forum.
- Develop of patient information building on that already available nationally regarding research participation and specific trials as appropriate.

New collaborations and ways of working

- Define an evidenced based framework of core standards and outcomes against which all MSK services in South London are commissioned and provided.
- Establish an MSK Clinical Network which acts as the hub of knowledge and expertise to support the implementation/ embedding/ diffusion of best practice, protocols, access to expert opinion, access to training and peer reviews and decisions about procedures of limited clinical effectiveness.
- Establish a framework for education and training building on existing provision. Where education and training is not perceived to be effective or appropriate this work programme will influence changes to commissioning/ de-commissioning i.e. through LETB - for pre-qualifying programmes and also the development of alternative CPD through online inter-professional/ simulator training models.
- Opportunities for more efficient procurement and concentration of resource and expertise. This bid acknowledges the new NHS landscape in which 12 new Clinical Commissioning Groups (CCGs) will operate in South London. Therefore the aim is to deliver an MSK Framework for a value-based commissioning - a package of validated data, research evidence, information, forecast modeling, evidence based outcomes/ standards / thresholds and tools to inform commissioning decisions and allow for some local determination based on the local population/ market requirements.

Stage 4 – implementation

There has been substantially less focus on MSK as a condition than has been the case in areas of national priority such as Diabetes and Dementia. Therefore planning is less advanced and more development is needed in order to design a credible implementation plan.

Stage 5 – outcomes measurement and evaluation

Patient reported outcomes measures would be a key metric for determining quality and acceptability of service provision. There are also number of economic and efficiency measures (e.g. waiting times, theatre productivity, OP new: follow-up) which could also be used to determine whether or not new models of care achieved greater value for the health economy.

The real value of this bid is to work on developing sophisticated and robust data analysis and validation and modelling to test scenarios of applying some of the learning from major trauma (front load high level clinical decision -making, concentrate expertise and resource, time to definitive treatment) and from chronic disease management (self efficacy, case management, lifestyle and behavioural change, patients as partners in their own care). The aim is to design an approach that will over 3-5 years produce sustainable gains in quality and cost.

Further work is therefore required in order to agree specific outcomes metrics and targets, where there is an evidence base and significant patient impact, and where consistent and robust information is available.

6.4 Alcohol

Stage 1 - Prioritisation

Management of alcohol related harm is a national, as well as a local priority. The recently published 'Government's Alcohol Strategy' has sought local, regional and national agencies to become involved in the consultation process to implement a strategy for change.

Alcohol consumption per capita has markedly increased over recent decades. National estimates of the incidence of alcohol use and morbidity per 100,000 people per year include:

- 2,000 people will be admitted to hospital with an alcohol-related condition;
- 1,000 people will be a victim of alcohol-related violent crime;
- Over 400 11-15 year olds will be drinking weekly;
- Over 13,000 people will binge-drink;
- Over 21,500 people will be regularly drinking above the lower-risk levels;
- Over 3,000 will be showing some signs of alcohol dependence; and
- Over 500 will be moderately or severely dependent on alcohol.

Substantial increases in alcohol related harm have also been reported by the Royal College of Physicians. Thirteen children per day are hospitalised as a result of alcohol misuse. Alcoholic liver cirrhosis increased by 95% from 2000 to 2006. Deaths related to alcohol increased by 18% from 2002 to 2005. Non-health related adverse impacts include rape, sexual assault, domestic and other violence, drunk driving and street disorder.

Is there a Public Health priority for our local population?

The local Public Health priority is significant. The recent Screening and intervention programme for sensible drinking study (SIPS) found that 40% of attendances at King's College and St Thomas's Hospital emergency department were alcohol related. Alcohol related inpatient admissions to acute care have doubled in the past 8 years in England and now account for 14% of all acute admissions in King's Health Partners (KHP). A study in South West London found that 50% of adult mental health admissions were alcohol related.

During 2011, emergency department attendances at St Thomas' Hospital and Kings College Hospital, coded with as 'apparently drunk', 'alcohol dependent' or 'alcohol cited on the GP letter' totalled 400 patients per month.

In outer London, the Sutton Health Profile 2011 indicates an above national value for rates of 'Increasing and higher risk drinking'. Although 'hospital stays for alcohol related harm', were below average at 1,523 admissions per 100,000 population.

Do we have specific expertise in the area?

Both clinical and academic expertise of national and international significance in alcohol disorders exists within services and institutions in South London.

Clinical services range from one of the largest addiction services in Europe, provided by South London and Maudsley NHS Foundation Trust, through to specialist medical care, such as hepatology at St Thomas' Hospital. The extensive NHS services are complimented by a range of non-statutory organisations delivering community and residential alcohol addiction interventions.

A wealth of research is conducted in South London, with addictions research focussed within the Addictions Clinical Academic Group within KHP, of which senior clinicians have held positions as chairs of NICE guideline groups on alcohol. A large academic Public Health department within King's College works across a range of organisations.

Notable examples of research at the Institute of Psychiatry include the SIPS alcohol screening and brief intervention (ASBI) research programme. This received funding from the Department of Health in 2006 as part of the national Alcohol Harm Reduction Strategy for England. The programme compares methods of screening and brief intervention across Primary Health Care, Emergency Departments, and Probation Services. The aims of the programme are to evaluate the effectiveness and cost effectiveness of different methods of screening and brief interventions for alcohol misuse as well as promoters or barriers of the implementation of interventions. The SIPS junior NIHR (National Institute for Health Research) programme aims to develop and evaluate interventions on adolescent alcohol related Emergency Department attendances.

An MRC funded trial to examine assertive outreach methods with frequent alcohol related attendees in acute mental health care is planned.

Several organisations provide teaching across South London. These include the Institute of Psychiatry which runs the Clinical & Public Health Aspects of Addiction Masters. The University of Greenwich runs a BSc in Mental Health Work, which includes a 12 week undergraduate module in Problematic Substance Misuse. Other teaching programmes include the recognition of alcohol problems for midwives, health visitors and A&E nurses and a day course for mental health nurses in the assessment and management of alcohol. A one year pilot involving clinical supervision for mental health professionals from the Greenwich Mental Health Recovery Team in the use of motivational interviewing techniques in substance misuse is in process.

Links with international projects include AMPHORA (Alcohol Measures for Public Health Research Alliance) which is a 4 year Europe wide project aimed at advancing alcohol policy research.

Stage 2 - Case for change

The management of alcohol use disorders and associated disorders is complex, with numerous clinical and non-clinical services contributing to complex pathways. The provision of many services by private or non-statutory providers adds further complexity.

Mapping how these services integrate and communicate within a pathway is necessary to further determine the case for change and to identify key priority areas for improvement.

Are there variable clinical outcomes?

A mapping exercise of services will be required to identify variation in clinical outcomes. This will also inform the case for change and identify key priorities across South London.

Are there variations in clinical models?

Again, the mapping exercise will aim to provide a comprehensive overview of variation in clinical models. In many circumstances, variation in clinical models may be desirable in meeting local demands due to social, cultural and demographic differences.

An example of variation in models is illustrated by the community addiction services available in Southwark. South London and Maudsley Foundation Trust provides the ‘Community Drug and Alcohol Team’ which is a full multidisciplinary community team, comprising doctors, nurses, psychologists and drug workers. A non-statutory service is provided by Foundation 66, which runs the ‘Elephant and Castle Community Alcohol Service’ delivering individual and group structured day programmes for alcohol addictions. These organisations work in partnership and complement each other.

Is there robust evidence to support best practice?

A large body of evidence has informed the development of the relevant NICE guidelines in addressing both clinical and public health standards.

Stage 3 - Define best practice and model of care

Research evidence

Research evidence has informed the development of NICE guidance. This remains a basis for best practice. The AHSN will help better ensure new evidence informs future best practice. An example is the SIPS study (see Section 1) which will help inform best practice for screening and brief interventions for alcohol.

Local initiatives in place

A mapping exercise needed to identify further important initiatives across South London, with only a selection described here.

A noteworthy clinical innovation is a proposed emergency alcohol transfer pathway to divert alcohol intoxicated patients from Kings College Hospital and Guys and St Thomas' Hospitals to an immediate assessment and treatment bed at the Maudsley Hospital. A pilot pathway has operated for 18 months at Kings College Hospital. This is the first such pathway in the United Kingdom and awaits formal evaluation.

A funding proposal has been submitted to develop 'An integrated programme to reduce alcohol related harm across KHP' aiming to develop partnerships across multiple organisations and groups. Such a programme will help inform integrated approaches in other areas in South London.

The Sutton Alcohol Harm Reduction Strategy also provides an example of multiple organisations working together with a view to developing effective strategies. Organisations involved in the strategy include health and social care providers, probation services, commissioning groups and other interest groups.

IMPARTS is an initiative funded by King's Health Partners to integrate mental and physical healthcare in research, training and clinical services at Guy's, St Thomas's and King's College Hospitals. The aim is to pioneer a new model of service delivery that facilitates 'whole person care' and promotes research as a natural outgrowth of patient care. The overall goal of IMPARTS is to improve mental healthcare provision within medical settings across KHP.

An example of work on establishing closer collaboration between statutory drug and alcohol services and the non-statutory sector is underway, such as between NHS services in Greenwich and the Crime Reduction Initiative organisation.

National guidance

Extensive NICE guidance on both management of alcohol use disorders and related conditions and models of care has been published, providing a basis for best practice. A pathway also developed by NICE demonstrates how prevention and management of alcohol disorders interrelate.

Of particular relevance is the public health guidance detailed in NICE Guideline PH24 'Preventing harmful drinking'. This provides a framework which advocates work at a population level to help a) those not in contact with relevant services b) creating an environment to support lower risk drinking c) preventing harmful drinking in the first place. Aims are to generate awareness of risks associated with alcohol at an early stage and prevent extensive damage. Recommended clinical interventions include screening and brief interventions by appropriately trained staff, an area which South London academic and clinical services have demonstrated leadership.

A project to assess compliance with NICE guidance for the management of alcohol is planned in South London (led by Professor Littlejohns). The aim of this project will also be to identify barriers to the implementation of guidance.

What do patients and carers require?
Consultation of service users, carers, and other relevant representatives will be crucial in informing key priorities and their implementation.

Costs/benefits of models
The high direct and indirect costs of alcohol related problems are likely to support investment to achieve future savings. A long term approach to achieve savings will be necessary in some areas.

A systematic health economic analysis will be conducted to examine the costs and benefits of models, once proposed. In addition a review of how alcohol related episodes are measured or coded across services (for example general medicine) is required to identify areas where data is insufficient or not accurately recorded to allow future costs/benefits to be adequately judged.

Stage 4 - Implementation of a model of care

A mapping and consultation phase will aim to identify key domains (proposed to be in the region of four) where new models of care will be implemented. New models in each domain will implemented according to a rigorous project managed approach, with a strategy tailored to each domain. Common to each domain will be an emphasis on the promoting partnership across all key stakeholders.

Collaboration with industry will be sought, such as the partnership between NHS Suffolk, Ipswich Borough Council, Suffolk County Council and Suffolk Police that resulted in supermarket chains agreeing to stop the sale of strong beer or cider within the region.

Stage 5 - Outcomes Measurement and Evaluation

The identification (or development) of suitable outcome measures and methods of evaluation will follow on from a mapping process of outcome measures and methods of evaluation currently used across South London and elsewhere. Consultation with stakeholders will inform this process. Further aims would be to develop new outcome measures and methods of evaluation to feed back into the improvement process.

Outcome measures may evaluate a number a domains such as service provision, data management or clinical outcomes, for example:

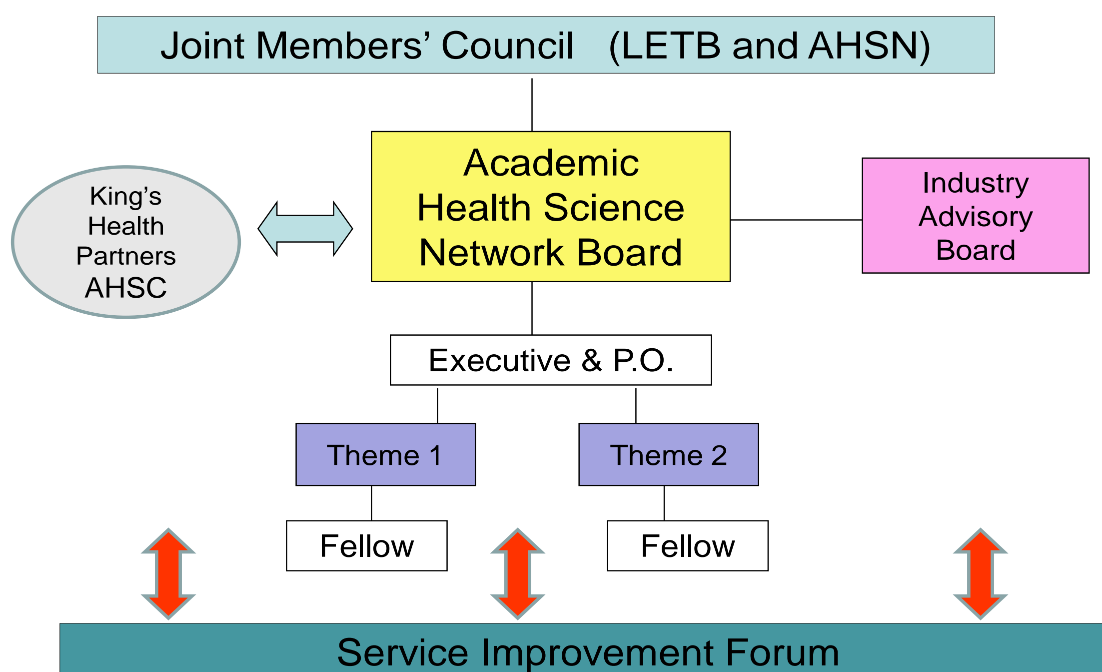
- Service provision may be assessed against NICE guidance, such as the availability of screening and brief interventions for alcohol disorders in A&E departments and other relevant services.
- Data management may be assessed by evaluating the accuracy of recording of co-morbid alcohol related disorders in general medicine departments.
- Clinical outcomes may be measured by using existing systems, such as through National Drug Treatment Monitoring System (NDTMS) which monitors outcomes from specialist addictions services through the use of the Treatment Outcome Profile tool (TOP). This measure may be adapted for use in non-specialist services.

Further work is therefore required in order to agree specific outcomes metrics and targets, where there is an evidence base and significant patient impact, and where consistent and robust information is available.

7. Governance and Leadership Arrangements

The arrangements we put in place to govern the network, and provide day to day management, will need to be reflect the scope and complexity of the network, give appropriate representation and voice to all members, as well provide clear accountability for decision making and delivery of key priorities and agreed objectives & metrics.

We have drawn on the plans and experiences of other related networks (including LETB, CLRN, London Cancer Alliance) in developing the current proposals.



7.1 Members' Council

This is the body that ensures representation and accountability for each of the individual organisation that are members of the ASHN. At the present time it is proposed that this is a merged function with the South London LETB, with a single meeting structure which meets the requirements of both the LETB and AHSN. It is envisaged that the Council will meet 2-3 times per year.

7.2 AHSN Board

The Board will be the formal decision-making body of the ASHN, comprising elected representatives from each of the major constituencies, and chaired by an independent non-executive chairman. It will oversee the development, and ultimately the performance, of the work programmes which comprise the activities of the AHSN, and will establish sub-groups or co-opt members to fulfil its functions as deemed necessary. The three legged stool of Academia, Industry and the NHS will be embedded in the structure and membership arrangements. The AHSC and Universities, a non-executive Chair from outside the NHS and the representatives of the Membership Council will formally ensure this is the case.

7.3 Industry Advisory Board

Developing productive partnerships with commercial organisations is a key function of the ASHN. However, it will be important in this context to ensure that conflicts of interest or anti-competitive situations are not created, therefore it is proposed that a number of senior private sector leaders are invited to participate in an Industry Advisory Board, which will play an important role in guiding the work of the AHSN Board. This Board will also include public sector colleagues with particular experience of managing commercial relationships. There is provisional agreement that we will establish a pan-London industry advisory function (for example, which may alternate meetings with a more locally focused industry grouping).

7.4 Executive Team and Programme Office

The Managing Director will be supported by a core team, including a senior academic lead, senior programme manager, an industry liaison manager, data / informatics management, communications and project managers.

The managing director will be a full time appointment, reflecting the scale and importance of the task, and the current incumbent has experience at CEO level, and in the clinical leadership of the delivery of large scale change of Stroke care across the capital.

7.5 Clinical Themes – programme structure

For each of the large clinical transformation programmes a Senior Responsible Office, a Clinical Academic Lead, a programme director, and a number of project managers.
These teams will work closely with the Executive Team. The Fellowship scheme will link the service level priorities with evaluative discipline and expertise, and the individuals who are seconded into fellowship positions will be supervised by appropriate academics within the HEI members.

7.6 Relationship with the Academic Health Science Centre

South London is fortunate in having at its heart a successful Academic Health Sciences Centre. There must be a strong relationship between the AHSN and its AHSC; the AHSN having a critical role as the mechanism by which the ASHC is able to translate innovation (across the tripartite mission of education and training, research and service improvement) throughout a broader patient population. The Managing Director of the AHSN is a member of the King's Health Partners AHSC Executive Team.

7.7 Service Improvement Forum

Brings together key service improvement leads (clinician, academics, managers and other professionals) and enthusiasts to share best practice rapidly, encourage spread of innovations, methodologies and knowledge, thereby creating a cadre of resourceful Service Improvement Practitioners who have greater insight and knowledge with regard to research and evaluation.

We will create a hub for brainstorming and problem solving and testing of new approaches across all domains of AHSN activity, at a greater scale than previously possible. This will be supported by innovative communications technology, and occasional face to face activities and conferences. The Forum will provide a focus for development and learning activities, and access point for industry to a broader range of public sector contacts from across South London.

7.8 Leadership development

For the AHSN to be effective in delivering against is challenging objectives, it will require strong leaders at every level. We are therefore designing a comprehensive programme of leadership development, with the support of Ashridge. To start with this will focus on three tiers, the Membership Council to ensure buy in from the membership and appropriate choice of priorities, the teams delivering the Clinical Priority areas, and the Service Improvement Network, to accelerate the diffusion of innovative ideas.

8. Performance & Outcomes Measurement in the AHSN

The creation of an AHSN is an ambitious and challenging task, requiring significant investment of public sector funding and resources within the local healthcare system. It is therefore critically important that we design a robust performance and outcomes framework that can be used to demonstrate transparently whether or not the AHSN is adding value.

Although there will no doubt be a formal national process to determine success and delivery of ANSHs, we are keen to show a real impact locally, such that the work of the AHSN becomes integrated with day to day business. We see a critical lever for changing being the commissioning process, and the CCGs are important members who can ensure that standards and measures of performance agreed across the AHSN are embedded in commissioning plans and incentives, such as CQUINs.

An effective Outcomes Measurement Framework will rely on systematic collection and integration of data from multiple sources across the member organisations, which can then be used to identify best practice and local variations in performance, drive adoption of innovation, and to address national standards and requirements.

The framework described below has begun to inform the discussions within each key function and the clinical themes, and will be more systematically applied as the AHSN develops.

Key principles & Process for Developing Framework

1. Development of strategic objectives in each area of activity linking population health, clinical outcomes and economic measures of effectiveness
2. Identify metrics for each for each of the strategic objectives (understanding availability and consistency of data). Build on national indicators where this is a well-established data set, and the 2012/13 Outcomes Frameworks for NHS, Social Care and Public Health
3. Understand our baseline before target setting
4. Agree ownership of milestones and targets and be clear who is responsible for delivery, and for reviewing and interpreting performance
5. Set realistic yet achievable targets (e.g. considering trends, variation and benchmark data) which support a continuous improvement culture
6. Design monitoring and reporting process and agree accessibility to data (e.g. provenance of the data, frequency of reporting)
7. Communicate and incentivise performance (including recognition of good performance) and agree action plans, as well as mechanisms to influence commissioning decision making

Areas of Performance

The performance framework will operate at 3 levels :

1. The overall aims and mission of the South London AHSN
2. Specific milestones and targets in each of the functional areas of the AHSN
3. Specific milestones and targets in relation to the major programmes of work (i.e. Alcohol, Diabetes

Illustrative Metrics

1. Overall aims of AHSN	• Health improvement (population measures such as incidence of disease) • Wealth creation (e.g. number of JVs, income raised by AHSN) • Effective network collaborations
2. Functional areas	• Service improvement (major transformation programmes launched, no. participants in Service Improvement Forum, specific outcomes measures (see clinical areas below) • Research participation (% patients consented / % enrolled in studies). Speed to study start. Speed to local and national research findings dissemination, and eventual adoption, locally and nationally. • Research translation (uptake of research findings – speed and spread) • Education and training (no. of Innovation & Improvement Fellowships, clinical leadership training programmes) • Wealth creation (as above) • Informatics (agreed outcomes measures framework & sharing of data, spread of tele-health pilot initiatives)
3. Clinical Themes (illustrative metrics)	**Diabetes** • HbA1c monitoring • Retinal screening rates • Uptake of structured self-management education programmes • Rate of emergency admissions for people with diabetes **Dementia** • GP use of mini-mental state on patients with memory problems • Reduction people with dementia in care homes presenting to A&E • Reduction in prescribing of anti-psychotics for dementia patients

	MSK • Patient reported outcomes measures (post-surgical procedures) • Improvement in waiting times / access to services • Reduction in spend on MSK related conditions as % of local health budget **Alcohol** • Increased referrals to acute alcohol treatment service from A&E departments • Increased uptake of NICE guidance across South London

Benchmarking

In order to provide assurance that the progress of our delivery is adequate, we should be able to compare our performance against others. We expect to do this is key common areas which we will agree with our neighbouring ASHNs (i.e. Kent, Surrey and Sussex, Imperial and UCLP). London comparators will be facilitated by the benchmarking work planned as part of the Improvement Science London initiative.

9. Relationships with Other Networks

It is likely that all 15 national networks will be differently configured, with differing leadership models, approaches and areas of priority. It will therefore be crucially important that close collaborative relationships are maintained which facilitate cross-boundary working and mutual learning. The national "network of networks" will provide a structure and framework for these interactions to initiated, but we will need to foster and build on the most appropriate relationships for us locally. In particular this will include Kent, Surrey and Sussex, where a number of cross-boundary patient flows exist, in particular in tertiary specialties where patients travel to London teaching hospitals for care. The sickle cell network across S London and KSS is a particularly strong example of this with high levels of research participation, common management plans and embedded multidisciplinary working.

Critical relationships also exist with the 2 AHSNs in the North of London, facilitated by the developing relationships between the 3 London AHSCs. There are many health issues relevant across London, and many existing linkages, such as the Improvement Science London initiative and the AHSC work on Life Sciences. The London Cancer Alliance and the South London Stroke and Cardiac Networks are already well established and we will draw on their experience and expertise.

We are anticipating that a number of joint projects will develop between South London and its neighbouring AHSNs, for example we are committed to expanding the pooling of our Industry Advisory function where appropriate across London, drawing on London's advantages as a centre of wealth and finance and we will ensure that resources are made available to support such work.