# NOTICE OF MEETING

**NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

Contact: Robert Mack

Direct line: 020 8489 2921
E-mail: rob.mack@haringey.gov.uk

Friday 25 March 2011 10:00 a.m.
Hendon Town Hall, The Burroughs, Hendon NW4 4BG

Councillors: Maureen Braun and Alison Cornelius (L.B.Barnet), Peter Brayshaw and John Bryant (L.B.Camden), Christine Hamilton and Mike Rye (L.B.Enfield), Gideon Bull and Dave Winskill (L.B.Haringey), Kate Groucutt and Martin Klute (L.B.Islington),

Support Officers: Sue Cripps, Katie McDonald, Robert Mack, Pete Moore and Jeremy Williams

## AGENDA

**1. WELCOME AND APOLOGIES FOR ABSENCE**

**2. URGENT BUSINESS**

**3. DECLARATIONS OF INTEREST (PAGES 1 - 2)**

Members of the Committee are invited to identify any personal or prejudicial interests relevant to items on the agenda. A definition of personal and prejudicial interests is attached.

**4. MINUTES (PAGES 3 - 10)**

To approve the minutes of the meeting of 21 January 2011 (attached).

**5. NHS NORTH CENTRAL LONDON (NCL) - TRANSITION AND GOVERNANCE (PAGES 11 - 44)**

To report on the governance and organisational structure of NHS North Central London.

**6. VASCULAR SURGERY (PAGES 45 - 84)**

To update the JHOSC on the development of a specialist vascular centre for the sector.

**7. NORTH CENTRAL LONDON SECTOR COMMISSIONING STRATEGY AND QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN (PAGES 85 - 134)**

To receive an update on the development of the North Central London Sector Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan.

**8. FINANCE**

To consider an overview of the financial position of PCTs within the sector. (TO FOLLOW)

**9. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY**

To receive a verbal update on the latest position in respect of the Barnet, Enfield and Haringey Clinical Strategy

**10. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC) FOR NORTH CENTRAL LONDON SECTOR - SUPPORT AND ADMINISTRATIVE ISSUES (PAGES 135 - 136)**

To consider support and administrative arrangements for the JHOSC.

**11. DATE AND VENUE OF NEXT MEETING**

Friday 27 May at 10:00 a.m. at Camden Town Hall.

**12. NEW ITEMS OF URGENT BUSINESS**

Agenda Item 3

**DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF**

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

**Note:** If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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**NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

Minutes of the meeting of the Joint Health Scrutiny Committee held on 21 January 2011 at Haringey Civic Centre, High Road, Wood Green N22 8LE

**Present: Councillors:** Alison Cornelius (Barnet), Peter Brayshaw and John Bryant (Camden), Christine Hamilton (Enfield), Gideon Bull and Dave Winskill (Haringey), Kate Groucutt and Martin Klute (Islington)

**Officers:** Hannah Hutter (Camden), Melissa James (Barnet), Pete Moore (Islington), Rob Mack and Carolyn Banks (Haringey)

## 1. WELCOME AND APOLOGIES FOR ABSENCE

Cllr John Bryant (Vice Chair) welcomed everyone to the meeting and gave apologies for lateness in respect of Cllr Gideon Bull (Chair).

## 2. URGENT BUSINESS

There was none. It was noted that an updated slide on proposed QUIP savings would be circulated shortly.

## 3. DECLARATION OF INTEREST

The following declarations were made:

Councillors Bryant and Winskill declared a personal interest in respect of item 8 – Low Priority Treatments.
Councillor Brayshaw - elected patient Governor of GULCH
Councillor Groucutt – Governor at GULCH
Councillor Cornelius – Chaplaincy at Barnet hospital (not Chase Farm as stated in the minutes of the meeting held on 19 November)
Councillor Bull – Employee at Moorfields Eye hospital

## 4. MINUTES

The minutes of the meeting held on 19 November 2010 were noted.

Regarding the challenges in using up to date population data, Members were advised that, although the figures across the boroughs had been checked, no further work had been carried out. It was noted that there was an opportunity with changes to GP consortia to ensure that the data was accurate.

It was agreed that in addition to Health and Well Being Boards, individual borough's Overview and Scrutiny Committees should receive updates on the GP Consortia.

It was agreed that Committee papers be circulated by hard copy as well as electronically and at least 7 – 10 days before the meeting.

## 5. VASCULAR SURGERY

Nick Losseff, Consultant Neurologist and Clinical Director, NHS North Central London gave an update on work being undertaken in the NHS in North Central London in response to the recently published Cardiovascular Strategy for London. This strategy proposed that there should be five specialist vascular centres in London.

Currently there were three specialist providers of arterial vascular surgery. These were based at Barnet Hospital, the Royal Free Hospital and University College Hospital. However, it was felt that none of these centres delivered the volume of work needed to develop a critical mass of patients or clinical expertise considered necessary to further improve patient outcomes. The benefits to patients of specialist centres were perceived to be significant and it was envisaged that they would mirror what had already been achieved in other specialities such as stroke and coronary heart disease. There was evidence that surgeons and institutions that maintained high volumes of vascular surgery achieved mortality rates 2-4% lower than surgeons that perform low volumes each year.

Efforts were being made to find a co-operative solution that was acceptable to the three service providers in the first instance, thus removing the need for an independent designation process to be run. A group of North Central London vascular surgeons had meet to discuss provision and an offer had been made to them by NHS NCL to host further talks. Also all Primary Care Trusts had been sent a letter and summary document and other stakeholders would be engaged in the process.

It was considered that it would be useful to have a set of criteria and guidance as to what the critical mass should be in determining where the centre of excellence should be located, similar to that which had been presented for the changes made to the delivery of stroke services. It was felt that a set of objective measures would assist with determining where and how the central unit of excellence would be created and how the specialist and non specialist work would be divided between institutions.

The principal argument against the proposals was the locality issue and the expectation that residents would want to go to their local hospital. It was noted that the number of patient affected was relatively low, at around 150

patients annually. Also there was an argument from surgeons that their current mortality figures were low. However, it was acknowledged that there were efficiency savings to be made by the proposals and many other parts of the country had already gone down this route. Indeed the NCL was considered to be behind the rest of the country and Europe in this area. The QIPP showed that vascular surgery was only around 25% of the vascular services, therefore leaving 75%of work still to be carried out at local hospitals. Members requested that further details on the number of cases and mortality rates dealt with by each of the three hospitals be provided. In response to members concerns that the performance of local hospitals may be affected by taking more complex procedures away from them, it was noted that it was likely to be the same surgeons carrying out procedures at the specialist centre.

It was noted that, although there was no response from the Royal Free within the papers sent to members, both the Royal Free and UCLH were keen to proceed with the proposals. There was some discussion about the hospitals being in competition with each other and a perception that only the teaching hospitals in Central London would be selected for the more complex surgery. However, the meeting was informed that the Royal free and UCLH were not going to be competing against each other. It was noted that, because of the high co-dependencies for high level surgery, it was likely that the specialist vascular services would be provided at a teaching hospital.

It was hoped to implement the changes during 2011/12. The NCL Cardiac and Stroke Network had agreed to work with officers on the changes to create a world class service.

**RESOLVED:**

1. That the report and appendices be noted.
2. That objective criteria be developed to determine the location of the proposed specialist centre and that the specification for the centre emulates best practice in the rest of the UK and Europe.
3. That Members be provided with further details on the number of cases including mortality rates for Barnet, Royal Free and UCLH.
4. That Cllr Cornelius be requested to provide officers with details of the precise information that she had requested in respect of blue light figures for the Barnet area.
5. That a further progress report be presented to the Committee in due course.

**6. QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION – COMMISSIONING PLANS FOR 2011/12**

An update on the planning process in respect of NHS North Central London Quality, innovation, productivity and prevention (QIPP) programme was given by Sylvia Kennedy, Director of Clinical Strategy.

Details of the issues and challenges relating to the seven priority areas of long term conditions, maternity, paediatrics, cancer, cardiovascular, mental health and unscheduled care were outlined.

Due to budget deficits within Barnet, Enfield and Haringey PCT's, the net position at the end of the current financial year for NCL was anticipated to be a deficit of £59m. If no savings were made over the next four years, it was predicted that the level would increase to an unacceptable deficit of £780m. There were a number of reasons for the deficit including the high population growth and the increase in the number of older people, particular in the northern part of the sector. Also there had been changes to calculation methods, market forces factor and technical changes in pricing. Additionally it was known that acute services in the area were operating at below the national average, whereas if they were in the top quartile around £30m would be saved per year and if they were the best in the country this figure would increase to around £100m. Additionally the primary care facilities were not well developed, especially in the north of the region. Plans had therefore been produced to address this debt and improve quality of care. Six broad categories of savings had been identified:- primary care, prescribing, acute, mental health/continuing care community/other and corporate. There would be associated work plans for finance, transition, workforce and contracting. A final plan was to be submitted to NHS London on 28 February 2011.

There were 12 priority worksteams within the QIPP Plan and 4 enabling workstreams. Each workstream had a number of individual initiatives sitting within it. It was agreed that future meetings receive progress reports on the work streams and targets. It was noted that the finalised QIPP Plan would be available in the next two months. It was suggested that there should be a seminar arranged to explain in detail the 12 priority workstreams and to ensure that there was an understanding of the major issues facing the NCL.A stakeholders event had been planned for 3 March, details of which would be shortly circulated to Members. It was agreed that there needed to be discussions with the emerging GP consortium at an early stage.

**RESOLVED:**

1. That a further report on work in progress be presented to the next meeting.
2. That the next meeting receive in depth reports on medicines management, care closer to home and unscheduled care.
3. That consideration be given to arranging a seminar to examine the twelve priority worksteams in more detail.

4. That details of the NCL stakeholder event had been planned for 3 March, be circulated to Members of the JHOSC

## 7. UPDATE ON THE MENTAL HEALTH WORK PROGRAMME

Further to the previous meeting updating members on the work taking place in the mental health field at a sector level, members were informed of a separate Barnet, Enfield and Haringey Mental Health Trust Transformation programme which had been established and consisted of 9 individual projects grouped into two broad areas of developing community services and specialist services.

The same broad strategic direction of development for mental health services had been agreed across the Borough's of Barnet, Enfield and Haringey. This was to be based on the recovery model, greater development of community services and reducing reliance on in patient care, providing the most clinically and cost effective value for money services and working in partnership to develop and implement an ongoing change programme. A summary of the strategies and the mental health programme was noted. Members were advised that there had been a significant amount of engagement with mental health boards, carers and users and it was hoped that in future service users would be more involved. It was noted that in Enfield community services had merged with mental health services and that this had bought huge benefits.

Also there was currently a local consultation being undertaken by the Camden and Islington NHS Foundation Trust in conjunction with their commissioners NHS Camden and NHS Islington .into the proposal to close inpatient beds and reduce the number of sites. The three affected local authorities were also represented on the transformation group. Furthermore the need to get GP involvement was recognised.

With regard to the child and adolescent eating disorder service it was noted that the services for under 18s was provided at the Royal Free hospital whereas the adults service was provided at St Ann's hospital, it was felt that this did not enhance continuity of care. However It was noted that there was a review of the existing care pathway and a new one was to be developed.

**RESOLVED:**

1. That the report be noted.
2. That information on the Whittington Integrated Care Organisation be circulated to Members of the JHOSC.

## 8. LOW PRIORITY TREATMENTS

Members were informed of the updated Low Priority Treatments extended policy which included additional procedures recommended by Commissioning Support for London (CSL) and incorporated changes made in the light of secondary care clinical feedback. It was considered that extending the list of low priority treatments would ensure that the limited budget would be utilised to ensure the maximum advantage of the maximum number of people and was anticipated to deliver financial benefits of £2,535,480 from 2011/12. It was noted that following discussions with GP's and secondary care providers some additional procedures had been added. Details of public consultations were noted, together with the rationale behind the decisions. The policy had been drawn up in the context of the principles framework used by three of the NCL PCT's and the new NHS Constitution. It was noted that requests for funding treatments could be made to the IFR Panel by GP's on an individual and exceptional basis.

Although there was an expectation that GP's might be able to provide alternative solutions, there was some concern expressed over the duration of the policy and whether the systems would be cost effective in that greater numbers would reach the critical level and be eligible for treatment.

Additionally although there was evidence that some non effective treatments were still being carried out, hospitals were moving towards no longer carrying them out as part of the programme for reasonable clinical behaviour.

The meeting agreed that there was a need to monitor numbers going through the system and costs and requested to be updated on the effectiveness of reducing the number of procedures on the list and the comparative impact of the extended policy across the sector.

**RESOLVED:**

That a further report outlining progress, including information on the effectiveness of reducing the number of procedures included on the list and the comparative impact across the sector, be submitted to the JHOSC in due course.

**9. NCL UPDATE**

Financial Update 2010/11

A financial deficit of £60m was projected to be carried forward into the next financial year. Representations had been made to the Challenge Trust Board for assistance, the outcome of which would be known by the end of January 2011. It was noted that the deficits would not be passed onto GP consortia.

PCT Budgets

For this current year the Challenge Trust Board mechanism was likely to help PCT's deliver a balanced budget but it was not likely to be continue into 2011/12.It was noted that GP's were likely to get together in respect of some functions such as around acute contracts. Nationwide, PCT's were making reductions and a single management structure had been created. A paper setting out full financial details was due to go to the NCL Board on 20 January 2011 seeking agreement to these changes.

GP Commissioning development

It was noted that all 5 GP consortia in NCL would be applying for Pathfinder status by March 2011 and would be coterminous with boroughs. Acute commissioning would remain at the NCL level for the time being.

BEH Clinical Strategy

NHS London was currently assessing the review of the Strategy against the four reconfiguration criteria set out in the revised operating framework for 2010/11. It was noted that Enfield had raised opposition to the strategy as they considered that the four tests had not been met. Consequently meetings had been set up with the 3 local MP's and Enfield were seeking agreement to referring the strategy back to the Secretary of State.

**10. NEW ITEMS OF URGENT BUSINESS**

There was none

**11. DATE AND VENUE OF NEXT MEETING**

Agreed as follows:-

25 March – Barnet
27 May – Camden

GIDEON BULL
Chair

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Agenda Item 5

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

| THE NHS IN NORTH CENTRAL LONDON | **BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON<br>**WARDS:** ALL |
|---|---|

**REPORT TITLE**:
NHS North Central London Transition and Governance Arrangements

**REPORT OF**:
Helen Pettersen
Chief Executive, NHS Islington and
Senior Responsible Officer for Transition, NHS North Central London

| **FOR SUBMISSION TO:**<br>North Central London Joint Health Overview & Scrutiny Committee | **DATE: 25 March 2011** |
|---|---|

**SUMMARY OF REPORT:**

Members have requested information about the transition and new governance arrangements for the single management structure for the NHS North Central London (NCL) Cluster.

This paper describes the NCL governance arrangements which will operate with a single management team and cluster board from 1 April 2011 in accordance with Department of Health (DH) guidance.

Several papers regarding the new arrangements were presented at extraordinary Board meetings held in each of the NCL PCTs on 28 February 2011. These are available on each PCT's website (see http://www.islington.nhs.uk/board-papers.htm). The key papers relating to governance and the staff appointment process have been provided for Members' information as Appendices to this report. They include:

- Composition of NCL Boards (Appendix 1)
- Partnership Agreement for Joint Working of five statutory boards (Appendix 2)
- Draft Governance Framework (including sources of assurance) (Appendix 3)
- (Extract of) Report of the staff consultation process (Appendix 4)
  - Consultation chronology: summary of consultation activities and documentation November to March 2011 (Appendix 4.1)
  - NCL structure chart (Appendix 4.2)
  - Numbers of posts affected (Appendix 4.3). Members will note this shows a reduction in Director level posts from 42 down to 15 posts, if they are recruited to.
  - Appointments Process to the Single Management Team for PCTs in North Central London, as implemented from 17 December 2010 (Appendix 4.4)

Staff in the five PCTs in NCL are currently undergoing a HR process to support the transition and the 54% management cost reduction required of London PCTs. Most staff are on redundancy notice while they await the outcome of the appointments process to confirm whether they secure a post in the NCL team.

A local presence will remain in each Borough, under the leadership of a Borough Director. These borough teams will remain until commissioning responsibility is handed over the GPs in 2013. They will cover: GP development and local commissioning; joint commissioning (with the local authority); local finance; safeguarding adults and children; medicines management; continuing care; and GP information technology.

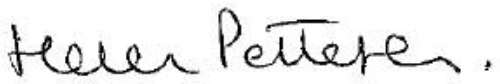
Whilst it isn't the role of the Joint Health Overview & Scrutiny Committee to scrutinise an NHS staff consultation, we are sharing this information with you to provide as full as context as possible.

Martin Machray will present this paper and respond to any Members' questions on 25 March, on behalf of Helen Pettersen.

CONTACT OFFICER:
Martin Machray
Associate Director, Communications and Engagement
NHS Islington
martin.machray@islingtonpct.nhs.uk

**RECOMMENDATIONS:** The Committee is asked to note this report and the appendices.

**SIGNED:**



Helen Pettersen
Chief Executive, NHS Islington and Lead for Transition
NHS North Central London

**DATE: 17 March 2011**

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

# NHS NORTH CENTRAL LONDON TRANSITION AND GOVERNANCE ARRANGEMENTS

## 1. INTRODUCTION

This paper describes the NHS North Central London (NCL) governance arrangements which will operate with a single management team and cluster board from 1 April 2011 in accordance with Department of Health (DH) guidance.

## 2. BACKGROUND AND CONTEXT

In November 2010 the Boards of the Primary Care Trusts (PCTs) in North Central London - Enfield, Haringey, Barnet, Islington and Camden PCTs gave approval in principle for the following:

1) The establishment of a single executive team covering all five PCTs to manage the commissioning of services, strategic transformation and organisational change on behalf of the five PCTs;

2) The designation of a single accountable officer for the five PCTs, with effect from 1 April 2011;

3) The revised governance arrangements for operating with a single management team; and

4) The delegation of responsibility for the agreement of the detailed structures and implementation plan to Chief Executive Officers.

## 3. DEPARTMENT OF HEALTH PCT CLUSTER IMPLEMENTATION GUIDANCE

DH PCT cluster implementation guidance was issued on 31 January 2011. This sets out the conclusion that it will not be possible to retain effective management capacity in all PCTs until their abolition in 2013, presenting unacceptable risks to quality and financial management. In response, current PCTs will be retained as statutory organisations, in order not to add further to disruption from reorganisation, but there will be consolidation of management capacity, with single executive teams each managing a cluster of PCTs. These new clusters are not statutory bodies, nor are they permanent features of the landscape, but they are necessary to sustain PCT capability and enable the creation of the new system.

## 4. NHS NCL'S PROPOSED CLUSTER GOVERNANCE CONFIGURATION

NHS NCL has reviewed its proposed governance framework to ensure that it is compatible with the DH guidance.

The underpinning principle is that the five statutory Boards will meet simultaneously and will transact business together, supporting each other through the breadth of joint discussion, building on the shared expertise across NHS Barnet, Camden, Enfield, Haringey, and Islington, while maintaining the statutory responsibilities of each board as a legal entity, and the integrated single executive management arrangements will support all of the Boards.

The five PCT Boards were asked to take resolutions on 28 February 2011 which confirm agreement to work to this governance framework as 5 PCT Boards working together and conducting business in joint meetings as a single cluster board. NHS NCL's proposed cluster

board configuration is consistent with the DH and Appointments Commission's cluster model 3.

Appendix 1 demonstrates how NHS NCL proposes its cluster board arrangements will meet statutory requirements for board membership.

## 5. NHS NCL'S PARTNERSHIP AGREEMENT

Central to NHS NCL's new governance arrangements is a Partnership Agreement between the five NCL PCTs. The five PCT boards have already approved a draft Partnership Agreement, which describes:

- how the five statutory Boards of NHS Barnet, Camden, Enfield, Haringey, and Islington will work together from 1 April 2011;
- how non-executive and executive directors will work across all five PCTs, and how they will relate to each individual PCT; and
- an overview of proposals for Board sub-committees.

The Partnership Agreement is intended to facilitate a new way of working and may be amended by the five boards as necessary. There will need to be sufficient flexibility to enable:

- the combined NHS North Central London Board to discharge its responsibilities in a manageable way without overly restrictive specification.
- GP consortia to develop their own governance arrangements and for incremental delegation to GP Consortia to happen over time.

The Partnership Agreement refers also to engagement with Local Authorities, LINks and GPs.

Further work will be carried out to prepare core governance documentation and detailed operating arrangements (including standing orders, schemes of delegation and operation and standing financial instructions) for adoption by the cluster board in April 2011 to enable the NHS North Central London Board and single management team to operate effectively from 1 April 2011. North Central London will continue to work with NHS London and other sectors to ensure that it follows guidance and benefits from exchanging good practice.

## 6. UPDATES TO PARTNERSHIP AGREEMENT

The existing NCL Board and PCT Boards discussed a draft Partnership Agreement at PCT Board meetings in January – early February 2011. Building upon those discussions and further to legal advice from Capsticks relating to PCT regulations, the following amendments have been made:

- Section 2.3 describing NED makeup of boards has been redrafted for clarity.
- It is provided now that in the normal course of events the sector Director of Public Health (DPH) will attend the cluster board. In the absence of the sector DPH, one of the borough DPHs will deputise. In the event of specific business that relates to a particular borough and requires local expertise and advice, the borough DPHs will attend for that item; and
- It is provided now that each PCT Board has to have nurse member who is a member of the Professional Executive Committee (PEC). Advice from Capsticks is that PCT regulations prohibit the nurse member from sitting on more than one PEC. In the normal course of events the nurse member of the sector executive management team will attend the cluster board. In the absence of the sector nurse, one of the borough PEC nurses will deputise. In the event of specific business that relates to a particular

borough and requires local expertise and advice, the borough PEC nurse member will attend for that item.
- Section 3.5 dealing with GP consortia has been revised to reflect emerging NHS London Guidance on consortia development.

When the draft Partnership Agreement was circulated, it was noted that the arrangements for Audit Committee(s) was subject to further discussion with External Auditors. Those discussions have now taken place. The External Auditors raise no objection to the proposal that there should be a single Audit Chair holding that office in all 5 PCTs, and consider that a single joint audit committee or a structure of 5 audit committees with overlapping membership could work in practice. They felt that, for the sake of continuity, it would be desirable for the existing 5 PCT Audit Chairs to be asked to participate on a consultancy basis in the process for auditing and approving the 2010/11 accounts if they have not been appointed to the new boards.

The External Auditors suggested that legal advice should be obtained, for assurance. Advice has been obtained from Capsticks. At the time of writing this paper the final advice note is not available, and it will be circulated separately.

For clarity, the Partnership Agreement has been amended to distinguish between board committees which are required by regulations and those which are discretionary and may be agreed by the new cluster board when it starts up.

## 7. IMPLEMENTING NHS NCL'S PARTNERSHIP AGREEMENT

It is proposed that NHS NCL Board meets for the first time as a Cluster Board on 7 April 2011. It will transact necessary business including adopting a corporate governance operating arrangements at that meeting.

There has been ongoing discussion about capacity at local borough level and the possibility of local NED associates. The Partnership Agreement provides for each PCT board to appoint up to 2 Associate NEDs. The NCL Governance Group recommends that decisions about associate NEDs should be made by the new PCT Boards and Cluster Board at its first meeting on 7 April 2011.

## 8. SOURCES OF ASSURANCE

We have used internal audit days from RSM Tenon to create a map of task and assurance processes against PCT statutory functions. It also includes a list of NHS toolkits, submissions and regulation that have to be completed for mapping on to functional areas. The mapping exercise is designed to clarify where responsibilities will fall. The sufficiency of resources to meet the identified responsibility, will remain with the NCL CEO as Accountable Officer and the relevant NCL Directors when they are appointed, having regard to decisions about priorities made by the Cluster Board.

The mapping exercise will help us meet the requirements set by the NCL Risk and Assurance Committee that by 31 March we can provide assurance that governance structures from 1 April are resilient and appropriate; that organisational design is appropriate; and that business as usual activities and processes will operate effectively (i.e. business continuity). Appointees to Director roles will be asked to sign off on the responsibilities that fall to their directorates. The Governance Task Group has recommended that the NCL audit committee incorporate a review of the implementation of the mapping exercise within its 2011/12 work programme to ensure that the single management team has taken effective ownership of all PCT responsibilities, and that nothing has been overlooked.

In addition to the mapping exercise, Capsticks will be undertaking an assurance process on behalf of NHS London. The work will be carried out by Colin Lynch and David Gibson, who have not been involved with the development of any of the individual sector proposals. They will be ensuring that each sector's framework satisfies the requirements of the Operating Framework; the PCT Cluster Implementation Guidance; and the relevant legislation. NHS London provided Capsticks with a checklist of the main tests which apply. We are in the process of preparing our proposals for submission shortly.

## 9. PCT BOARD RESOLUTIONS

PCT Boards met on Monday, 28 February and resolved to:

- terminate the Joint Committee of PCTs (JCPCT) and existing Establishment Agreement on 31 March 2011 as it is acknowledged that the JCPCT is now defunct; and

- adopt the NHS NCL Partnership Agreement to run from 1 April 2011.

## 10. NEXT STEPS

Implementation of the Partnership Agreement will be a matter for the new NHS North Central London Cluster Board to resolve. Views from existing PCT Boards will feed into this process.

An integrated continuity plan for PCT Boards will soon be prepared. PCT Board secretaries have been asked to supply details of work programmes, commitments and decisions outstanding.

In consultation with the Delivery Board, a model agenda will be drawn up for PCT March Board meetings so that close-down work is carried out consistently.

Helen Pettersen
Chief Executive, NHS Islington and
Senior Responsible Officer for Transition, NHS North Central London

**Appendix 1**

COMPOSITION OF NCL BOARDS

North Central London NHS
Barnet - Camden - Enfield
Haringey - Islington

## North Central London Boards - February 2011

| Statutory PCT Boards | Joint Board | | | | | Joint Board |
|---|---|---|---|---|---|---|
| Chair | ← Chair → | | | | | Chair |
| Vice Chair LOCAL NED 1 | Vice Chair NED Barnet | Vice Chair NED Camden | Vice Chair NED Enfield | Vice Chair NED Haringey | Vice Chair NED Islington | Vice Chair x 5 |
| Audit Chair | ← Audit Chair → | | | | | Audit Chair |
| LOCAL NED 2 | NED B | NED C | NED E | NED H | NED I | NED x 5 |
| NED 3 (Shared) | NED C | NED E | NED H | NED I | NED B | |
| NED 4 (Shared) | NED VC E | NED VC H | NED VC I | NED VC B | NED VC C | |
| 6 | | | | | | 12 |
| CEO | ← Chief Executive → | | | | | CEO |
| DOF | ← Director of Finance → | | | | | DOF |
| DPH (See Note) | ← Director of Public Health → | | | | | DPH (See Note) |
| Nurse (See Note) | ← Nurse → | | | | | Nurse (See Note) |
| PEC Chair | PEC Chair B | PEC Chair C | PEC Chair E | PEC Chair H | PEC Chair I | PEC Chairs x5 |
| 5 | | | | | | 9 |
| **11** | **PCT 1** | **PCT 2** | **PCT 3** | **PCT 4** | **PCT 5** | **21** |
| Up to 2 Associate NED (s) | **5 x GP Consortia Representatives** | | | | | 5 |
| | **5 x Local Authority Representatives** | | | | | 5 |
| | **5 x LiNK Representatives** | | | | | 5 |

NOTES

DPH - The DPH on each PCT Board will be the current local DPH. At joint Board meetings, the Cluster designated DPH will normally be the only DPH present. In her absence one of the other DPH's will deputise. In the event there is specific business relating to one PCT the local DPH will attend for that business.

Nurse – (Under PEC Membership Regulations, each PEC must have a nurse member, and each PCT Board must include 2 members nominated by the PEC, one of whom must be a nurse). The Nurse on each PCT Board will be the Nurse nominated by the PEC. At joint Board meetings, the Cluster Director of Quality (Nurse) will normally be the only nurse present. In the absence of that person, one of the other PCT Board Nurse members will deputise. In the event there is specific business relating to one PCT the local Board Nurse member will attend for that business.

Sharing of NEDs – the distribution of NEDs shown above is for illustration only. Allocation of NEDS to Boards will be made at the time of appointment of NEDS

**Appendix 2**

**NHS NORTH CENTRAL LONDON**
**PARTNERSHIP AGREEMENT FOR JOINT WORKING OF FIVE STATUTORY PCT BOARDS**

## 1. BACKGROUND

This Partnership Agreement sets out the working arrangements for the five statutory Boards of NHS Barnet, Camden, Enfield, Haringey, and Islington in north central London working together.
Since July 2009 the five statutory Boards for NHS Barnet, Camden, Enfield, Haringey, and Islington have been working together sharing acute commissioning and strategic planning functions governed by the Joint Committee of PCTs. Collective working was enhanced in June 2010 with a revised establishment agreement and the setting up of a Sector Board.
In response to the challenge of reducing management costs by 54% in NCL and in light of the White Paper: Equity and Excellence: Liberating the NHS, the five PCTs of NHS Barnet, Camden, Enfield, Haringey, and Islington are coming together to share executive and non-executive capacity and governance.
This Partnership Agreement is designed to describe the way the five statutory Boards will work together. It provides a framework, and allows for more details to be added or reflected in other supporting documents such as the scheme of delegation. It sets out how the Non Executive and Executive Directors will work across all 5 PCTs and how they will relate to each individual PCT.

## 2. PRINCIPLES

The shared governance and integrated working arrangements are designed to maximise capacity and capability, simplify tiers of management and enable flexible pace of development of the emerging GP consortia. The principles are as follows:

### 2.1 Design Principles

i. The collective governance arrangements are based on each of the five PCTs continuing as statutory bodies until the legislation enacting the white paper, Equity and Excellence: Liberating the NHS is in place. The new shared governance agreement reflects the requirement set out in the Operating Framework to establish clusters so as to offer capacity to emerging GP consortia and reduce running costs.

ii. The shared governance will be achieved by the five statutory PCT Boards coming together to transact business and effectively to meet as Joint Boards. This will be the normal mode of operation. Each statutory Board may where essential meet separately to conduct local business. Through the Joint Boards, each Board continues to retain the right to delegate functions and establish formal sub-committees or joint committees for particular purposes as appropriate.

iii. Each PCT receives a financial allocation for its population and must meet the costs of NHS health care for that population. Where costs are shared, the shares will be attributed pro rata under an allocation formula agreed by the Boards (such as ration of weighted capitation). As at present PCTs can agree to risk sharing and risk pooling arrangements (as they do for example for specialised commissioning)

iv. Budgets, targets and performance management as required will apply individually to each PCT to ensure clear and transparent accountability for services and a clear audit trail.

v. Standing Orders, Standing Financial Instructions and the Scheme of Delegation and reserved matters will be adopted by all five PCTs.

vi. Principal objectives for NHS Barnet, Camden, Enfield, Haringey, and Islington will be agreed and approved by the Joint Boards, and will form the basis of a joint Board Assurance Framework.

2.2 Arrangements in Common: Joint Boards

i. One Chair who is the Chair for each of the five PCTs.

ii. One Audit Chair who is Chair of Audit for each of the five PCTs.

iii. A total of 10 Non Executive Directors (NEDs) whose responsibilities will be corporate as well as PCT specific, which can be achieved via The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment Regulations 2010. NEDs will need to be clear when making decisions which role they are fulfilling.

iv. One Accountable Officer/Chief Executive who is the Accountable Officer/Chief Executive for each of the five PCTs.

v. One Finance Director who is the statutory Finance Director for each of the five PCTs.

vi. One Director of Public Health.

vii. Five PEC Chairs

viii. One Nurse Member

2.3 Arrangements distinct to each PCT Board

i. A Vice Chair will be appointed for each of the PCTs providing leadership for local business including partnerships, projects and local transition and effective interface with the Joint Boards. Each Vice-Chair will be appointed to his/her Board from the existing complement of Chair and NEDs for that PCT. Remuneration of the Vice Chair will be as determined by NHS London and the Appointments Commission.

ii. Each PCT Board will have a Chair (common to all five), and five NEDs (the minimum provided for in statutory regulations). One of those five will be the Audit Chair (an appointment common to all PCTs). The other four NEDs will be made up of two NEDs appointed to the board from the existing complement of Chair and NEDs for that PCT and two NEDs appointed from amongst the NED Members (and Vice-Chairs) of other PCTs in NCL (all appointed in accordance with those same principles). In total there will a Chair and 11 NEDs across all the PCTs in NCL ( one audit chair, 5 vice chairs and 5 other NEDs).

iii. Each PCT Board will have 5 Executive Members, consisting of the Cluster CEO and DoF, the local DPH and two Members nominated by each PCTs Professional Executive Committee, one being the Chairperson and including a GP and a Nurse member.

iv. With agreement of the Joint Boards, each PCT Board may also appoint up to two of Associate (Consultant) NEDs who will have specific responsibilities in respect of aspects of the PCT Board's work at borough level (or corporately in committees).

## 3. MEETINGS OF THE FIVE STATUTORY BOARDS (JOINT BOARDS)

3.1 The combined membership will maintain a majority of NEDs including the chair.

3.2 Board Executive members (voting)

3.2.1 Shared members:

i. Chief Executive/Accountable Officer
ii. Director of Finance
iii. One Nurse Member.
iv. One Director of Public Health

3.2.2 Local members:

i. One PEC Chair per PCT

3.2.3 Total Executive members are four shared and five local (Total 9).

3.2.4 The Local DPH and Nurse Member for a PCT will attend if there is business specific to that PCT.

3.3 Non Executive Director members (voting)

3.3.1 Total voting NED members are 12. Associate NEDs will not be voting members and will not attend meetings of the Joint Boards unless invited.

i. Chair
ii. Audit Chair
iii. Five Vice Chairs
iv. Five Non Executive Directors

3.4 Observers (non-voting)

3.4.1 The Joint Boards will invite attendance from the following as observers with speaking rights (subject always to the discretion of the Chair):

i. GP consortia representatives, one per PCT
ii. Local authority representatives, one per PCT
iii. LINK representatives, one per PCT.

3.5 Flexibility for developing GP consortia

PCTs are required by statute to have PECs, and they have to nominate two Board members including a GP and a nurse. These are the sole requirements. This provides considerable flexibility as consortia develop to meet the statutory requirements from the proposed Consortia governance models.

i. During the development period for GP Consortia (GPC) governance arrangements will operate in accordance with NHS London guidance for consortia Development. Shadow GPC with delegated commissioning responsibilities and budgets will operate as committees of the relevant PCT as they will not be a formally established entity until April 2013. As the development of GPCs and Health and Wellbeing Boards gathers pace NEDs and Executive working arrangements will need to be reviewed. The role of the Joint Boards in relation to the GPCs when they are established will be performance management until these responsibilities transfer to the National Commissioning Board.

3.6 Board meetings

- The five PCT Boards will meet simultaneously and will support each other through the breadth of joint discussion, building on the shared expertise across NHS Barnet, Camden, Enfield, Haringey, and Islington and the single integrated executive management arrangements which support the Boards.

- Arrangements for the meetings of the Joint Boards will be set out in Standing Orders, and the Board meetings will be conducted with due compliance.

- Meetings of the Joint Boards will take place in public on alternate months; in the intervening month the boards will meet in seminar sessions. Standing Orders will provide for the calling of Extraordinary Meetings. The public meetings will be held as far as possible on a rotational basis in each borough.

- Each PCT Board must be quorate (as defined in Standing Orders) at the meeting of the Joint Boards.

- Each PCT will appoint a Vice Chair whose role is to provide a leadership with local partners and a link to the Joint Boards. One of the Vice Chairs will be identified to deputise for the Chair of the Joint Boards. .

- An annual cycle of business will be prepared which will be agreed by the Joint Boards which will ensure that agenda items are planned to meet the business of all five PCT Boards, whilst responding where appropriate to the specific needs of each PCT.

- Agenda items and associated reports will where appropriate refer to the specifics of each PCT e.g. with regard to budgets, performance, capital schemes and health needs.

- Agendas for the Joint Boards meeting will be agreed by the Chief Executive and Chair with input from all Board members in accordance with the recent guidance on board governance – 'Healthy NHS Boards: Principles of Good Governance': February 2010, National Leadership Council.

- In accordance with Standing Orders, members of the public and representatives of the press will be asked to withdraw at the end of the public session of Joint Boards meeting to enable confidential matters to be discussed.

- Confidential issues will be dealt with under a separate agenda and minuted as confidential.

- It will be a convention enshrined in Standing Orders that in discussion of matters pertaining to a specific PCT Board, members of the other Boards will acknowledge that whilst they may feel able to contribute to the discussion, the primary discussion and decision making on the matter will rest with the relevant PCT Board members.

- Where a matter requires a vote, only statutory voting Board members of each Board will vote.

- Where a matter requiring a vote pertains to all five PCTs, voting will be by PCT. If at least four of the PCT Boards vote in favour of a proposal it will be adopted equally by all five PCTs.

- Where a matter requiring a vote pertains specifically to one PCT only the voting members of that PCT will vote.

3.7 Seminar sessions

Seminar sessions in private will be planned in the corporate calendar to enable deeper discussion on individual subjects/issues, and within which Board development will be undertaken. Agenda planning will be flexible to facilitate programming of topics raised by NEDs.

3.8 Joint Committees

The Joint Boards will establish committees which will be integrated across the five PCTs which are required by regulation and which are:

i. Joint Audit Committee
ii. Joint Pay and Remuneration Committee

The Joint Boards may establish other committees, to be agreed by the cluster board when it starts up. It is envisaged that at the outset there will be the following committees each to be chaired by a NED or in the case of Quality and Safety a clinician (with NED membership). Others may be identified.

iii. Financial Stability Committee
iv. Joint Strategy and Commissioning Committee
v. Joint Quality & Safety Committee.

## 4. OTHER COLLECTIVE AND LOCAL ARRANGEMENTS

a. Shared business and working arrangements

The five PCTs will continue to build on collective working arrangements for strategic planning and clinical leadership, reviewing these as appropriate as GP consortia develop. All PCT Boards retain the right to establish Joint Committees with other PCTs as appropriate to conduct business in common e.g. consultation on major service changes across London.

b. Individual PCT Board meetings

4.2.1 Each PCT Board retains the right to meet individually to conduct specific local business in exceptional circumstances

4.2.2 Committees may be set up in each PCT to take forward the business of the Joint Boards, including with specific delegated responsibility. The arrangements will need to be flexible during the transition period and reflect the development of GP consortia and Health &Wellbeing Boards.

4.3 Local clinical commissioning

Each PCT will build on its clinical commissioning arrangements to support the development of the emerging GP consortia, in collaboration with the local authority and LINks. A PEC Chair will be required to fulfil the statutory role in each PCT until such time as this is no longer a statutory requirement, and/or it is superseded by legislation relating to the formal establishment of GP Consortia.

4.4 Local leadership and relationship management

The local PCT Vice-Chair, the local NED *(NEDs)*, the PEC Chair and any Associate NEDs in each PCT will play a key role in:

i. Supporting and guiding the Borough Director and local PCT staff team and overseeing local projects and programmes within the programme set by the Joint Boards.

ii. Developing and supporting productive partnerships between the emerging GP Consortia, the local Authority, LINks and 3rd Sector.

iii. Sharing an understanding of the Joint Strategic Needs Assessment (JSNA), existing partnership arrangements, local commissioning issues and local performance.

## 5. DISPUTE RESOLUTION

This Partnership Agreement is voluntarily entered into and will be observed and adhered to by all five PCTs, but it is not an enforceable legal agreement. It follows that there is the potential for unresolved disputes on points of interpretation or application of this Agreement. If the Chair and Vice Chairs cannot between them agree to resolve a dispute between the five PCTs and broker agreement with their Boards, then they or the Chief Executive will refer the matter to the SHA for mediation or arbitration. Arbitration will be a last resort – the Chair and Vice Chairs will take all reasonable steps to resolve any dispute, including any discussion needed to seek compromise with Board members (executive and non-executive).

## 6. REVIEW OF THE PARTNERSHIP AGREEMENT

The effectiveness of the working arrangements under this Agreement will be reviewed every six months and more frequently if necessary, in the light of changing circumstances and when one or more GP Consortia reach the Intermediate Stage.

## 7. SIGNATURES

Signed for and on behalf of NHS Barnet; NHS Camden; NHS Enfield; NHS Haringey; and NHS Islington by the five PCT Chairs:

NHS Barnet
Name

Signature

Date

NHS Camden
Name

Signature

Date

NHS Enfield
Name

Signature

Date

NHS Haringey
Name

Signature

Date

NHS Islington
Name

Signature

Date

**Appendix 3**

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

# Draft Governance Framework (including Sources of Assurance)

This framework draws substantially on work developed in South West London. It has been amended to reflect the local circumstances and agreements in North Central London. We acknowledge South West London's contribution to our work.

The governance framework will form the basis upon which the new NHS North Central London Board will operate from 1 April 2011. It is acknowledged that there will need to be sufficient flexibility within this to enable:

- the combined NHS North Central London Board to discharge its responsibilities in a manageable way without overly restrictive specification.
- GP consortia to develop their own governance arrangements and for incremental delegation to GP Consortia to happen over time.

The proposed arrangements are set out in a draft Partnership Agreement between the five NCL PCTs. This sets out:

- how the five statutory Boards of NHS Barnet, Camden, Enfield, Haringey, and Islington will work together from 1 April 2011;
- how non-executive and executive directors will work across all five PCTs, and how they will relate to each individual PCT; and
- an overview of proposals for Board sub-committees.

The Partnership Agreement sets out a framework for joint working in North Central London. Further work will be carried out on the operating arrangements including standing orders, schemes of delegation and operation and standing financial instructions to enable the NHS North Central London Board and single management team to operate effectively from 1 April 2011. North Central London will continue to work with NHS London and other sectors to ensure that it follows guidance and benefits from exchanging good practice.

# DRAFT GOVERNANCE FRAMEWORK (including SOURCES OF ASSURANCE)

## 1. INTRODUCTION

The North Central London (NCL) Board was established in 2009 to support collective working across the five PCTs in NCL to strengthen commissioning arrangements. The staffing structures to support these arrangements were put in place from autumn 2009. Since the establishment of the NCL Board there have been two particular changes to the context in which we work. The first is the tightening public sector finances. The Operating Framework for the NHS in England 2010/11 highlighted the need to significantly reduce management costs across PCTs. In London the requirement is a 54% reduction in management costs. The second significant change to the context is the proposals set out in the July White Paper "Equity and Excellence – Liberating the NHS" which signals a fundamental change to the structure of the NHS, including the introduction of GP commissioning consortia.

The management cost reduction is a key driver to enable investment in the maintenance and development of services, as well as providing funding to support the new commissioning arrangements. NHS London, which has overall responsibility for the transition from current to the new NHS structures, made it clear that it expects to use the existing sectors as the transitional vehicle in London. NHS London will also monitor the management cost reduction target for the sector as a whole rather than by individual PCT. To enable this, PCT Boards agreed to establish a single management team for NCL to enable key functions to be carried out with significantly reduced management resource and to reduce duplication.

The NCL Board concluded that the reduction required in management costs meant that the current operational model is not viable, and that we need to do more things once and fewer functions five or six times across the patch. The Board also decided that it would be appropriate to reorganise management functions with a view to the future organisational form of the NHS whilst maintaining a focus on the delivery of key functions in the short term. The reorganisation of management functions has also considered the views of key stakeholders, particularly GPs and Local Authorities.

## 2. NCL'S PRIORITIES FOR THE TRANSITIONAL PERIOD

During this period of substantial change, NHS NCL has agreed that to retain focus on the key priorities for health in North Central London, which are:

- Improving health outcomes for the population of North Central London;
- Financial recovery through effective service commissioning;
- Service change and transformation, with a focus on primary care;
- Assuring the quality and safety of services provided to patients in our communities; and
- Managing the transition to new commissioning arrangements for the NHS in NCL including GP Commissioning Consortia and the local authority role in Public Health.

The structure and governance for the new management arrangements must support the delivery of these key objectives across all of five PCTs in NCL.

## 2. PURPOSE OF THIS DOCUMENT

2.1 The primary purpose of this draft Governance Framework document is to describe in more detail the revised governance arrangements reached thus enabling those arrangements to be embedded effectively and to aid better understanding of them. It includes a Partnership Agreement for the five statutory Boards, emerging thinking on Board sub-committee structures, details of accountability arrangements as well as Executive Director roles and

responsibilities. A corporate calendar and annual cycle of business for the statutory Boards will be developed in due course once the Board sub-committee structure has been agreed.

2.2 The document describes the Governance arrangements (which are the system for controlling and directing the organisation to meet its objectives). It also sets out the assurance arrangements (both internal and external) upon which the organisation relies to ensure that its governance arrangements are working effectively. Details of these are provided in Section 10.

2.3 This document will need to be read alongside NCL's Risk Management Strategy when published and its corporate risk register. Five PCT registers together with the sector risk register will be consolidated into a single risk register by 1 April 2011. This register draws together the high level risks to which the organisation are exposed together with details of the controls for managing them. This single Risk Register will be subject to regular review by the Joint Boards as statutory Boards meeting jointly as well as the proposed single NCL Audit Committee.

2.5 These governance and assurance arrangements will be reviewed after six months following agreement to their implementation in April 2011, then annually (or more frequently if required) to ensure that they reflect the needs of the organisation and current NHS guidance and best practice. It is noted that The NHS National Leadership Council is leading a project to renew *Governing the NHS: A Guide for NHS Boards,* originally published by the Appointments Commission and the Department of Health in 2003 and upon which the governance framework within this document is based. The revised guidance was published in February 2010 (The Healthy Board; Principles for Good Governance) and will be incorporated in future reviews of this document

2.6 The NCL Organisational Development and Transitional Programme has developed alongside NCL's proposed new governance framework. The new organisational structure creates the accountability and ownership to take governance forward. As team members come into new posts they will lead on relevant areas. Working with Internal Audit, NCL has used an assurance mapping process to ensure that it is clear where duties and responsibilities fall.

## 3. TERMINOLOGY USED IN THIS DOCUMENT

### 3.1 Governance

A basic definition of (corporate) governance is:

> "the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness".

Governance is concerned with the systems, controls, accountabilities and decision-making at the highest level of the organisation. It is about the way the organisation leads and manages through its values (in the public sector of accountability, probity and openness) and its systems (such as governance structures and risk management).

### 3.2 Governance Framework

The governance framework describes the structure and systems that are in place to "direct and control" the organisation. For NHS NCL these are the Committee structures, management arrangements, Standing Orders, Standing Financial Instructions, Scheme of Delegation and risk management strategy. These arrangements also provide the "assurance" that the organisation relies on to know that its governance arrangements are effective.

For the purpose of this document we are confining the definition of governance framework to our Committee structures and high level management arrangements, reflecting strategic and operational accountabilities.

### 3.3 Assurance

Assurance is the positive evidence that the controls are managing a given risk and it is likely that the objective will be achieved. There are a wide variety of sources of assurance available to the Joint Boards, both internal and external and these are described at Section 10.

The Board Assurance Framework (BAF) is a key document that sets out the organisation's principal objectives and the risks to achieving them, along with the controls in place and assurances available on their operation. It forms a key part of the annual statutory requirement for completion of the Statement on Internal Control, which provides confirmation that the governance and assurance arrangements for the organisation are operating as they should be.

### 3.4 Risk Management

Risk Management is a key element of the governance framework and its components are described as follows;

**Risk** is the chance that something will happen that will have an impact on the achievement of NHS NCL objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).
**Risk Assessment** is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk.
**Risk Management** is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

### 3.5 Glossary of Terms

A detailed glossary of terms relating to Corporate Governance is attached at Appendix 1.

## 4. STRATEGIC AND OPERATIONAL ACCOUNTABILITY

### *4.1 The Role of the statutory Boards (as set out in the NHS Reform and Health Care Professions Act 2002)*

The board has **collective** responsibility for

- Adding value to, and promoting the success of the organisation.
- Providing leadership to the organisation within a framework of prudent and effective controls
- Setting strategic direction, ensuring management capacity and capability, and monitoring and managing performance.
- Safeguarding values and ensuring the organisation's obligations to its key stakeholders are met.

Non Executive Directors on the Board share responsibility with other directors for the success of the organisation and the role of the Board set out above. However they have a special role to play within the Board team providing an independent view which is removed from the day-to-day running of the organisation. In line with the duties of non-executives in the private sector set out by Higgs[1], they have the following duties:

- *Constructively challenging and contributing to the development of strategy.*
- *Scrutinising the performance of management in meeting goals and standards, and monitoring the reporting of performance and service quality.*
- *Satisfying themselves that financial information is accurate and that financial controls and system of risk management are robust and defensible.*
- *Determining appropriate levels of remuneration of executive directors, and prime role in appointment, and where necessary removal, of senior management and in succession planning*
- *Ensuring the board acts in the best interests of the public and other stakeholders and is fully accountable for the services provided and the public funds used.*

The Joint Boards will continue to fulfil this responsibility. They will maintain their statutory responsibility conducting their business in concert as Boards meeting jointly.

### 4.2 The Role of the PCT Chair

The Chair is responsible for

- Leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda.
- Ensuring the provision of accurate, timely and clear information to directors.
- Arranging the regular evaluation of the performance of the board, its committees and individual directors.
- Facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

Although appointed by the NHS Appointments Commission on behalf of the local community, the Non Executive Directors report to the NHS NCL Chair, who is the Chair of the five PCTs. The Chair has a duty to meet with and support the NEDs to ensure that they are able to perform their role effectively.

### 4.3 Chief Executive as Accountable Officer

The NHS NCL Chief Executive is accountable to each of the statutory Boards for meeting their objectives and, as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation, via the Strategic Health Authority. It is recognised that this is likely to transfer to the National Commissioning Board subject to legislation. As Accountable Officer for each of the statutory Boards the Chief Executive has responsibility for ensuring that the organisation meets all its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and information governance, health and safety and risk management. The Chief Executive is required to sign off the Statement on Internal Control for each PCT Board annually in keeping with these responsibilities.

[1] [1] *Review of the Role and Effectiveness of Non-Executive Directors. D Higgs (2003)*

Whilst this overall responsibility is maintained, responsibilities for some aspects of governance have been delegated to statutory Board executive directors as follows, including:

| | |
|---|---|
| Clinical Governance | Medical Director for the five PCTs who will work with the Professional Executive Committee Chairs for each PCT |
| Corporate Governance & Strategic Risk Management | Director of Finance |
| Financial Governance | Director of Finance<br>(appointed as Accounting Officer for each of the 5 PCTs) |
| Information Governance | Director of Finance |

The Director of Infection Prevention and Control (DIPC) role will be undertaken by the Medical Director or Directors of Public Health through expert advice from the nursing and infection control to the Board.

The responsibilities of the Chief Executive, in addition to the significant leadership and managerial elements of the role are to ensure that the Boards are empowered to govern the Trusts and that the objectives they set are accomplished through effective and properly controlled executive action.

The Chief Executive's roles and responsibilities cover:

- Leadership - helping to create the vision for the board and the organisation to modernise and improve services, with the skill to communicate this vision to others and the ability to empower them to deliver the PCTs' agendas.

- Delivery planning - by ensuring that the Board has sufficient information to agree the Strategic and Quality, Innovation, Prevention and Productivity Plan (QIPP) and/or service level agreements (SLAs) that meet the NHS Operating Framework and other priorities and that are based on realistic estimates of physical, workforce, financial capacity and patient and public involvement.

- Performance management - by ensuring that the Boards' plans and objectives are implemented and that progress towards implementation is regularly reported to the Boards using accurate systems of measurement and data management, such information being regular and timely. By agreeing the objectives of the senior executive team and reviewing their performance.

- Governance - by ensuring that the systems on which the Boards rely to govern the organisation are effective. This will enable the Chief Executive to sign the annual Statement on Internal Control on behalf of the respective Boards, to state that the systems of governance, including financial governance and risk management, are properly controlled.

### 4.4 Role of the Professional Executive Committee Chair

The Professional Executive Committee (PEC) Chairs are required by statue. They are responsible for clinical leadership within each PCT. Arrangements will need to be agreed in each PCT as GP Commissioning Consortia emerge to make sure that the statutory requirements for PECs are met as these new governance structures develop.

## 5. BOARD GOVERNANCE ARRANGEMENTS

5.1 The statutory Boards' governance arrangements are set out in the NHS NCL Partnership Agreement (Appendix 2) which has been put to all PCT Boards to agree in late February 2011. These describe clear principles for integrated working, the ways in which the statutory Boards will work together and, in the unlikely event, a mechanism for resolving disputes between the PCTs.

5.2 This Governance Framework will be supplemented with a scheme of corporate governance which includes Standing Orders, a Scheme of Delegation and Schedule of Matters Reserved to the Board, and Standing Financial Instructions. The matters reserved to the Board comprise:

- Regulations and controls
- Appointments and dismissals
- Strategy, Annual Operational Plan and Budgets
- Audit
- Annual Reports and Accounts
- Monitoring

5.3 Key features of the revised governance arrangements that will be in place from 1 April 2011 include:

- The five statutory Boards will meet simultaneously and will support each other through the breadth of joint discussion, building on the shared expertise across NHS Barnet, Camden, Enfield, Haringey, and Islington and the single integrated executive management arrangements which support the Boards.

- Board meetings will be conducted with due compliance with Standing Orders.

- Each Board must be quorate at the meeting of the Joint Boards.

- Each PCT will appoint a Vice Chair whose role in addition to being a member of the Joint Boards is to provide local leadership.

- An annual cycle of business which will ensure that agenda items are planned to meet the business of all five PCT Boards, whilst responding where appropriate to the specific needs of each PCT.

- Agenda items and associated reports will, where appropriate, refer to the specifics of each PCT eg with regard to budgets, capital schemes and health needs.

- In accordance with Standing Orders, members of the public and representatives of the press will be asked to withdraw at the end of part one of the Joint Boards meeting to enable confidential matters to be discussed.

- Confidential issues will be dealt with under a separate agenda and minuted as confidential.

- It will be a convention enshrined in Standing Orders that in discussion of matters pertaining to a specific PCT Board, members of the other Boards will acknowledge that whilst they may support discussion, primary discussion and decision making on the matter will rest with the relevant PCT Board members.

- Where a matter requires a vote, only statutory Board members of each Board will vote.

- Where a matter requires a vote which pertains specifically to one PCT only the Voting members of that PCT will vote.

5.4 Non Executive Director appointments

The framework proposes 12 voting Non Executive Director posts: a Chair; Audit Chair; five Vice Chairs; five Non Executive Directors. This means that each PCT has two local Non Executive Directors and two pooled Non Executive Directors. The Vice Chairs would be in the pool of Non Executive Director posts, meaning that each Non Executive Director will be on two PCT Boards. This proposal is designed to create capacity and resilience for PCT Boards.

There is ongoing discussion about the capacity at borough level and the possibility of local associates.

## 6 CORE GOVERNANCE COMMITTEE STRUCTURE

6.1 In order to deliver the Principal Objectives and the strategic priorities within the NHS NCL Strategic Plan and Quality, Innovation, Prevention and Productivity (QIPP) Plan, the Boards will establish relevant sub-Committees, the remits of which are still under discussion.

6.2 Each Committee is authorised by the statutory Boards of the PCTs to pursue any activity within their Terms of Reference and within the Scheme of Reservation and Delegation. They are required to comply with:

- the PCTs' Standing Orders and Standing Financial Instructions
- the PCTs' Conflict Of Interest Policy
- the section of the PCTs' Scheme of Delegation which refers to the committee.

## 6 BOARD COMMITTEES

The statutory Boards will establish a single Joint Audit Committee and a Joint Remuneration and Terms of Services Committee which will be integrated across the five PCTs. All other Board sub-committees are being determined. Should functions be delegated to pathfinder GP consortia until 2013 PCT Board sub-committees will be established and will adopt the NHS London model terms of reference and scheme of delegation.

### 7.1 Single Audit Committee (that is meeting of each PCTs' Audit Committees jointly)

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the five statutory Boards propose to establish a Joint Audit Committee. The Committees will provide each of the five Boards with an independent and objective review of their financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Committees' cycle of business will include a review of an integrated Boards Assurance Framework and corporate risk register. The Committees are non-executive committees of the Joint Boards and have no executive powers, other than those specifically delegated. Accounts will continue to be produced for each of the five PCTs. Terms of reference for the single Audit Committee are under discussion and will be in place by 1 April 2011.

Reporting arrangements: The formal minutes of Joint Audit Committee meetings shall be recorded and submitted to the Joint Boards. The Audit Chair shall draw to the attention of the Joint Boards any issues that require disclosure, or require executive action.

The Audit Committee will report to the Joint Boards annually on its work in support of the Statements on Internal Control, specifically commenting on the fitness for purpose of the governance and assurance arrangements, the extent to which it considers the application

of risk management as a discipline to be embedded within the organisation, and the appropriateness of the self-assessment against the Care Quality Commission standards. The single Audit Committee will ensure each PCT completes their annual accounts.

*7.2 Joint Remuneration and Terms of Service Committee*

The Committee is established to advise on and make recommendations to the Statutory Boards in respect of the remuneration and terms of service for the Chief Executive, Directors and other officer members paid through the Very Senior Manager Pay Framework. The Committee will also take decisions on appointment, remuneration and terms of service for the Clinical Executive Committee in line with Department of Health guidance.

Reporting arrangements: The membership of the Committee for each of its meetings should be recorded and recommendations should be formally reviewed by the Joint Chair of the PCTs, Non Executive Directors and the Chief Executive.

The Committee will report in writing to the Joint Boards the basis for its recommendations. The Joint Boards will use that report as the basis for their decisions but remain accountable for taking decisions on the remunerations, allowances and terms of service of other officer members. Minutes of the Statutory Boards' meetings shall record such decisions.

*7.3 Local Committees*

*Each statutory Board may in exceptional circumstances meet individually to conduct specific local business.*

**7.4 Governance Support to Statutory Boards and Board Committees**

Support is provided to the statutory Boards to conduct their business and to the Board Committees through governance resources falling under the Director of Transition and Corporate Affairs, as well as functional lead directors' team for the committees. The support role is to ensure that all meetings operate effectively with regard to their Terms of Reference and their reporting arrangements.

An annual cycle of business for the Statutory Boards will be prepared which will be refreshed annually.
A Board development programme will be developed annually to support Directors in fulfilling their roles and responsibilities, and will be evaluated at Board seminars.

**8. PARTNERSHIP WORKING**

The local PCT Vice-Chair, the local Non-Executive Director, the PEC Chair or GP Consortia leads and any Associate Non-Executive Directors (if confirmed) will play a key role in:

- supporting and guiding the Borough Director and local PCT staff team and overseeing local programmes and projects within remit set by joint boards/CEO; and
- developing and supporting productive partnerships between the emerging GP Consortia, the Local Authority, LINks and the third sector, sharing an understanding of the Joint Strategic Needs Assessments (JSNAs), partnership arrangements, local commissioning issues and local performance.

The statutory Boards retain the right to establish Joint Committees with other PCTs as appropriate to conduct business in common e.g. consultation on major service changes across NCL or London.

### 8.1 Local partnerships

A range of partnerships are in place in each borough to support communities to thrive, deliver improved outcomes for local people, achieve improvements in respect of 'place', make best use of resources and secure integrated services that better meet health and social care needs. The White Paper Equity and Excellence: Liberating the NHS increases the role of Local Authorities in respect of democratic accountability, strategic planning, holding the ring and health and well-being. Public Health led by the Directors of Public Health will play an increasingly important role in supporting both parties to achieve joint solutions and better health and well being outcomes as well as efficiencies in the planning and commissioning of health and social care services. The JSNAs, led by Directors of Public Health, will provide a solid foundation for this work. Each PCT will continue to play an active part in local planning and partnership arrangements with governance arrangements led by the respective Local Authorities.

### 8.2 Development of pathfinder GP Consortia

By April 2013 consortia will be established as freestanding NHS bodies with responsibility for commissioning a wide range of services. PCTs will be accountable for commissioning up to April 2013. NHS NCL will be:

- working within the single London-wide process for assessing pathfinder proposals;
- agreeing with pathfinders a timetable setting out when they will be assuming delegated responsibilities; and
- adopting London-wide model terms of reference and a scheme of delegation for a PCT Board committee to support delegation of responsibilities to pathfinders.

### 8.3 Links with Pan London commissioning arrangements

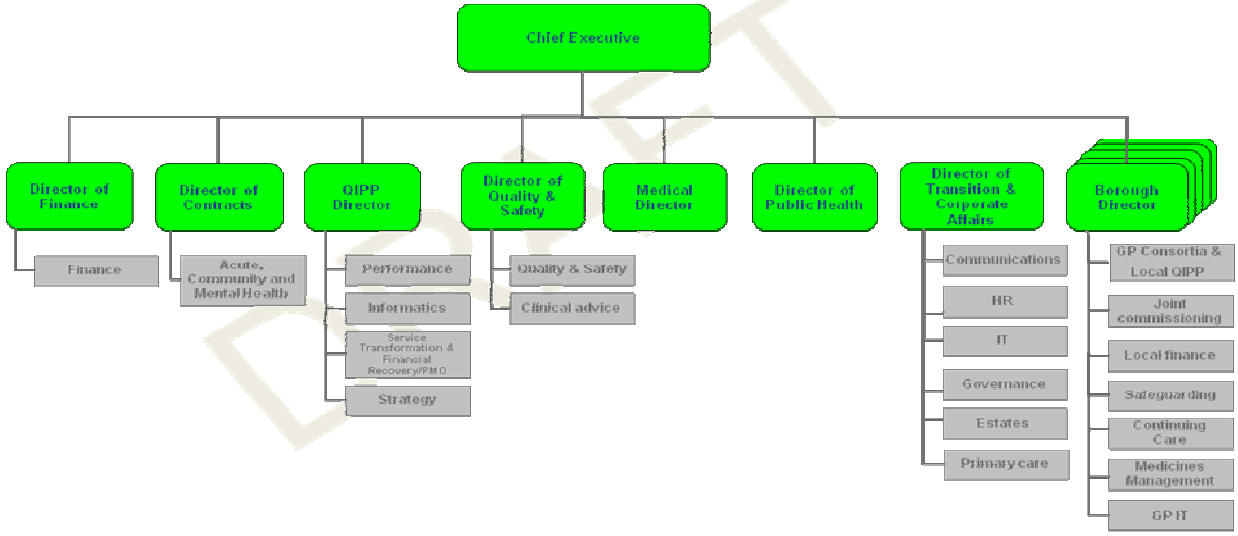
London Specialised Commissioning Group (LSCG) is hosted by NHS Croydon and is governed by the NHS NCL Governance Framework. The NHS NCL Chief Executive is accountable for the commissioning of these specialised services with NCL management responsibility lying with the Director of Contracts.

The current operating arrangements will be maintained with leadership from a Board whose non-executive directors are drawn from each of the London sectors including NCL.

## 9. OPERATIONAL DELIVERY - MANAGEMENT ARRANGEMENTS

9.1 In line with the Transitional arrangements approved by the PCT Boards in November 2010 for consultation the proposed senior structure is set out below.

NCL Structure






9.2 Directors have specific responsibility for the identification and management of risks as follows;

- co-ordinating operational risk in their specific area
- ensuring that all services for which they have responsibility are assessed appropriately for risks and mitigating action taken
- complying with the requirement for completion of their Directorate risk register(s)
- ensuring that risk treatment plans are produced for all extreme and high risks
- advising the Audit Committee where funding is not available to manage extreme or high risks
- monitoring progress against action plans
- ensuring that their staff are aware of their risk management responsibilities
- establishing and maintaining a team brief forum where risk management is a regular item
- incorporating risk management in the business planning process
- ensuring that policies and procedures agreed by the statutory Boards are implemented.

## 10. ASSURANCE ARRANGEMENTS

10.1 To complement and support the Governance arrangements, the Joint Boards will also receive assurance, both internally and externally, with the objectives of;

- providing the means of assurance as required by the Governance Framework
- using the Assurance processes as a means of ensuring that the Governance framework is complete and current

The various sources of internal and external assurance available to the Boards are set out in Appendix i.

10.2 As part of the overall assurance arrangements and in order to meet the requirement to complete an annual Statement on Internal Control, the Board is required to have in place a Board Assurance Framework (BAF). The BAF is a document that sets out the risks for each organisational objective, along with the controls in place and assurances available on their operation.

10.3 The purpose of the BAF is to provide the statutory Boards with "reasonable" assurance that systems are in place to identify and control risks that may prevent the organisation from achieving its principal organisational objectives. The term "reasonable" assurance is used in recognition of the fact that it is unlikely ever to be possible to provide absolute assurance that all risks have been identified and effectively controlled. Nevertheless, the BAF aims to provide the board with assurance that risks have been identified and are being appropriately controlled, and that there is timely and reliable assurance in place to evidence this. Importantly, there are a number of questions that this process sets out to answer as follows;

- How can the board be confident that its objectives can be achieved, what assurances exist?
- What are the risks that may prevent the achievement of strategic and corporate objectives?
- What actions are in place to manage those risks?
- How does the board know that these are effective?

In assessing risks, NHS NCL will ensure through its risk management strategy that this is done on a realistic basis and that any potential risks to achievement of its objectives and reasonably foreseeable. Full details of processes for gaining assurance through the BAF will be set out in the NCL risk management strategy.

## 11. MONITORING AND REPORTING

The Joint Boards will draw assurance from the following arrangements for ensuring that both the risk register and assurance framework are proactively monitored so that the processes are embedded within the organisation and link to key business, planning and investment decisions:

- Directorate Risk Registers - monitored at directorate level Directorate level and reviewed at the Operational Risk Committee
- Corporate Risk Register - monitored at Audit Committee.
- Assurance Framework - monitored at corporate level by lead Directors; for fitness of assurances/controls at Audit Committee; reviewed by statutory Boards.

## 12. CONCLUSION

12.1 The governance strategy and assurance framework are supported by the implementation of the key strategies, policies and plans. The Joint Boards need to remain confident that the systems, policies and people they have in place are operating in a way that is effective, are managing the delivery of objectives and targets and are focused on good governance practices.

12.2 In order to achieve this confidence, the PCT statutory Boards will

- review the governance arrangements after six months, and then annually to ensure they remain fit for purpose

- review and revise the organisational objectives identified with the assurance framework on an annual basis
- review the internal and independent assurances on which the assurance framework relies and make adequate arrangements to address any gaps
- require corporate documents and policies to be regularly reviewed, monitored and audited in accordance with the process identified within each document.
- implement and maintain an adequate performance review framework
- receive information/annual reports in accordance with the Boards' annual programme, and as delegated to Committees
- consider the internal auditor's opinion statement to improve the robustness of the assurance framework
- consider the outcomes of other independent assurance to improve the robustness of the assurance framework
- receive annual and other reports from core governance committees
- receive reports and communication from directors, managers and staff
- undertake evaluation of the performance of the statutory Boards as a minimum bi-annually.

12.3 Effective governance and assurance arrangements are critical in ensuring the confidence of the boards, staff, patients, the public and partner organisations and for the effective delivery and execution of its functions. Developing a culture of openness and transparency is integral to assuring all of the effectiveness of these arrangements, together with an environment that fosters and develops personal and organisational growth as a key to success.

**Appendix i**

## "Corporate Governance" in the NHS – A Glossary of Terms

*"The ideas, principles and mechanisms constituting governance in the NHS derive from an amalgam drawn from corporate governance, public governance and a variety of other sources. The resulting miscellany presents directors, managers and senior clinicians with a considerable sense-making challenge".*

(Richard Solti & John Storey, Clinical and non clinical director's sense making of the new governance arrangements in the NHS. Open University Business School, May 2008).

### 1. Corporate Governance

A basic definition of (corporate) governance is:

***"the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness."***

In effect, it is concerned with systems, processes, controls, accountabilities and decision-making at the heart of and at the highest levels of an organisation. It is about the way the organisation leads and manages through its values (in the public sector usually accountability, probity, openness) and its systems (such as governance structures and risk management).

### 2. Governance Framework

This describes the arrangements and systems that are in place to "direct and control" the organisation. For NHS NCL these are our Committee structures, management arrangements, Standing Orders, and risk management strategy and systems. These arrangements also provide the "**assurance"** that the organisation relies on to know that its governance arrangements are effective.

### 3. Assurance

3.1 **Assurance** is the positive evidence that controls are managing a given risk and it is likely that the underlying objective will be achieved. As the Audit Commission report "Taking it On Trust" suggests an informal way of looking at it was given by the chief executive of a Foundation Trust who said "assurance is about me being able to sleep at night" or put another way, "how do I know what is being done in my name?".

3.2 For a Board there are many sources of assurance (sometimes referred to as the **Assurance Framework**), some of which are as follows;

**Sources of Assurance**

| Internal sources of assurance | External sources of assurance |
|---|---|
| • Internal audit<br>• Performance monitoring reports<br>• KPIs<br>• Sub – committee reports<br>• Compliance audit reports<br>• Clinical audit<br>• Local counter fraud work<br>• Staff satisfaction surveys<br>• Staff appraisals<br>• Training records<br>• Training evaluation reports<br>• Results of internal investigations<br>• SUI reports<br>• Complaints records<br>• Infection control reports<br>• Standards for Better Health self assessment<br>• Patient advice and liaison reports<br>• Human resource reports<br>• Internal benchmarking<br>• Board Assurance Framework<br>• Strategic Plan/Annual Operating Plan objectives (delivery of national objectives)<br>• Risk Management Strategy<br>• Executive Director Board reports<br>• Executive Director reports to Committees and periodic attendance for review of risks/assurance | • External audit<br>• Audit Commission<br>• NHS Litigation Authority<br>• Clinical Negligence Scheme for Trusts<br>• Care Quality Commission<br>• Strategic health authority reports/reviews<br>• Royal College visits<br>• Deanery visits<br>• External benchmarking<br>• Patient environment action team reports<br>• Accreditation schemes<br>• National and regional audits<br>• Peer reviews<br>• Feedback from service users<br>• External advisers<br>• Local networks<br>• Investors in people<br>• World class commissioning assessment |

***(Primary Source: "Taking it on Trust", Audit Commission, 2009)***

3.3 The **Board Assurance Framework** (BAF) is a key document that sets out the trust's strategic objectives and the risks to achieving them, along with the controls in place and assurances available on their operation. It forms a key part of the annual statutory requirement for completion of the **Statement on Internal Control** (SIC) which the Chief Executive and Board sign off. The SIC represents confirmation that the governance and assurance arrangements for the organisation are operating as they should be.

## 4. Risk Management

4.1 Risk management is a key element of the governance framework and its components are described as follows;

**Risk** is the chance that something will happen that will have an impact on the achievement of the organisation's objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

**Risk Management** is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

**Risk Assessment** is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk.

## 5. Risk Registers

5.1 A **Risk Register** is

"***A log of risks of all kinds that threaten an organisation's success in achieving its declared aims and objectives. It is a dynamic living document, which is populated through the organisation's risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how these risks should be treated."*** *(Risk Register Working Group 2002, NHS Controls Assurance).*

5.2 NHS NCL has a structured approach in place for completion of its risk registers, as follows;

- The **Directorate Risk Register** contains a local record of all potential risks identified within the Directorate.
- The **Corporate Risk Register** contains those extreme and high risks that have been identified in the Directorate risk registers to the achievement of organisational objectives.
- The **Top Risks report** sets out the most significant risks to the organisation identified from the Corporate Risk Register. The risks are mapped to the Board Assurance Framework.

## 6. Other Important Terms

6.1 **Integrated Governance** has become the overall term to describe the various forms of governance such as corporate, clinical and financial, and is described as follows;

***"Systems, processes and behaviours by which organisations lead, direct and control their function in order to achieve organisational objectives, safety and quality of service…."*** *(Integrated Governance Handbook, 2006).*

6.2 **Clinical Governance** is described as;

***"The means by which organisations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards."*** *(Clinical Governance; a quality duty for health organisations 1998, Liam Donaldson)*

February 2011

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North Central London
NHS
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**Appendix 4.0**

# Implementation of a Single Management Team for the PCTs in North Central London

## Report of the staff consultation process

(This is an extract. Full report available online at http://www.islington.nhs.uk/board-papers.htm)

### 1. Background and national context

This report outlines the final proposals for establishing a single management team for the commissioning PCTs in North Central London (NHS Barnet, NHS Camden, NHS Enfield, NHS Haringey and NHS Islington). This follows a 90 day consultation with commissioning staff from the five PCTs and the current NCL Sector team.

Change is necessary to meet the national requirement to make significant management cost savings by 2012/13. Across North Central London (NCL) we have to make approximately 54% management cost savings by 2011/12, which equates to around £28 million.

In order to meet these savings, the five PCTs in NCL proposed to create a single transitional organisation across all five NCL PCTs, led by a single management team. There would also be a local presence retained in each of the five boroughs. These arrangements would come into effect from 1 April 2011.

This proposal was primarily designed to meet the management cost savings target. However, the single management team arrangement will also allow our PCTs the flexibility to transition to the future commissioning arrangements set out in the Government's July 2010 White Paper (*Equity and Excellence: Liberating the NHS*). It is anticipated that PCTs will be abolished by April 2013 when commissioning responsibility will hand over to GP consortia, the National Commissioning Board or local authorities.

Arrangements for public health services are changing too, as set out in the Public Health White Paper released in December 2010. The single management team proposal recognises that future public health structures will be determined by further national guidance and discussion with local authorities.

The five PCT Boards agreed in November 2010 that an integrated single management team structure was the best solution for the transition period from 1 April 2011 – 31 March 2013 and to achieve the management cost savings target.

This approach has been reinforced by David Nicholson, NHS Chief Executive. In a letter to all NHS chief executives across the country (December 2010), he proposed the establishment of PCT clusters, with a single management team, to:

- Deliver PCT statutory functions until April 2013
- Support emerging GP commissioning consortia
- Develop commissioning support providers to support consortia post April 2013.

This report outlines the consultation process conducted, the key issues arising from the consultation, the main comments received from staff and responses to them, and the final proposals for the single management structure.

## 2. Consultation

Formal consultation on draft proposals for a single management team was undertaken between 22 November 2010 – 21 February 2011 (90 days), following the principles set out in the London Change Management Policy. This policy is NHS London's change management policy which was adopted by all PCTs in NCL for use during this change process and made available to staff on intranets.

Consultation took place with staff and their representatives from the five commissioning PCTs in NCL, as well as staff working in the current NCL Sector team who are also affected by these changes. Other key stakeholders were engaged during the 90 day consultation period, including PCT non-executive directors, local authorities and GPs.

### 2.1 Consultation principles

The principles that have underpinned this consultation were set out in the consultation document and have been followed to ensure meaningful consultation with staff. These are:

- Provision of information for meaningful consultation
- Openness and transparency
- Informing all affected staff
- Treating staff as individuals
- Right of representation
- Taking steps to reduce number of compulsory redundancies
- Support through the process and to obtain future employment

### 2.2 Structure design workshops and consultation documents

Formal consultation was based on a consultation document which contained the proposed structures for a single management team comprising a central team and five teams based in each of the NCL boroughs.

The draft structures were put together prior to consultation in a series of design workshops held with PCT and Sector directors, chief executives and senior staff. Staff were invited to comment on the draft structures throughout the consultation period.

Throughout the consultation, new versions of the consultation document were released to staff to reflect refined information or changes to the structures made in light of comments received. Appendix 4.1 shows the chronology of consultation activities and release of information to staff during consultation, including revisions to the original consultation document.

### 2.3 The consultation process (staff)

Consultation took place between individuals and their employing PCT. This meant that PCT HR and communications leads took responsibility for managing their consultation process locally. However, there were a number of centrally produced resources for all staff and central guidance for PCTs on managing the consultation. This included ensuring that all staff in the five PCTs and current Sector team received new information at the same time and had similar opportunities to comment and express their views throughout the consultation period.

During the consultation period, across the cluster:

- 23 staff briefing sessions took place with chief executives and HR leads;
- 14 all staff consultation update emails were sent out;
- 138 questions were answered through the central online intranet portal;
- 18 partnership or local joint staffside meetings took place.

### 2.4 The consultation process (staffside)

Staffside have played a key role in this consultation and their input has shaped many aspects of the consultation process and supporting documentation. Before formal consultation began, managers and staffside formed a partnership group. This group comprised key managers and staffside representatives who worked together during the change process. This group met regularly during consultation.

### 2.5 The wider consultation process

PCT non-executive directors (NEDs) were engaged during the consultation period. A NEDs transition group, with representation from each PCT, worked closely with the transition project team to offer support, input and challenge throughout consultation. Meetings took place fortnightly during the consultation period and their input fed into several areas of the consultation process including voluntary redundancy processes, proposed structures, the appointments process and staff communication activities.

## 3. Other key decisions and changes throughout the consultation process

### 3.1 Office location

NHS NCL staff will move to offices at Stephenson House, 75 Hampstead Road, NW1 2PL. Local Borough teams and local Public Health teams will continue to be based in their local boroughs for the foreseeable future. The process of agreeing any change to the local borough presence locations can be shared with local Overview & Scrutiny Committees.

### 3.2 Number of posts affected

Appendix 4.3 shows a revised number of affected posts (764 wtes), together with an estimated number of compulsory redundancies that are expected as a result of these changes. Our best estimate of the number of compulsory redundancies is within the range of 80 to 120 wtes. We are unable to be more precise until the appointments process has been concluded because redeployment of staff at-risk into the posts available for recruitment cannot be predicted.

It should be noted that the final estimated number of compulsory redundancies is much lower than originally estimated. The lower estimate arises from the reduction in staffing numbers as a result of steps taken to avoid compulsory redundancy:

- Restricted recruitment has been in place across all NCL PCTs for the last 12 months.
- PCTs have been reducing interim and agency usage.
- Natural turnover of staff.
- Following agreement with staffside and in line with the London Voluntary Redundancy Policy, voluntary redundancy has been offered twice to staff affected by this change during the consultation period.

## 4. Final proposed structures

The final proposed structure for the single senior management team is shown in appendix 4.2.

## 5. Next steps

The next steps to implement the proposals include:

- Completing the staff appointment process
- A programme of work focused on business continuity is underway to ensure that knowledge and information is not lost during the transition from six organisations into one. Significant work has gone into producing comprehensive handover guidance for any staff leaving the Sector or changing roles. This handover guidance is being championed by chief executives and directors and has been communicated widely to all staff and managers.
- A Transition Board has been established to oversee all transition programme activities that are not related to HR. This includes office relocation, business continuity, IT, organisation development and governance.
- Outplacement services to support staff who have been unable to be redeployed are being developed and will be promoted to affected staff.
- The new organisational structures will be operational from 1 April 2011.

## 6. Appendices

4.1 Chronology of consultation activities
4.2 Final NCL structure chart
4.3 Number of posts affected by the consultation and changes
4.4 The appointments process

North Central London NHS
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## Appendix 4.1

## Consultation chronology: summary of consultation activities and documentation November – March 2011

| November 2010 |
| --- |
| 1-12: First round of structure design workshops |
| 2: NHS Haringey staff email |
| 5: NCL Sector Delivery Board meeting |
| 5: NHS Haringey staff email |
| 7: NHS Haringey staff briefing session |
| 9: Partnership Meeting |
| 12: NCL Sector Delivery Board meeting |
| 15: All staff email |
| 16: NHS Camden Primary Care Directorate Briefing |
| 18: NHS Islington Extraordinary Board meeting |
| 18: NHS Camden Extraordinary Board meeting |
| 18: NHS Barnet Extraordinary Board Meeting |
| 18: NHS Haringey Extraordinary Board Meeting |
| 18: NHS Camden Public Health Directorate Briefing |
| 19: NHS Enfield Extraordinary board meeting |
| 22: Launch of staff consultation |
| 22: All staff email |
| 22: Launch of dedicated consultation intranet pages |
| 22: All PCTs and the NCL Sector hold staff briefing sessions to launch the consultation |
| 22: Dedicated HR helplines set up (for two weeks) – all PCTs and NCL Sector |
| 24: NHS Enfield staff email |
| 24: NHS Haringey Public Board Meeting |
| 25: NHS Islington Public Board meeting |
| 25: NHS Enfield Public Board meeting |
| 25: NHS Barnet JSC meeting |
| 25: NHS Camden JSC meeting |
| 26: NCL Sector Delivery Board meeting |
| 26: NHS Enfield staff email |
| 26: NHS Camden senior managers briefing |
| 26: NHS Haringey JSC meeting |

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| 29: Version 2 of staff consultation document issued – to include public health structures |
| 29: NHS Enfield staff email |
| 29: NHS Camden Communications and Corporate Development Directorate briefing session |
| 29: All staff email |
| 30: NHS Camden Finance Directorate briefing session |
| 30: NHS Camden staff email |
| **December 2010** |
| 1: Voluntary redundancy scheme round 1 opens for applications. |
| 1: All staff email and FAQs to launch voluntary redundancy scheme |
| 2: NHS Barnet Public Board Meeting |
| 3: Partnership Meeting |
| 6: Version 3 of consultation document released – to include IT structures, and some amendments |
| 6: NHS Islington JSC meeting |
| 6: NHS Islington staff email |
| 6-10: At risk/Not at risk letters issued to staff |
| 8: NHS Enfield staff email |
| 9: NCL Sector Public Board Meeting |
| 9: NHS Enfield staff email |
| 9: NHS Haringey staff briefing session |
| 10: NCL Sector Delivery Board meeting |
| 10: NHS Camden staff email |
| 13-21: Second round of structure design workshops take place to address comments received to date. |
| 13: Version 4 of consultation document released - to include role summaries for each posts and revisions to the number of posts affected by consultation |
| 13: Equality Impact Assessment updated, including baseline data. |
| 13: All staff email |
| 13: NHS Camden Public Board meeting |
| 14: Applications for voluntary redundancy scheme round 1 close |
| 14: NHS Islington staff email |
| 15: NHS Enfield staff email |
| 17: Draft appointments process issued via all staff email and intranet |
| 17: NHS Haringey JSC meeting |
| 17: NHS Camden staff briefing session |

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| 17: NHS Camden Public Health Directorate briefing session |
| 17: NHS Camden staff email |
| 21: All staff email |
| 21: NHS Islington staff briefing session |
| 21: NHS Enfield staff briefing session |
| 22: NHS Camden staff email |
| 22: NHS Camden JSC meeting |
| **January 2011** |
| 4: Partnership Meeting |
| 5: NHS Barnet JSC meeting |
| 5: NHS Barnet staff email |
| 6: Job description drafts completed |
| 6-28: Job evaluation and matching panels (continued in February for any outstanding issues) |
| 7: New NHS NCL Chief Executive appointed – Caroline Taylor |
| 7: NCL Sector Delivery Board meeting |
| 12: All staff email |
| 12: Verification workshop – PCT and Sector chief executives meet to agree changes proposed to structures in the second round of design workshops. |
| 13: NHS Camden staff briefing session |
| 14: Voluntary redundancy scheme round 2 opens for applications. Launched by all staff email and intranet. |
| 17: NHS Enfield staff email |
| 17: NHS Islington staff email |
| 17: Guidance and supporting documentation for managers to carry out formal one-to-one meetings with staff is released. Meetings start. |
| 17: NHS Camden Public Health Directorate briefing session |
| 18: NHS Enfield staff briefing session |
| 18: NHS Islington staff briefing session |
| 18: NHS Camden staff email |
| 18: NHS Camden Primary Care and Finance Directorate briefing sessions |
| 19: Version 5 of consultation document issued – to include changes to structures agreed at the verification workshop on 12 January. |
| 20: NHS Barnet staff email |
| 20: NCL Sector Public Board Meeting |
| 20: NHS Barnet Public Board Meeting |
| 21: NCL Sector Delivery Board meeting |

| |
|---|
| 21: All staff email regarding new office locations |
| 22: NHS Enfield staff briefing session |
| 24: NHS Camden Public Board meeting |
| 24: NHS Haringey staff briefing session |
| 24: NHS Camden staff email |
| 25: NCL Sector staff briefing session |
| 25: NHS Barnet staff briefing session |
| 25: NHS Enfield staff email |
| 26: Partnership meeting |
| 26: NHS Camden JSC meeting |
| 26: NHS Haringey staff briefing session |
| 26: NHS Haringey Public Board meeting |
| 27: NHS Islington Public Board meeting |
| 27: Public Board meeting |
| 27: NHS Enfield staff email |
| 28: Director appointments process started |
| 28: All staff email |
| 28: Most job descriptions made available on intranets and on an external site so staff could view from home. |
| 28: NHS Haringey JSC meeting |
| 31: Letter to all staff re transfer of personal data to NCL sector transition team |
| 31: Applications for voluntary redundancy scheme round 2 close. |
| 31: NHS Enfield staff email |
| 31: NHS Camden staff email |
| **February 2011** |
| 1: NHS Camden staff email |
| 2: Partnership meeting |
| 2: NHS Enfield JSC meeting |
| 3: NHS Barnet Public Board meeting |
| 4: NCL Sector Delivery Board meeting |
| 7: NHS Islington staff briefing session |
| 7: NHS Islington JSC meeting |
| 9: All staff email |
| 11: Version 6 of the consultation document issued – to include revised figures for the number of posts affected by consultation and additional changes to structures made since version 5. |
| 11: NHS Camden staff briefing session |

14: All staff email from new NCL Chief Executive

16: NHS Camden JSC meeting

16: NHS Haringey staff briefing session

16: All staff email

17: Completion of formal staff one to one meetings with managers

18: NCL Sector Delivery Board meeting

18: NHS Enfield JSC meeting

18: NHS Haringey staff briefing session

19: Version 6.1 of the consultation document issued – corrected minor errors in version 6.

21: Staff consultation ends

22: NHS Barnet staff briefing session

24: NCL Sector Public Board Meeting

25: NHS Haringey JSC meeting

28: PCT Board Meetings (x 5)

March - appointments process

1 April – new sector organisation arrangements come into effect.

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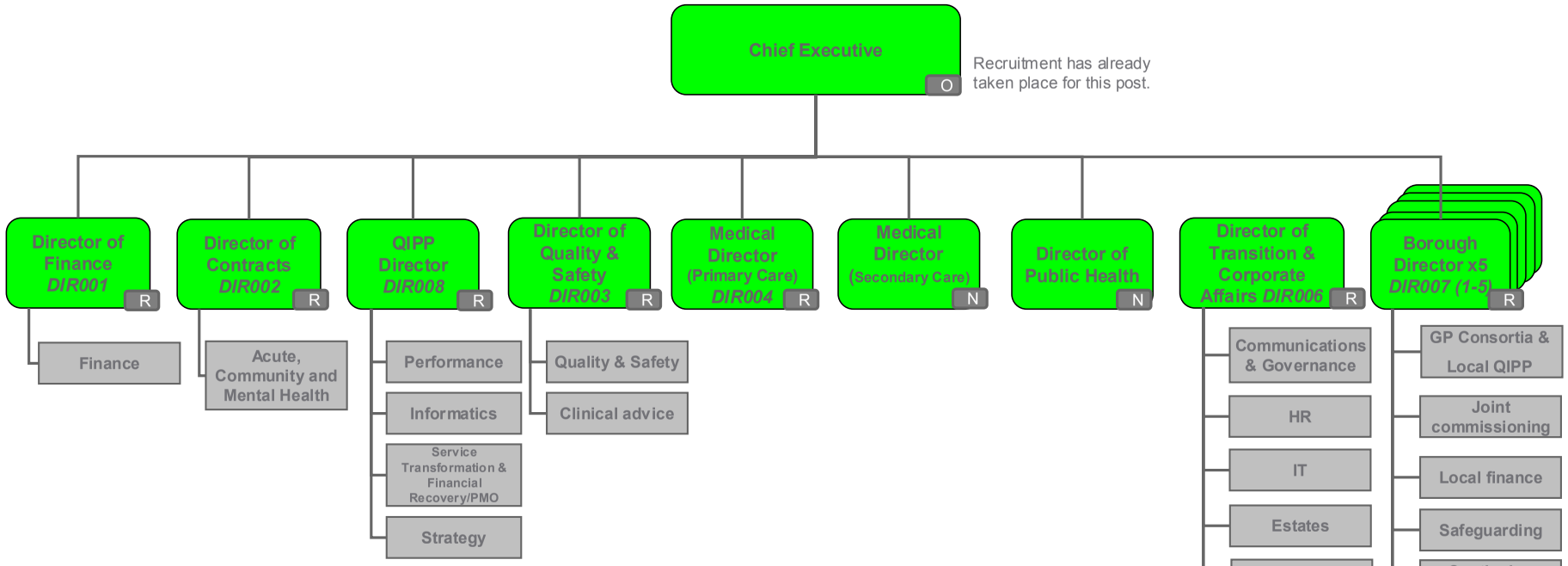
**Appendix 4.2**
**Final NCL structure chart**

# NCL Structure




**Key for Pay Bands**

- VSM and 9
- 8d and 8c
- 8b and 8a
- 7 and 6
- 5 and below

**Key for Recruitment**

- R — Post will be open for recruitment (or potential slot-in) following consultation.
- N — There is no change to this post and no recruitment
- O — O = Other. *Explanation is given.*

* QIPP – Quality, Innovation, Productivity and Prevention

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**Appendix 4.3**

**Numbers of posts affected**

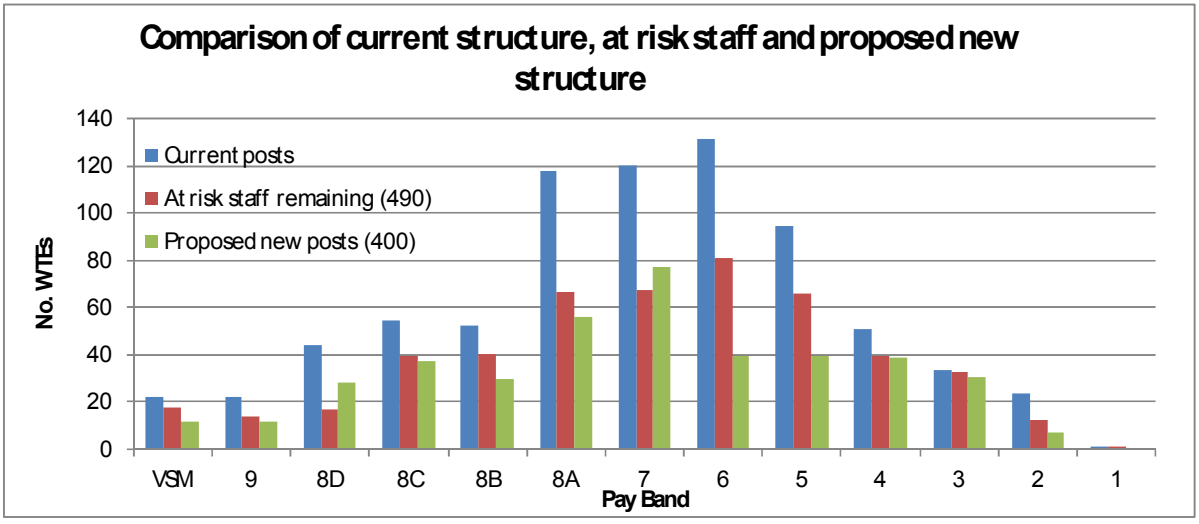
Validation and rechecking of the current posts and staff impacted by the consultation has been an ongoing process. The final outturn is summarised in the following table:

| | **WTEs** |
|---|---|
| **(1)** Impacted posts in current PCT structures identified at the start of this consultation. | 764 |
| **(2)** Above posts which were vacant, or filled by non-permanent staff, or where the member of staff has subsequently resigned. | (170) |
| **(3)** At risk staff – staff who have been issued with an "at risk" letter and whose existing post are confirmed as being included in (1) above. | 594 |
| **(4)** At risk staff who have applied for, have had their application approved, and have accepted voluntary redundancy. | (105) |
| **(5)** Staff remaining at risk. | 489 |
| **(6)** Jobs in the new structure available for competitive selection or slot in*. | (401) |
| **(7)** Net at risk staff | **88** |

* There are approximately 30 vacant posts included in the structure charts which are not within the "management cost" definition. Applications for these posts will initially be restricted to the at risk staff.

In summary, there are 88 fewer available posts when compared to the number of at risk staff remaining. However the eventual number of compulsory redundancies is likely to differ from 88. It may not be possible to fill all posts from the NCL at risk pool due to mismatches of skills. On the other hand, some of the at risk staff may secure employment in other sectors or elsewhere within the NHS and therefore will not be eligible for redundancy. Our best estimate of the number of compulsory redundancies is therefore in the range 80 to 120.

A banding comparison of at risk staff to available posts is summarised in the following graph:




Appendix 4.3 – number of posts affected

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North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

## Appendix 4.4

## Appointments Process to the Single Management Team for PCTs in North Central London (as implemented from 17 December 2010)

### Introduction

The appointment and selection process has been developed based on the principles set out in *Strengthening Commissioning and Management Cost Savings London HR Framework.*

In the first instance, commissioning staff with permanent contractual employment status in one of the five NCL PCTs (Enfield, Barnet, Haringey, Camden and Islington, including sector staff) and placed at risk of redundancy by the changes planned to reduce management costs, will be eligible for appointment to the new structure.

The only exception to this is staff employed on Very Senior Managers (VSM) terms of employment and seconded into NCL from another sector, who following an NHS London directive, may choose in which sector pool they are ring-fenced (please see 'Special Circumstances' section, paragraph 1, for more detail).

The new structure will be operational from 1 April 2011.

### Principles for filling posts in the revised commissioning management structure for North Central London

1. Restricted competition will apply to all posts to ensure that existing staff have maximum opportunities to be considered for posts, and thereby minimising the number of redundancies.

2. Where staff are at risk they will be given priority at each stage of the recruitment process.

3. All HR processes should be fair and transparent and appointment and selection procedures should seek to match individual abilities with available posts while meeting the requirements both of equal opportunities legislation and best practice.

4. Staff in jobs directly comparable to a vacancy will have first consideration for a post (see slotting in and ring-fencing sections below for details).

5. New or changed jobs, or those not filled by slotting in or through the ring-fenced recruitment process, will be filled by restricted recruitment as follows:

    - Initially for NCL PCT and Sector commissioning staff.
    - Then in phase two for other NCL PCT staff affected by change and Commissioning Support for London (CSL) staff who are at risk.
    - Posts that remain vacant will then be filled using the London Redeployment Service.

6. The appointment process will be carried out in a timely way to enable changes to be made as required, minimise uncertainty and support business continuity.

**Agreeing new roles**

Once structures are agreed, posts will have a role description and person specification which will be subject to banding under Agenda for Change (AfC) and carry AfC terms and conditions of employment. The banding will be undertaken through normal partnership arrangements with unions.

A more tailored Knowledge and Skills Framework (KSF) outline will be agreed with each post holder once appointed.

**Slotting in**

There is a process for slotting in and ring fencing competition, where appropriate.

**Pay protection**

For staff on Agenda for Change (AfC), this will be in line with local protection policies. Protection for staff in VSM posts will be time limited and agreed up to 20% on top of the AfC salary point for the post, or up to 20% on top of the basic VSM rate for the job.

**References**

This HR Framework is based on the principles in the April 2010 Strengthening Commissioning HR Framework and also in the London NHS Partnership Model Change Management Policy (October 2009). It also aligns with the draft guidance being produced by DH “The NHS in a different resourcing environment: HR Framework to support the management of changes in employment patterns”.

| THE NHS IN NORTH CENTRAL LONDON | **BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON<br>**WARDS:** ALL |
|---|---|

**REPORT TITLE**: **Vascular Service Standards and Provider Activity**

**REPORT OF**:

Nick Losseff
Consultant Neurologist and Clinical Director, NHS North central London
Senior Responsible Officer, QIPP, NHS North Central London.

| **FOR SUBMISSION TO:**<br>North Central London Joint Health Overview & Scrutiny Committee (JHOSC) | **DATE: 25 March 2011** |
|---|---|

**SUMMARY:**

Following a presentation at the previous JHOSC meeting (21 January 2011), Members requested further information about the criteria being used by NHS North Central London (NCL) to ensure vascular services are configured according to best clinical practice.

Attached in Appendix 1 are the NCL clinical standards for vascular services. This is a working document, currently being iterated by vascular clinicians across the NCL.

Members also requested activity data for the three vascular surgery providers. Please see attached activity data for different areas of vascular surgery, including Aortic Aneurysms (Appendix 2), Lower Limb Revascularisation (Appendix 3), and Carotid Endarterectomy (Appendix 4). This data includes mortality rates across the various surgical areas and providers.

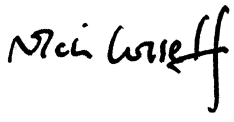
Dr Nick Losseff will discuss the clinical standards and the activity data with Members on 25 March, and respond to any questions they may have.

CONTACT OFFICER:
Sylvia Kennedy
Director of Clinical Strategy
NHS North Central London
Telephone 0203 317 2794
Email sylvia.kennedy@islingtonpct.nhs.uk

**RECOMMENDATIONS:**

The Committee is asked to note the content of the Appendices 1, 2, 3, 4.

**SIGNED:**



Dr Nick Losseff
Clinical Director, NHS North Central London
DATE: 17 March 2011

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Vascular: Appendix 1

# Vascular standards
## DRAFT

## 1. Organisation of Vascular Services

National guidance on the organisation of vascular services identifies that clinical outcomes will be improved if patients are cared for by an appropriately staffed and equipped specialist vascular service. This service should comprise a single hospital with in-patient facilities supported by day case and out-patient care in appropriate locations closer to patients' homes. For some patients, especially those needing care in an emergency, this will involve transfer to a hospital with appropriate facilities. There are, however, significant benefits of maintaining local out-patient and day case vascular services and supporting links with local acute and rehabilitation services. A minimum population of 800,000 is considered necessary for a vascular service. This is based on the population required for an aortic aneurysm screening service, the number of patients needed to maintain competence among vascular specialists and nursing staff and the most efficient use of specialist equipment, staff and facilities.

The expected improvements to the quality of vascular services following implementation of the Quality Standards can be summarised as:

| | |
|---|---|
| Access | • Reduction in access for in-patient services as some patients will need to travel further.<br>• Access to out-patient, day case and rehabilitation services will be unchanged (and quality improved). |
| Patient experience | • Reduced length of hospital stay for vascular surgery patients<br>• AA repair is carried out by a specialist vascular surgeon |
| Clinical outcomes | • Reduction in mortality rates for Aortic Aneurysm (AA) repair<br>• Vascular surgery is carried out by a "high volume" surgeon at a "high volume" centralised hospital in a hybrid theatre<br>• The vascular surgeon is supported by a vascular specialist team including radiologists<br>• Specialist radiologists are available 24 hours per day for AAA repair<br>• Increased endovascular aneurysm repair rate |

| | |
|---|---|
| Service Outcomes | • Vascular Surgery patients should be treated in a centre with appropriate co-dependencies i.e.<br>- (1) coronary vascularisation facilities,<br>- (2) interventional radiology,<br>- (3) specialist anaesthetists,<br>- (4) dedicated vascular specialist nursing care,<br>- (5) dedicated vascular specialist PAM staff e.g. Physiotherapists, Occupational therapists and Social Workers<br>- (6) specialist neurology staff and facilities<br>- (7) interventional cardiology,<br>- (8) interventional radiology,<br>- (9) specialist intensive care unit,<br>- (10) specialist anaesthetics,<br>- (11) diabetic and neurology specialists,<br>- (12) cardiac surgery,<br>- (13) step down intensive care facility,<br>- (14) renal unit that includes dialysis facilities |

## 2. Introduction to Quality Standards

These Quality Standards are based on the Vascular Society's guidance '*The Provision of Services for Patients with Vascular Disease 2009*' and other relevant national guidance. The Quality Standards reflect the guidance in a form that is suitable for use in service specifications and in quality reviews. The Quality Standards aim to follow the patients' pathway and to ensure that the highest possible quality of care is available at each stage of the patients' journey. The Quality Standards help to answer the question "If I walk into a vascular service today, how I will know that best-practice guidance has been implemented?" They should be achievable by all services in two to five years. They concentrate on the structure and process aspects of quality and should be seen alongside indicators of outcomes.

## 3. Responsibilities

Responsibilities for achieving the quality standard are as follows

| **Quality Standard** | **Responsibility** |
|---|---|
| 1 – 2 | TBA |
| 3 - 52 | Lead consultant and lead nurse with the support of the Chief Executives of all Trusts within which the vascular service provides care for patients. |

## 4. Definitions and Abbreviations

**Vascular service:** A vascular service provides specialist care for people with vascular disease. Services for patients will be provided in several different locations by staff with specialist expertise in the care of patients with vascular disease who work together and link closely with support staff and other local services. The service may work across more than one Trust, although one Trust should host the service and take overall responsibility for its governance.

**Vascular specialist:** A consultant vascular specialist is a consultant vascular surgeon or a consultant interventional radiologist. A consultant vascular surgeon is a consultant who has undertaken a minimum of two years final stage training in a recognised vascular unit or who has equivalent experience and who regularly manages patients with aortic aneurysm disease and its associated conditions. A consultant interventional radiologist is a consultant radiologist who has developed a range of skills in interventional techniques and has maintained these skills through Continuing Medical Education, such as that provided by the British Society for Interventional Radiology, and, if necessary, by spending time in larger departments3 *The Royal College of Radiologists 'Standards for providing a 24 hour interventional radiology service'*

**Policies, Protocols, Guidelines and Procedures**

The Quality Standards use the words policy, protocol, guideline and procedure based on the following definitions:

**Policy:** A course or general plan adopted by a Trust, which sets out the overall aims and objectives in a particular area.

**Protocol:** A document laying down in precise detail the tests/steps that must be performed.

**Guidelines:** Principles which are set down to help determine a course of action. They assist the practitioner to decide on a course of action but do not need to be automatically applied. Clinical guidelines do not replace professional judgement and discretion.

For simplicity, some standards use the term 'guidelines and protocols' which should be taken as referring to policies, protocols, guidelines and procedures. All clinical guidelines should be based on national guidance, including NICE guidance where available. Local guidelines and protocols should specify the way in which national guidance will be implemented locally and should show consideration of local circumstances.

**Abbreviations:**

AAA Abdominal Aortic Aneurysm
CT Computer Tomography
DVLA Drivers and Vehicle Licensing Agency
HCA Health Care Assistant
HES Hospital Episode Statistics
MDT Multi-Disciplinary Team

NSF National Service Framework
PCT Primary Care Trust
TIA Transient Ischaemic Attack

| **Hospital Name:** | | **Date action plan last amended:** | | |
|---|---|---|---|---|
| Lead Surgeon accountable for delivery of service standards: | | | | |
| Lead Nurse accountable for delivery of service standards: | | | | |
| Lead Manager accountable for delivery of service standards: | | | | |
| **Quality Standard** | **Demonstration of Compliance** | **Base RAG** | **Action Plan** | Completion date |
| **SERVICE CONFIGURATION** | | | | |
| 1 | All service providers in North Central London should meet the commissioning requirements as outlined by NHS London. The current commissioning standards are for units to complete<br>• X number (e.g. 50) or more abdominal aortic aneurysms (AAAs).<br>• X number (e.g. 40) or more lower extremity bypass procedures<br>• X number (e.g. 30) or more carotid endarterectomies | Catchment area for the service agreed by the Acute Commissioning Unit.<br><br>Activity Data | | |

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| 2 | The service should have defined the locations on which in-patient, day case and outpatient vascular services are provided and the locations for the treatment of varicose veins. Each vascular service should normally have only one in-patient service. Outpatient vascular services should take place on, at least, all hospital sites accepting general medical and surgical emergency admissions. | Locations of services agreed by Acute Commissioning Unit.<br>*Notes:*<br>*1: In hospitals without complex on-site in-patient vascular services, outpatient and day surgery may be provided by local vascular specialists or by specialists visiting from another hospital – usually the hospital with complex in-patient vascular services.* | | | |

**SUPPORT FOR PATIENTS AND CARERS**

| | **Quality Standard** | **Demonstration of Compliance** | **Base RAG** | **Action Plan** | Completion date |
|---|---|---|---|---|---|
| | | | | | |
| 3 | Information should be offered to all patients covering at least:<br><br>• Vascular disease, including its causation and physical impact,<br><br>• Treatment options available | Examples of information available<br><br>*Notes:*<br>*1 Information should be available in formats and languages appropriate to the needs of the patients. This may include large* | | 1. Enlist patient Advisory Panel representative to ensure appropriate communication link with service users | |

| | | | | | |
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| | • Promoting good health, including smoking cessation.<br><br>• Symptoms and action to take if become unwell and who to contact with queries or for advice.<br><br>• Where to go for further information, including useful websites.<br><br>• Support groups available<br><br>• Vascular service staff and facilities available, including facilities for relatives | *print and or CD / DVD information.* | | | |
| 4 | All patients should be offered:<br>• A copy of the letter sent to their GP<br><br>• A permanent record of consultations at which changes to their treatment plan are discussed.<br><br>• The GP should receive a copy of the consultation letter within 5 days. | Discussion with patients. Review of case notes.<br><br>*Note: Patients should receive a copy of their letter within a week of the consultation at which it was discussed or less as per local performance standards* | | | |
| **STAFFING AND SUPPORT SERVICES** | | | | | |

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| 5 | The service should have a nominated lead consultant vascular specialist to support audit and governance. The service should have a nominated lead nurse with responsibility for ensuring implementation of the Quality and governance Standards. The nurse should also act as a patient advocate. | Name of lead consultant and lead nurse.<br>*Note: The lead consultant and nurse may be supported by senior clinicians who take a lead role on particular aspects of the service, for example, screening or training.* | | | |
| 6 | All emergency and elective vascular surgery should be undertaken by consultant vascular surgeons or by staff under their supervision. All vascular surgeons should undertake sufficient operations per annum to maintain competence. | Details of staffing available. Including consultant job plans junior Drs job plans and on call rotas.<br><br>Audit results.<br><br>Details of up to date MDT training and education programmes<br>*Note: 1 For the purpose of considering operations to maintain competence, activity undertaken in hospitals outside the vascular service under review may be included as part of surgeons' activity.* | | | |
| 7. | A nurse with specialist expertise in the following areas should be available: | Staffing details, including cover arrangements<br>*Notes:* | | | |

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| | • Wound and diabetic foot management.<br>• Explanation and lifestyle advice<br>• Amputation and liaison with rehabilitation<br><br>These nurses should have responsibility for leadership and service development for their area of specialist expertise. There should be arrangements for cover during absences.<br>As well as working with the MDT to support and develop acute nursing skills at ward level to ensure safe management of care 24/7 | *1 The nurse with specialist expertise in vascular access may be managed by the renal service or by the vascular service*<br><br>*2 These specialist roles may or may not be undertaken on a full-time basis and may include, for example, senior ward nurses with additional responsibilities. Sufficient time should, however, be allocated for the leadership and service development aspects of the roles.*<br><br>*3 Specialist expertise should be available to all patients across the network. The roles may, however, be undertaken by different people in different localities.*<br><br>*4 A system should be in place to support and train new members of staff working on the unit.* | | | |

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| 8 | Endovascular aneurysm repair and carotid stenting should be undertaken only by vascular specialists with competences in these procedures. | List of vascular specialists with competences in endovascular aneurysm repair and carotid stenting. Audit results.<br>*Note: Trust processes for introduction of new procedures should also be applied to the introduction of these procedures. Outcome data on performance of each specialist should be readily available via the Vascular data base and a case audit should be annually reviewed by peers within the network* | | | |
| 9 | A vascular specialist and support staff with competences in interventional radiology should be available for all elective vascular radiology procedures. | Staffing details<br>*Notes:*<br>*1 In hospitals without on-site in-patient vascular services, the vascular specialist and support staff may be based in the local hospital or may travel from another hospital – usually the one where in-patient services are located.*<br>*2 These services should comply with The Royal College of Radiologists, the British Society of Interventional Radiology 'Achieving Standards for Vascular Radiology' (2007) (or subsequent* | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | *updates of this guidance).* | | | |
| | **Quality Standard** | **Demonstration of Compliance** | **Base RAG** | **Action Plan** | Completion date |
| 10 | Sufficient administrative and clerical support should be available for data collection and timely discharge summaries. | Discussion with staff<br>Staff Job descriptions Rotas etc<br><br>*Note: 'Sufficient' is not strictly defined. Clinical staff should not be spending unreasonable amounts of time on administrative duties, including data collection, which detracts from their ability to provide patient care.* | | | |
| **STAFFING: HOSPITAL SITES ACCEPTING VASCULAR EMERGENCY ADMISSIONS**<br>**QS11 to QS17 apply only to hospitals accepting vascular emergency admissions and having in-patient services.** | | | | | |
| 11 | A consultant vascular surgeon should be available at all times. | Staffing details<br>*Note: A minimum of a X (E.g. 1:5) on call rota is required to achieve this QS.* | | | |
| 12. | An interventional radiology service should be available on-site at all times. | Details of service available:<br>*Note: A minimum of a X (E.g. 1:5) on call rota is required to achieve this QS. This service should meet The Royal College* | | | |

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| | | *of Radiologists 'Standards for providing a 24-hour interventional service' (2008) and The R.C.R British Society of Interventional Radiology 'Achieving Standards for Vascular Radiology' (2007) (and updates to these Standards).*<br>*The network will agree formal contingency plans to provide cross cover in case of emergencies as part of A2 sign off* | | | |
| 13. | An anaesthetist with up to date experience dealing with major complex surgical cases such a acute trauma vascular and other emergencies should be available at all times. | Detail of services available including rotas and job plans | | | |
| 14. | An in-patient ward should be available, staffed by nurses and HCAs with appropriate competences in care of patients with vascular disease. The competence framework should cover at least:<br>•Acute Life-threatening Events | Staffing details, competence framework showing expected competences and summary of competence assessments. | | | |

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| | Recognition and Treatment (ALERT)<br>• Tissue viability and wound care<br>• Pain management<br>• Care of patients with diabetes<br>• High Dependency Care | | | | |
| 15. | A member of staff with competences in vascular ultrasound should be available during normal working hours. At weekends there should be a system for identifying patients needing vascular ultrasound and providing scanning, if required, on a daily basis. | Staffing details including 7/7 working schedules<br><br>*Note: The member or staff may be a vascular technologist, radiographer, nurse or radiologist.* | | | |
| 16. | In hospitals providing in-patient vascular services, the following facilities and services should be available at all times:<br>• Emergency theatre<br>• Vascular angiography suite<br>• Critical care (at least level 3)<br>• Haematology (for urgent cross-match and blood products)<br>• Facilities for electronic transfer of imaging from, or ability remotely to view imaging at, other acute hospitals within the Network.<br>• Cardiac surgery | Details of facilities and staffing available | | | |

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| | • Renal unit that includes dialysis facilities | | | | |
| 17. | All vascular surgery should take place in a theatre with:<br><br>• Theatre staff trained in vascular instruments, prosthetics and techniques and in the use of cell salvage devices for blood conservation<br>• Stocks of grafts, instruments and sutures required for patients with vascular disease<br>• Hand-held Doppler ultrasound machine and portable duplex devices<br>• Access to blood and blood products<br><br>See Separate List (SO to complete) | Viewing facilities<br><br>*Note: This QS applies to all vascular surgery, including day case surgery on hospital sites other than that where in-patient vascular services are based.* | | | |
| 18 | In hospitals providing in-patient vascular services, the following facilities and services should be available at all times:<br><br>• Dedicated vascular specialist PAM staff e.g.<br>• Physiotherapists,<br>• Occupational therapists and<br>• Social Workers | Details of facilities and staffing available | | | |

| | | | | | |
|---|---|---|---|---|---|
| | • Specialist Neurology staff and facilities | | | | |
| **GUIDELINES AND PROTOCOLS** | | | | | |
| 19 | Clinical guidelines should be agreed with LAS covering the clinical indications for transferring patients from Accident and Emergency Departments of hospitals without inpatient vascular services to the hospital/s providing in-patient vascular services. | Written guidelines agreed with the ambulance service. | | | |

| | | | | | |
|---|---|---|---|---|---|
| 21 | Clinical guidelines covering referral to the vascular service should be in use in all Emergency Departments and General Surgery services. These guidelines should cover:<br><br>• Investigation and management of emergency vascular patients<br>• Management of haemodynamically unstable vascular patients<br>• Indications for seeking advice from the vascular service<br>• Indications and arrangements for emergency transfer<br>• Indications and arrangements for non-urgent referral. | Written guidelines<br>*Notes:*<br>*The network will provide a structure and process to support clinical engagement.*<br><br>*1 This QS applies to all Emergency Departments and general surgery services within the catchment area of the vascular service.*<br><br>*2 Guidelines should be explicit about the arrangements for transfer of cross-matched blood.* | | | |
| 22 | A protocol for EVAR/TVAR graft surveillance should be in place. | Written protocol<br>*Note: The protocol may be that no surveillance is undertaken unless further evidence of effectiveness becomes available.* | | | |

| | | | | | |
|---|---|---|---|---|---|
| 23 | Discharge planning guidelines should be in use covering, at least:<br>• Discharge to rehabilitation facilities<br>• Discharge home with support from local rehabilitation facilities<br>• Referral to limb-fitting service<br>• Communication with the patient's General Practitioner.<br>• Primary care nurses for the support of long term conditions | Written guidelines<br><br>Will include clear referral process and protocols for transferring care back to local units and clinicians<br><br>Local steering groups will be in place as part of A2 standards to monitor and manage the referral process and identify risks | | | |
| 24 | The vascular service should be aware of local guidelines for end of life care. | Availability of guidelines relating to end of life care that are used by specialist palliative care services in the local area. | | | |
| **SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 25 | A multi-disciplinary team meeting to review the care of patients with vascular disease should be held at least weekly involving at least:<br><br>• Vascular specialists<br><br>• Radiologists regularly involved with the care of patients with vascular disease<br>• | Notes of meetings held.<br>*Notes:*<br>*Meetings will have records of attendance.*<br>*Recommendation/plan will be formally recorded in the medical notes*<br>*10 notes to be audited for quality assurance*<br><br>*1 All interventional radiologists and surgeons providing vascular services should attend the MDT meeting regularly.*<br>*2 Other staff, for example, ward manager, may also attend the MDT meetings.* | | | |

**GOVERNANCE**

| | **Quality Standard** | **Demonstration of Compliance** | **Base RAG** | **Action Plan** | Completion date |
|---|---|---|---|---|---|
| 26 | A ward-based multi-disciplinary team meeting to discuss the care of patients with complex rehabilitation and discharge needs should be held at least weekly involving at least: | Notes of meetings held<br>*Note: This QS applies only to hospitals with in-patient vascular services.* | | | |

| | | | | | |
|---|---|---|---|---|---|
| | • Ward manager<br>• Nurse with specialist expertise in care of patients with amputations (QS7)<br>• Physiotherapy (QS34)<br>• Occupational therapy (QS35)<br>• Social work (QS35) | | | | |
| 27 | The service should be collecting and submitting data on all index procedures to the National Vascular Database. | National Vascular Database reports showing risk-adjusted comparative outcomes for the service.<br>*Note: Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient services.* | | | |
| 28. | The service should have an annual programme of audits covering at least:<br><br>• Number of vascular operations undertaken by surgeon across the service's catchment area. | Details of audit programme.<br>*Note: Audits should cover all parts of the vascular service including activity in hospitals without on-site in-patient services and should include comparison of HES data and National Vascular Database numbers. Audits of operations by surgeon should include all vascular operations, including any undertaken by general surgeons.* | | | |

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|---|---|---|---|---|---|
| 29. | All policies, procedures and guidelines should comply with Trust document control procedures. | Policies, procedures and guidelines meeting reasonable document control quality requirements of monitoring, review and version control. | | | |
| 30 | The in patient service must have detailed business continuity plan to ensure that in the event of technical break down, theatre unavailability or other emergency situation, a formal protocol and back up service arrangements are available for the management of emergency and urgent patients. This may include formal transfer protocols within or outside NC London Vascular service | Business continuity plans for<br>Imaging<br>Theatre Services<br>Emergency Transfers, with clear links to LAS<br>Others | | | |
| | **TRUST AND COMMUNITY STAFFING AND SUPPORT SERVICES** | | | | |
| 31. | In-patient and community-based rehabilitation services with expertise in the care of patients with vascular disease, including amputees, should be available, including at least:<br>• Physiotherapy<br>• Occupational therapy<br>• Social Work | Description of services available and the local arrangements for patients being discharged back to a referring hospital without a complex vascular service.<br>*Notes: These services should be available for the whole of* | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | *the vascular service's usual catchment population but may be organised in different ways in different locations.* | | | |
| | **A2 Standards to be completed 6 months after original sign off.** | | | | |
| | **A2 SUPPORT FOR PATIENTS AND CARERS** | | | | |
| | **Quality Standard** | **Demonstration of Compliance** | **Base RAG** | **Action Plan** | Completion date |
| 32. | The following support services should be available:<br>• Interfaith and spiritual support<br>• Interpreters<br>• Bereavement support<br>• Information about these services should also be available. | Support services and relevant information available.<br><br>*Note: 'Availability' of support services is not defined but should be appropriate to the case mix and needs of the patients.* | | | |
| 33. | The vascular service should have:<br><br>• Mechanisms for receiving feedback from patients and carers about the treatment and care they receive. | Description of current arrangements.<br>Examples of changes made as a result of feedback from patients and carers.<br>*Note: Arrangements for feedback from patients and carers should involve surveys, focus groups & or other arrangements. If they are part of Trust-wide arrangements they must clearly identify* | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | *vascular services issues* | | | |
| **A2 STAFFING: HOSPITAL SITES ACCEPTING VASCULAR EMERGENCY ADMISSIONS** | | | | | |
| 34. | Physiotherapy services should be available with time allocated for their work with in-patients with vascular disease on weekdays and an on-call service at weekends. | Details of services available | | | |
| 35. | Access to the following services should be available for in-patients<br>• Occupational therapy<br>• Social Work | Details of services available<br><br>*Note: These services may be provided by staff who provide the post-discharge service (QS13) or by different staff.* | | | |
| 36. | In hospitals providing in-patient vascular services, magnetic resonance angiography should be available during normal working hours. | Viewing facilities<br><br>*Note: This QS is applicable only to hospitals with in-patient vascular services.* | | | |

| | | | | | |
|---|---|---|---|---|---|
| 37 | The Vascular Outpatient Service should have access to<br><br>• Vascular ultrasound<br>• Facilities to perform ankle brachial pressure tests<br>• Portable duplex scanner<br><br>All staff will be expected to evidence a competence framework for assessing, scanning and reporting carotid duplexes. | Observation of facilities and equipment<br><br>Staffing details<br><br>Summary of competence assessments.<br>*Note:*<br>*1 The service may be available within the outpatient clinic or imaging department. The service may be provided by a vascular technologist, radiographer, nurse or radiologist.* | | | |
| 38. | In-patient vascular wards should have:<br><br>• Hand-held Doppler ultrasound machine | Viewing facilities | | | |
| 39. | Guidelines on lifestyle advice for all patients should be in use covering, at least:<br>• Support for smoking cessation<br>• Dietary advice<br>• Programmes of physical activity and weight management. | Written guidelines<br><br>Evidence of secondary health promotion protocols for patients; follow up advice including contact details of key worker.<br><br>Audit of numbers of patients | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | referred to primary care smoking cessation teams<br><br>Review 10 sets of notes. | | | |
| **A2 GUIDELINES AND PROTOCOLS** | | | | | |
| 40 | Clinical guidelines should be in use covering indications for involvement of cardiology services in the care of patients with vascular disease. | Written guidelines agreed with cardiology service and pre-assessment. | | | |
| 41 | Clinical guidelines should be in use covering indications and arrangements for referral for psychological support. | Written guidelines | | | |
| 42 | Guidelines, agreed with the specialist palliative care services serving the local population, should be in use covering, at least:<br><br>• Arrangements for accessing advice and support from the specialist palliative care team.<br>• Indications for referral of patients to the specialist palliative care team.<br>• Arrangements for shared care between the vascular service and palliative care services. | Written guidelines, agreed with specialist palliative care service/s serving the local population. | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| 43 | A meeting with local rehabilitation services (QS13) should be held at least annually to review the links with the vascular service and address any problems identified. | Notes of meetings held. | | | |
| **A2 GOVERNANCE** | | | | | |
| 44 | The service should produce an annual report summarising activity, compliance with quality standards and clinical outcomes. The report should identify actions required to meet expected quality standards and progress since the previous year's annual report. | Annual report/s.<br>*Note: The National Vascular Database reports will provide much of the data for the annual report.* | | | |

**6. Outcome Indicators (To discuss....)**

| **Indicator** | **Unsafe** | **Acceptable** | **Achievable** | **Monitored by AAA Screening?** |
|---|---|---|---|---|
| 1. 30 day mortality following elective AAA surgery | >10% | <8% | <6% | Yes |
| **Domain of practice:** | **Data Source** | **Rationale** | **Target/norms/tolerance level** | |
| 2. Stroke rate (self-reported, 30 day)<br>Disabling<br>Non-disabling | NVD/HES | Key indicator | Target 2%, less than 3% acceptable 5% | |
| 3. 30 day mortality for Carotid Endarterectomy | HES | Key indicator | Target 1% (from UK carotid interventions audit 5) | |
| 4. Elective open infrarenal aneurysm mortality rate:<br>Crude<br>Case-Mix adjusted | HES/<br>NVD | Key indicator | Target – 3.5% (Vascular Society, 10)<br>Demonstration of mortality within Vascular society funnel plots | |
| 5. Ruptured infrarenal aneurysm repair mortality rate<br>Crude<br>Case-Mix adjusted | HES/<br>NVD | Key indicator | Demonstration of mortality within Vascular society funnel plots | |
| 6. EVAR – mortality rate<br>Crude<br>Case-mix adjusted | HES/NVD | Key indicator | < 3% | |
| 7. Amputation for critical limb ischaemia<br>30 day mortality – casemix adjusted | HES | Key indicator | Demonstration of mortality within Vascular Society risk-adjusted funnel plots | |
| 8. 30 day mortality rate following infrainguinal bypass<br>• Crude<br>• Case mix adjusted | HES | Key indicator | Target:<br>Demonstration of mortality within Vascular Society funnel plot<br>National average 4.2% (Fourth National Vascular Database Report, | |

| | | | |
|---|---|---|---|
| | | | Vascular Society report 2004, 12) |
| 9. In hospital graft occlusion rate<br>Diabetic<br>Non-diabetic | NVD | Marker of technical success of operation | Norms and benchmarks need to be established. |
| 10. In-hospital surgical site infection rate | HES/ NVD | Key indicator | Norms and benchmarks need to be established |
| 11. Readmission rate-stratified as:<br>Directly Related to vascular admission<br>Indirectly related<br>Not related | HES | Appropriate rates indicates good quality care with low complication rates and good discharge planning | Norms and benchmarks need to be established by the ACU. |

**Process Indicators (To discuss....)**

| **Domain of practice:** | **Data Source** | **Rationale** | **Target/norms/tolerance level** |
|---|---|---|---|
| **Carotid endarterectomy:** | | | |
| 12. Time from first event (stroke or TIA) to carotid endarterectomy (percentage of appropriate symptomatic cases operated on within 2 weeks)<br>Change to London stroke standard | NVD | Maximum benefit of operation derived from early intervention 1,2 | 100% (tolerance 90% to allow for patient choice) |
| 13. Pre-operative length of stay | HES/N VD | Shorter stay indicates good use of resources | < 24 hours – target 100% (tolerance level 95% to account for emergency surgery) |

| Domain of practice: | Data Source | Rationale | Target/norms/tolerance level |
|---|---|---|---|
| 14. Post-operative length of stay | HES/ NVD | Shorter stay indicates good use of resources | < 3 days (median from UK Carotid interventions audit 5) |
| 15. Carotid endarterectomy rate per 100,000 population | HES | Appropriate rate indicates good referral mechanisms and access to recommended treatment | 12 per 100,000 population (www.nice.org.uk 6) |
| 16. Number of carotid endarterectomies performed per unit per year | HES | Higher volumes associated with improved outcomes 7,8 | Minimum threshold – 30 cases per year 7,8 |
| **Aortic surgery:** | | | |
| 17. Length of pre-operative stay (elective repair) | HES | Shorter stay indicates good use of resources | < 1 day |
| 18. Length of stay (elective and emergency) | HES | Shorter stay indicates good use of resources | Elective - <9 days –median from HES Emergency -< 10 days- median from HES |
| **Amputation for critical limb ischaemia:** | | | |
| 19. Below knee to above knee revision rate | NVD/HES | Low rate indicates good decision making | Revision of amputation to higher level < 13.5% when compared to below knee amputation rate (HES) |
| 20. Post-operative length of stay – casemix adjusted | HES/NVD | Shorter stay indicates good use of resources and appropriate discharge to rehabilitation facilities | Median 25 days (HES) |
| 21. Amputation rate per 100,000 population – casemix adjusted | HES | Appropriate figures demonstrate good limb salvage rates and adequacy of care for patients with diabetes or CLI | Range 10-76 per 100,000 depending on casemix 11 |
| **Lower limb ischaemia: infrainguinal bypass** | | | |

| Domain of practice: | Data Source | Rationale | Target/norms/tolerance level |
|---|---|---|---|
| 22. Rate of operative revascularisation per 100,000 population (casemix adjusted) | HES | Appropriate figures demonstrate a proactive approach to revascularisation | Range 22-83 per 100,000 depending on casemix 11 |
| 23. Rate of endovascular revascularisation per 100,000 population (casemix adjusted) | HES | Appropriate figures demonstrate a proactive approach to revascularisation | Range 10-91 per 100,000 depending on casemix 11 |
| 24. Pre-operative length of stay (infrainguinal bypass)-<br>-Case mix adjusted | HES | Shorter stay indicates good use of resources, timely imaging and decision making | Target:<br>Elective - <1 day<br>Emergency -< 3 days |
| 25. Post-operative length of stay (infrainguinal bypass)<br>-Casemix adjusted | HES | Shorter stay indicates less complications, good use of resources and appropriate rehabilitation | Norms:<br>Elective – median 8 days<br>Emergency – median 14 days (HES) |
| 26. Ratio of prosthetic to vein grafts used | HES/ NVD | Vein graft associated with better outcomes | Target:<br>Prosthetic graft rate 0% (Tolerance up to 25%)<br>(Based on rate of 35% in Fourth National Vascular Database Report, Vascular Society report 2004, 12) |
| **Global measures:** | | | |
| 27. 18 weeks compliance | Trust Dashboard | Key indicator<br>Indicates efficient working, good practices and ease of access to services | National targets:<br>Admitted pathways > 90%<br>Non-admitted pathway >95% |
| 28. Completeness of data submission to NVD (percentage) | NVD / HES | Indicates engagement with clinical governance and quality improvement | Target 100% completion |

## 7. Relevant Guidance

| Year | Title | Published by |
|---|---|---|
| July 2010 | UK Audit of Vascular Surgical Services & Carotid Endarterectomy | The Vascular Society of Great Britain and Ireland |
| November 2009 | Interventional Radiology: Improving Quality and Outcomes for Patients. | Department of Health. Gateway Ref: 12788 |
| September 2009 | At a Glance Guide to the current Medical Standards of Fitness to Drive | Drivers Medical Group, DVLA, Swansea |
| August 2009 (Version 2.1) | Essential Elements in Developing an Abdominal Aortic Aneurysm (AAA) Screening and Surveillance Programme | UK National Screening Committee/ NHS Screening Programmes Abdominal Aortic Aneurism |
| August 3rd 2009, (Version 1.1) | NHS Abdominal Aortic Aneurysm Screening Programme - Quality Standards and Service Objectives | UK National Screening Committee/ NHS Screening Programmes Abdominal Aortic Aneurism |
| July 2009 (Version 2.0) | NHS Abdominal Aortic Aneurysm Screening Programme – Guidance for Public Health and Commissioners | UK National Screening Committee/ NHS Screening Programmes Abdominal Aortic Aneurism |
| May 2009 (Final Version) | Framework for improving the results of elective AAA repair | Council of the Vascular Society of Great Britain and Ireland |
| November 2008 | The Provision of Services for Patients with Vascular Disease 2009 – "Patients with a vascular emergency should have rapid access to a specialist vascular team in all parts of the UK" | The Vascular Society of Great Britain and Ireland |
| 2007 | The Provision of Emergency Vascular Services 2007 | The Vascular Society of Great Britain and Ireland |
| August 2006 | The Organisation and Delivery of the Vascular Access Service for Maintenance Haemodialysis Patients – Report of a Joint Working Party | The Renal Association<br>The Vascular Society<br>British Society of Interventional Radiology |

## 8. References

1. West Midlands Quality Review Service, West Midlands Clinical Advisory Group, 'Quality Standards for Services for Patients with Vascular Disease.
2. Department of Health, Stroke Team, Vascular Programme. National Stroke Strategy. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandguidance/dh_081062
3. Intercollegiate Stroke Working Party, College of Physicians. National Clinical Guidelines for Stroke Available at http://www.rcplondon.ac.uk/CLINICAL-STANDARDS/CEEU/CURRENT-WORK/Pages/Stroke-programme.aspx
4. Antithrombotic Trialists' Collaboration collaborative meta-analysis of randomised trials of anitplatelet therapy for prevention of death, myocardial infarction and stroke in high-risk patients. BMJ 2002:324:71-86
5. Fluvastin and perioperative events in patients undergoing vascular surgery. Schouten O et al., NEJM 2009 361:10, 980-989
6. UK carotid interventions audit. Available at: http://www.vascularsociety.org.uk/library/audit-and-research.html?start=10
7. Assumptions used in estimating a population benchmark. Available at http://www.nice.org.uk/usingguidance/commissioningguides/tia/assumptionstiaservice.jsp
8. Statistical modelling of the volume=outcome effect carotid endarterectomy for 10 years of statewide database. Griswold, M. E., Chang, D. C., Perler, A. P., 59:12,2002
9. Hospital and surgical determinants of carotid endarterectomy outcome. Feasby, T. E, Quan, H., Ghali, W. A.
10. Patch angioplasty versus primary closure for carotid endarterectomy. Bond R et al., Cochrane Database Syst Rev. 2009 (4): CD000160.
11. Framework for improving the results of AAA repair. Vascular Society. Available at: http://www.vascularsociety.org.uk/library/quality-improvement.html
12. Lower Limb Revascularisation Rates and Major Amputation Rates in England., McCaslin J. E., Hafez, H., Stansby G., British Journal of Surgery, 2007, 94:835-839.
13. Vascular Society of Great Britain and Ireland, Fourth National Database Report, 2004. Available at: http://www.vascularsociety.org.uk/library/audit-and-research.html

**Vascular Appendix 2: Aortic Aneurysms**

| | uclh | | | rfh | | | bcf | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Elective | Unplanned | Emergency | Elective | Unplanned | Emergency | Elective | Unplanned | Emergency | | Comment |
| Total Patients operated on | 64 | 0 | 13 | 78 | 0 | 18 | 42 | 0 | 7 | | Complex Aneurysm repair at UCLH was suspended between 8th Sep 2010 and 13th Dec 2010. The number of cases that were postponed during this period was 13 (at one per week). Hence the total annual run rate is 90 |
| Proportion of patients who are operated on who came in from screening programme? | 0% | n/a | 0% | 0.16% | n/a | 0.00% | 0% | n/a | 0% | | Clarified as National Screening Program |
| Proportion of patients with a known un-ruptured AAA of at least 5.5cms that are declined surgery | 11% | n/a | 0% | | n/a | 0.00% | 2.4% | n/a | 0% | | 8 patients |
| Pre-operative length of stay for elective patients to be kept below 1 day average. | 1.25 | n/a | n/a | 0.9 | n/a | N/A | 1 | n/a | n/a | | mean average shown<br>Median figures are<br>Elec = 1<br>Emer = 0 |
| On the day cancellation rate for elective AAA procedures | 0% | n/a | 0% | 0% | n/a | 0% | 0% | n/a | 0% | | |
| Number of patients who suffer a ruptured AAA whilst on the elective AAA waiting list | 1 | n/a | n/a | 1 | n/a | n/a | 0 | n/a | n/a | | |
| Proportion of AAA procedures performed using EVAR | 95% | n/a | 61% | 92% | n/a | 89% | 76% | n/a | 0% | | |
| Crude in-hospital mortality rate | 6.3% | n/a | 7.7% | 1.4% | n/a | 11.1% | 0.0% | n/a | 26.0% | | 5 deaths of which<br>4 complex abdominal<br>1 arch |
| Crude 30 day mortality rate | 4.7% | n/a | 7.7% | 0.0% | n/a | 11.1% | 0.0% | n/a | 0.0% | | 4 deaths of which<br>3 complex abdominal<br>1 arch |
| Proportion of patients discharged to level 3 critical care/ITU bed immediately following surgery | 100% | n/a | 100% | 8% | n/a | 42% | 0% | n/a | 100% | | |
| 30 day re-admission rate for patients who have undergone AAA surgery | 4.7% | n/a | 15.4% | 6.4% | n/a | 11.1% | 4.7% | n/a | 15.4% | | |
| Total length of hospital stay | 12 | n/a | 24 | 5.5 | n/a | 7 | 5 | n/a | 14 | | |

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**Vascular Appendix 3: Vascular Lower Limb**

| | | UCH | | RFH | | BCF | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Total** | **Claudication** | **Critical Limb Ischaemia** | **Claudication** | **Critical Limb Ischaemia** | **Claudication** | **Critical Limb Ischaemia** | **Claudication** | **Critical Limb Ischaemia** | **Comments** |
| Total Patients | 226 | 113 | 113 | 32 | 138 | | | 145 | 251 | |
| Leg Bypass patients | 56 | 23 | 33 | 9 | 22 | 0 | 18 | 32 | 73 | |
| Angioplasty patients | 170 | 90 | 80 | 23 | 116 | 54 | 160 | 167 | 356 | |
| Proportion of arterial bypass operations compared to angioplasty procedures | 24% | 20% | 29% | 39% | 19% | 0% | 11% | 19% | 21% | expressed as % of bypass patients as proportion of total |
| Pre-operative length of stay to be kept below 1 day for elective patients | 85% | 93% | 56% | 88% | 88% | 90% | 0% | 0.92 | 1.35 | 153 elective patients total<br>50 ischemic elective<br>103 claudicant elective |
| Primary amputation rate (i.e. amputations without prior attempt at revascularisation) | | | | | | | | | | |
| Secondary amputation rate below the knee (i.e. amputations following previous revascularisation) | | | | | | | | | | |
| Secondary amputation rate above the knee (i.e. amputations following previous revascularisation) | | | | | | | | | | |
| 30 day re-admission rate for patients who have undergone surgery | 3.10% | 1.70% | 4.40% | 3.10% | 1.40% | | | 2.10% | 2.80% | |
| Total length of hospital stay | 13 | 3 | 23 | 4.9 | 15 | | | 3.42 | 19 | |
| | | 2 | 5 | 1 | 2 | | | | | |
| | | | | | 1.921 | | | | | |

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**Vascular Appendix 4: Carotid Endarterectomy Quality Markers** **Calendar 2010 data**

| | UCH | | RFH | | BCF | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Symptomatic** | **Asymptomatic** | **Symptomatic** | **Asymptomatic** | **Symptomatic** | **Asymptomatic** | **Symptomatic** | **Asymptomatic** | **Comments** |
| Patient numbers | 40 | 4 | 16 | 2 | 26 | 11 | 82 | 17 | BLT |
| Proportion of patients treated within two weeks | 91% | 0% | 93% | 0% | 90% | 0% | 91% | 0% | |
| Pre-operative length of stay to be kept below 1 day for elective patients | 3 | 0 | 0.9 | 0 | 1 | 0 | 1.63 | 0 | One outlier at 9 days median = 0 |
| Crude in-hospital stroke rate | 4.5% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 2.4% | 0.0% | 1 cea patient 1 stent patient |
| Crude in-hospital mortality rate | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | |
| Proportion of procedures undertaken using a carotid artery stent | 4.5% | 0.0% | 2.6% | 0.0% | 0.0% | 0.0% | 3.7% | 0.0% | N=3 |
| 30 day re-admission rate for patients who have undergone CEA surgery | 4.8% | 0.0% | 0.0% | 0.0% | 2.7% | 0.0% | 3.7% | 0.0% | N=3 |
| 30 day persistent evidence of cranial nerve injury | 0.0% | 0.0% | 5.8% | 0.0% | 11.5% | 0.0% | 4.9% | 0.0% | N=4 |
| Proportion of patients who return to theatre within 30 days following surgery | 7.5% | 25.0% | 0.0% | 0.0% | 3.8% | 0.0% | 4.9% | 5.9% | Symptomatic = 4, Asymptomatic = 1 |
| Total length of hospital stay | 10 | 2 | 2 | 7.5 | 2 | 10 | 5.9 | 7.8 | Symptomatic skewed by HASU |

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Agenda Item 7

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

| THE NHS IN NORTH CENTRAL LONDON | **BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON<br>**WARDS:** ALL |
|---|---|

**REPORT TITLE**:
Overview of NHS NCL Commissioning Strategy and QIPP Plan 2011/12-2014/15

**REPORT OF**:
Nick Losseff, Consultant Neurologist and Clinical Director, NHS North Central London
Senior Responsible Officer QIPP, NHS North Central London.

| **FOR SUBMISSION TO:**<br>North Central London Joint Health Overview & Scrutiny Committee | **DATE:**<br>25 March 2011 |
|---|---|

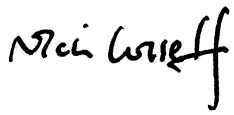
**SUMMARY OF REPORT:**

This paper provides Members with an overview of the key components of NHS North Central London's Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan for 2011/12-2014/15.

CONTACT OFFICER:
Anna Bokobza
Assistant Director – Strategic Programmes
NHS North Central London
Anna.Bokobza@islingtonpct.nhs.uk

**RECOMMENDATIONS:** The Committee is asked to note the contents of the report and the attached appendix, which is an extract from the NHS NCL Commissioning Strategy and QIPP Plan that gives additional detail on the individual initiatives planned.

**SIGNED:**



Dr Nick Losseff
Clinical Director, NHS North Central London

**DATE:** 17 March 2011

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

**Overview of NHS NCL Commissioning Strategy and QIPP Plan 2011/12-2014/15**

**Introduction**
This paper provides Members with an overview of the key components of NHS North Central London's (NCL) Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan for 2011/12-2014/15.

**Development of the plan**
Building on its existing Commissioning Strategy Plan, published in January 2010, the NCL Cluster commissioned a refresh of its plans in view of the new government agenda announced in the July White Paper together with a progressively more challenging financial position. This work has taken place in three key phases, in each case supported by a programme of stakeholder engagement:

1. The evidence underpinning the Case for Change was reviewed and updated between August and October 2010, when the draft was published entitled *Health and Health Services in North Central London. Now and into the future – 2011/12 to 2014/15* (www.ncl.nhs.uk);
2. An initial initiatives generation exercise took place between September and November 2010, to agree a long list of potential schemes that could be implemented to deliver the improvements required to address the quality and financial issues set out in the refreshed Case for Change;
3. A prioritisation framework was then applied to agree a shorter list of initiatives to be fully developed into robust programme and project plans, substantiated by detailed activity assumptions and financial savings estimates. A financial risk rating exercise was then completed, to inform the detail of the final plan submitted to NHS London on 7 March 2011.

**Case for Change**
The Case for Change clearly illustrates that doing nothing to change the way health services in NCL are commissioned is not an option:

- The "do nothing" scenario shows that the cluster will face a commissioning deficit in excess of £150m by the end of 2011/12, which would rise to a cumulative deficit of £730 million by 2014/15;
- There are additional financial risks to our healthcare providers that challenge their long-term sustainability. To date, only four of 11 Trusts have achieved Foundation Trust status;
- There are health inequalities between communities within the five boroughs;
- The quality of services varies across the sector;
- Primary care is underdeveloped relative to other areas and very variable;
- Our workforce needs to adapt in order to meet these challenges.

**Key QIPP work streams**
Our priority clinical areas have been identified from national, regional or local priorities where there are recognised issues with financial or workforce sustainability, either in terms of the current level of investment of levels or future demand, and/or quality of outcomes and patient experience. The list was developed and agreed in partnership with the GP commissioners of NCL.

Our programme of work can be grouped into a series of clinical priority work streams or cross-cutting QIPP themes as set out in the tables below.

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

| Work stream | Savings identified 11/12 (£m) | Cumulative savings identified 11/12-14/15 (£m) |
|---|---|---|
| **Clinical priority work streams** | | |
| Unscheduled care | 1.9 | 26.6 |
| Mental health | 6.2 | 17.7 |
| Care closer to home | 4.9 | 6.4 |
| Cancer | 0 | 20.5 |
| Cardiovascular | 0.2 | 2.1 |
| Maternity | TBC | TBC |
| Paediatrics | TBC | TBC |
| **Cross-cutting QIPP themes** | | |
| Acute productivity | 46.7 | 186.8 |
| Medicines management | 9.3 | 81.8 |
| Management costs | 10.1 | 71.4 |
| Low Priority Treatments, decommissioning and thresholds | 12.8 | 53.6 |
| QIPP in Primary Care | 2.1 | 4.2 |
| Staying Healthy | TBC | TBC |
| Local PCT QIPP | 14.1 | 56.6 |
| Unidentified QIPP | 25.0 | 230.5 |
| **Total** | **123.2** | **758.2** |
| **Surplus/(deficit)** | **(16.1)** | **93.6** |

The detail of the individual initiatives within each work stream, together with a summary of the Case for Change and the quality benefits can be found in Appendix 1 (extract from the NHS NCL Commissioning Strategy and QIPP Plan 2011/12-2014/15), which was shared with key stakeholders including local authority officers and councillors, GPs, LINk representatives, and service providers at the NCL Stakeholder Event on 3 March 2011.

Anna Bokobza
Assistant Director – Strategic Programmes
NHS North Central London
Anna.Bokobza@islingtonpct.nhs.uk

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North Central London

NHS

Barnet - Camden - Enfield
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# North Central London Sector Commissioning Strategy and QIPP Plan

28 February 2011

## KEY SECTIONS OF FINAL DRAFT
## Pre-reading for 3 March 2011 Stakeholder Event

Version: 110228 NCLQIPPUpdate prereading

# Foreword



The next few years will be extremely challenging for the NHS as we implement the vision contained in the coalition government's White Paper, "Liberating the NHS" together with the Health and Social Care Bill 2011, and deal with the unprecedented financial challenges facing us over the next four years.

This plan describes the North Central London (NCL) sector's strategic commissioning and Quality, Innovation, Productivity and Prevention (QIPP) plans for the next four years to support improvement in health and healthcare provision in NCL within the financial resources available. Within this, there will be a particular focus on the next two years as we aim to ensure that the healthcare system our General Practitioners inherit is both financially sustainable and clinically able to meet the needs of the local population.

The plan builds on our previous Commissioning Strategy Plan (CSP) published in January 2010 and retains the key themes of that plan of transferring care, where appropriate, from hospitals to community and primary care settings. Our discussions with GP commissioners as part of the planning process highlighted this as a key priority for them, along with improving services for Mental Health patients. Other priorities in the plan reflect work undertaken across London to improve patient outcomes in specialist services such as cancer and cardiovascular, local services such has maternity and areas where we have benchmarked our performance against others and identified improvement opportunities.

Our plan takes account of the approval of the Barnet, Enfield and Haringey (BEH) Clinical Strategy in January 2011 and assumes that the consultation on the reduction of Mental Health bed capacity with Camden and Islington NHS Foundation Trust leads to bed closures taking place. At this point, our plan does not include other major service or provider reconfigurations other than those agreed across London in specialist services. Throughout the course of our planning we have continued to discuss and review with providers the implications of our plan on them both in the short and longer terms. Potentially, these discussions may conclude that there is a need for further reconfiguration of provider services within NCL.

Similarly, we recognise that health service changes are very important to the public, patients, partners and other stakeholders. We have already engaged with various groups in developing our plan and, in keeping with out stated aim of being open and transparent, we will look to build further on this in the coming months, both in relation to the overall plan and individual initiatives and proposals with in.

We appreciate the importance of ensuring that in implementing the plan and developing it further, GP commissioners continue to be involved and where possible, assume leadership responsibility for its key elements.

Paula Kahn,

Sector Chair, NHS North Central London

Caroline Taylor,

Sector Chief Executive, NHS North Central London

# Contents



The final QIPP Plan will contain the following sections. To inform the discussions and debate at the stakeholder event on 3rd March, key extracts have been assembled in this pack but some elements are not included as they will either be covered on the day or are not critical elements in the plan.

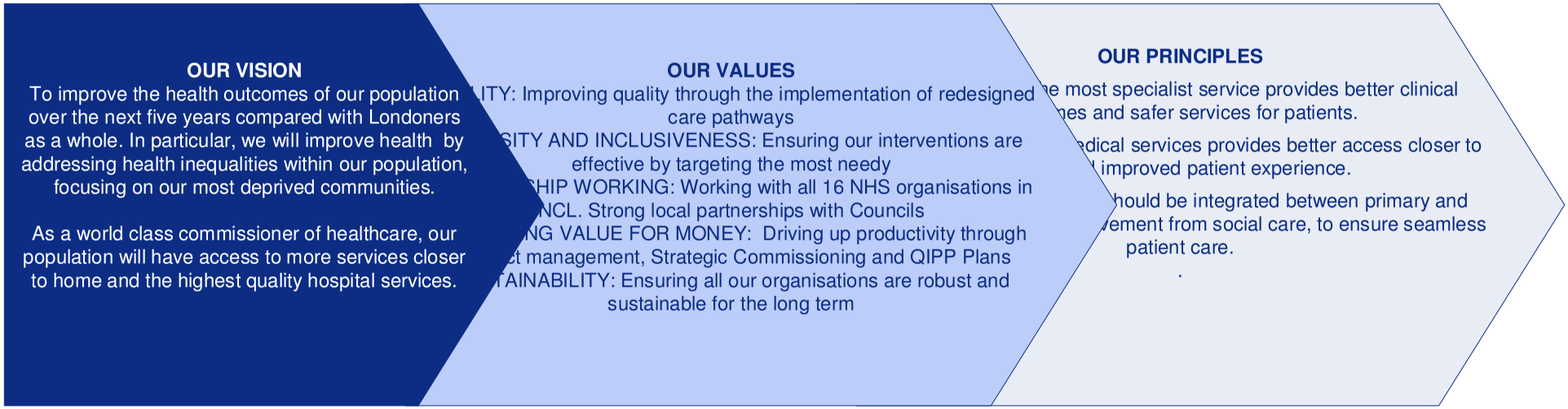
## VISION, VALUES AND PRINCIPLES

In developing the strategy and QIPP Plan for North Central London, we have maintained a clear focus on improving health and addressing health inequalities:

- Our vision sets out what we want to achieve for our population;
- Our values are embedded in each of our organisations as fundamental ways of working;
- Three overarching principles underpin our models of care.

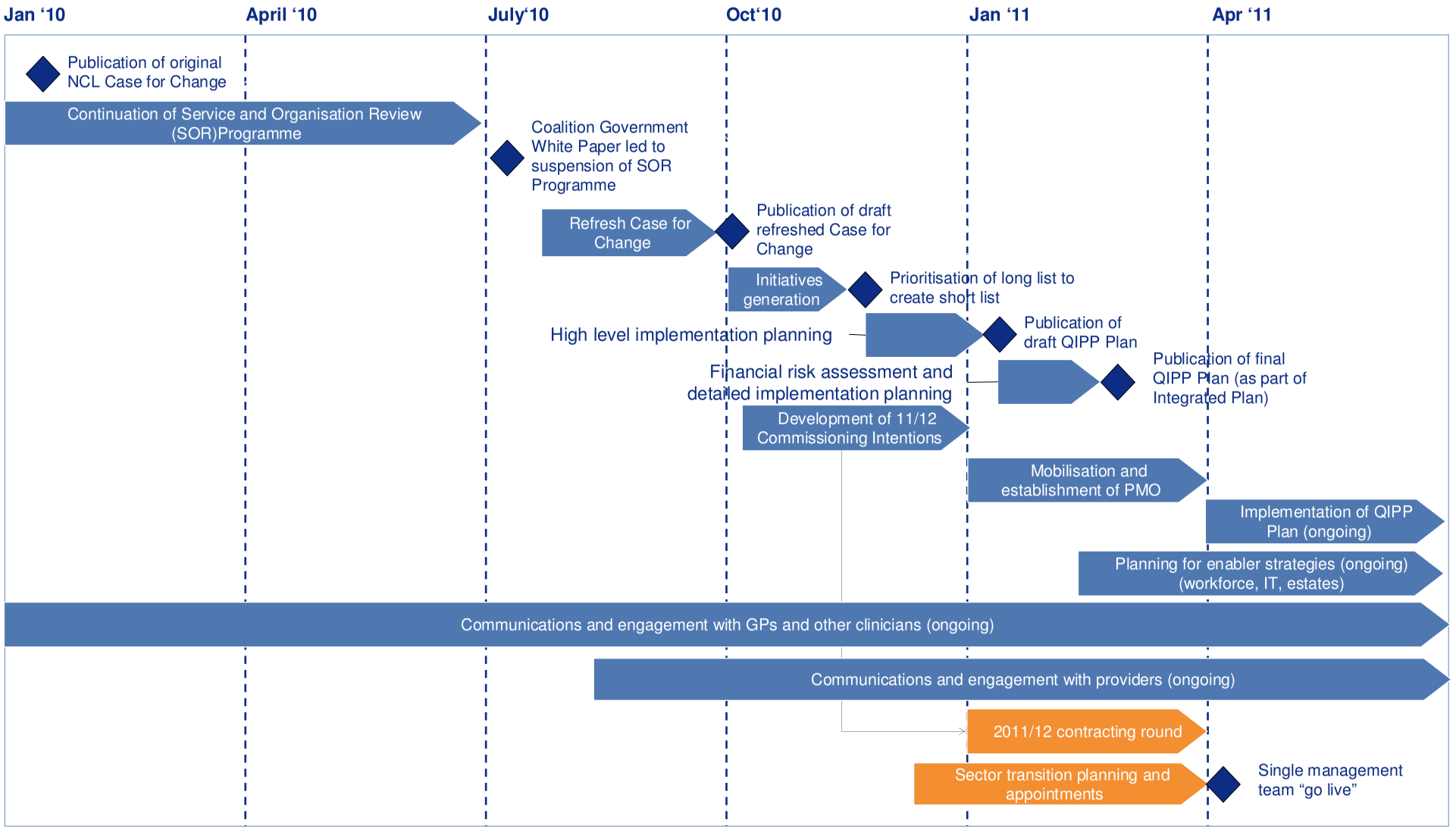
Together:

**Our vision, values and core principles have guided our approach to developing our plans for the future and will remain central as we deliver their content.**



# Our Approach to Developing the NCL Commissioning Strategy and QIPP Plan

**FINAL DRAFT**




***Key:***

*Core strategy development /QIPP programme activity*

*Adjacent activity impacting on QIPP programme*

*Milestone*

# Our Approach to Developing the NCL Commissioning Strategy and QIPP Plan (contd.)



| KEY ACTIVITITES | Service and Organisational Review (SOR) | Refresh Case for Change | Initiatives generation and prioritisation | Implementation planning | Mobilisation | Communications and engagement |
|---|---|---|---|---|---|---|
| **Activity** | ● Development and communication of detailed Case for Change<br>● Development and evaluation of options for the configuration and provision of health services in NCL | ● Detailed review and update of existing underpinning evidence base<br>● Benchmarking of NCL against peer regions<br>● Remodelling of financial base case<br>● Engagement with key stakeholders<br>● Refresh and publication of draft refreshed Case for Change building on past work<br>● Development of finance and activity baseline model including sharing with providers | ● Development of long list of potential QIPP initiatives designed to address issues in refreshed case for change<br>● Collaboration with PCTs to ensure all existing QIPP plans are captured in long list<br>● Development of PiDs<br>● Application of agreed prioritisation framework to agree short list<br>● Two clinically led challenge and review panels held<br>● Consultation and workshops with GP Commissioners<br>● Development and publication of 11/12 Commissioning Intentions | ● Development of detailed delivery and implementation plan for each initiative<br>● Evaluation and communication of finance and activity impact of initiatives on acute providers at speciality level | ● Identification of temporary Programme Management Office resource<br>● Development and agreement of Programme Management Strategy<br>● Programme governance structure reviewed (further review will follow NCL transition to single management team) | ● Develop overall Communications and Engagement Strategy<br>● Hold three GP engagement events<br>● Engagement events with Local Authorities, scrutiny committees, LiNKs and other stakeholders<br>● Engagement exercise around the BEH Clinical Strategy and Mental Health reconfigurations |
| **Impact** | ● Reduction in variation in health services<br>● Increase in quality of patient outcomes<br>● Improvement in productivity | ● Clear commissioner understanding of the issues that the QIPP plan should be designed to address<br>● Increased understanding of the issues facing the NHS in NCL across a wide stakeholder population<br>● Alignment of strategic planning objectives with providers | ● Priority areas identified by GPs for revised QIPP Plan<br>● Agreed priority work streams to enable best allocation of management resource | ● Detailed plans available on the basis of which 11/12 contract negotiations can take place<br>● Clearer understanding of impact on provider sustainability | ● Robust programme management strategy in place<br>● Appropriate assurance, review and sign off for QIPP Plan | ● Shared understanding of the challenges facing the NCL sector<br>● GP acceptance of the issues and ownership of the emerging plans<br>● Building consensus on priorities and plans<br>● Proactively managing media coverage |
| **Key Stakeholders** | ● PCT Boards<br>● NCL Board<br>● All providers<br>● Clinical, patient and local authority groups<br>● Scrutiny committees | ● Clinical, patient and local authority groups<br>● All providers | ● GP Commissioners<br>● PCTs<br>● QIPP Delivery Group<br>● NCL Delivery Board<br>● NCL Strategy Committee<br>● NCL Board | ● All providers<br>● PCTs<br>● NHS London | ● QIPP Delivery Group<br>● NCL Delivery Board<br>● NCL Strategy Committee<br>● NCL Board | ● GP Commissioners<br>● PCT Commissioners<br>● Clinical community<br>● Local Authorities<br>● Scrutiny committees<br>● LiNks<br>● Patients and public |
| **Status** | ● Suspended August 2010 on publication of the White Paper "Liberating the NHS" | ● Completed October 2010 | ● Completed December 2010 | ● On track for completion March 2010 | ● On-going – will be completed by 1st April 2011 | ● On-going |

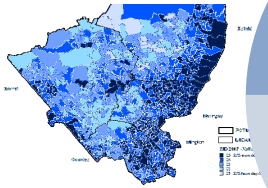
## SUMMARY OF KEY CHALLENGES

**SUSTAINABLE PROVIDERS**

There are risks to the potential long-term sustainability of our healthcare providers

**POPULATION NEEDS**

There are wide health inequalities with huge variations in life expectancy and wellbeing between communities within the five boroughs of NCL



**QUALITY**

There are big differences in the quality of service being delivered by the NHS across NCL


**CLINICAL PRIORITIES**

These five challenges underpin the development of our QIPP Plan.

**WORKFORCE SUSTAINABILITY**

The workforce responsible for delivering the service needs to change to adapt to future requirements

**FINANCIAL CHALLENGE**

If not controlled, the cost of healthcare will rise more quickly than the amount of money available for our residents

# Contents

# Key Priorities

| 1.0 CARE CLOSER TO HOME | |
|---|---|
| Case for Change | • Too many preventable admissions/readmissions are leading to inefficient use of resources<br>• Aim to provide right care in the right place at the right time not yet being realised<br>• Over-reliance on secondary care, particularly by patients with Long Term Conditions<br>• Need to Improved patient experience and outcomes together with clinical productivity |
| Scope | • Proactive model of care for Long Term Conditions<br>• Improve provision of 'Out of Hospital care<br>• Improving care in nursing homes<br>• Reprovision of selected elective services in a community setting<br>• Admission avoidance and early discharge schemes |
| Initiatives / Projects | Local PCTs have developed a wide range of pathway redesign initiatives covering three areas:<br>1. Admission Avoidance<br>  ○ Implementation of virtual wards and early intervention programmes<br>  ○ Schemes to reduce preventable admissions from Care Homes<br>2. Planned Care (largely focused on shifting a proportion of existing outpatient activity into the community where clinically and financially beneficial)<br>  ○ Cardiology<br>  ○ Anti-coagulation<br>  ○ Dermatology<br>  ○ Urology<br>  ○ ENT services<br>  ○ Ophthalmology<br>  ○ Gynaecology<br>  ○ Specialist colorectal<br>  ○ Oral/dental<br>3. Long Term Conditions management schemes |

# Key Priorities



| 1.0 CARE CLOSER TO HOME (cont.) | |
|---|---|
| Innovation | • Use of Teleheath and PACE schemes<br>• Risk stratification and case management approach<br>• Development and systematic and consistent implementation of evidence based pathways<br>• Development and sophisticated use of referral management processes to avoid unnecessary admissions |
| Mode of delivery | • Pathway redesign to redeliver appropriate activity in community settings<br>• Build support and commitment to adherence to pathways with consortia, providers and the public<br>• Use of contractual levers and performance management processes<br>• Development of protocols and agreement on right sizing of secondary care to combat the “Roemer effect”<br>• Development of incentives and risk/gain sharing schemes<br>• Pathway approach to commissioning based on specified outcomes |
| System Levers and Incentives | • Contracting<br>• Detailed service specification<br>• Procurement<br>• Incentive Schemes<br>• Performance Management |
| Key Enablers | • Engagement of consortia, providers and the public<br>• Development of primary care and community services to ensure capacity and capability to support services being transferred out of acute setting<br>• Systematic workforce modernisation to ensure fitness for purpose<br>• Telehealth system implementation<br>• Establishment of Integrated Care Organisation to provide whole pathway services |

# Key Priorities



| 1.0 CARE CLOSER TO HOME (cont.) | |
|---|---|
| Identified savings | • 2011/12 = £1.2m<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • Failure to close capacity in acute setting leading to increased activity due to admissions of the "next sickest patient"<br>• Impact of commissioner change and consortia development derailing initiatives<br>• Workforce availability and competence not sufficient to implement new initiatives quickly enough<br>• Under developed use of data undermines commissioners' ability to drive meaningful change<br>• Collective impact on provider sustainability has negative effect on provider landscape |
| Risks | • Failure to close capacity in acute setting leading to increased activity due to admissions of the "next sickest patient"<br>• Impact of commissioner change and consortia development derailing initiatives<br>• Workforce availability and competence not sufficient to implement new initiatives quickly enough<br>• Under developed use of data undermines commissioners' ability to drive meaningful change<br>• Collective impact on provider sustainability has negative effect on provider landscape |
| Progress to Date | • Engagement with clinicians on care pathway redesign<br>• Delivery plans for initiatives developed<br>• Detailed finance and activity modeling completed and benefits identified<br>• Development of Integrated Care Organisation (ICO) covering two PCTs with support from UCLP to maximise impact and cross sector learning<br>• Inclusion of most developed plans in 2011/12 contract negotiations |
| Next Steps | • Implement effective performance management processes to assure the Board of implementation progress<br>• Further engagement with GP consortia and wider clinicians to develop and deliver initiatives<br>• Engagement with acute sector to prepare for change<br>• Development of plans to rapidly and systematically roll out projects across the Sector |

# Key Priorities



| 2.0 UNSCHEDULED CARE | |
|---|---|
| Case for Change | • Multiple access points for unscheduled care needs resulting in duplication of services and confusion for patients<br>• High levels of A&E attendances for non-urgent conditions resulting in ineffective use of resources and patients travelling unnecessarily<br>• Inconsistent access to primary care services driving over-reliance on A&E and high levels of spend on this service |
| Scope | • Streamlining of access points to 24/7 unscheduled care across all 5 PCT areas<br>• Remove duplication of services in the system to reduce cost of providing non – urgent care in A&E<br>• Co-location of urgent care services with A&E<br>• Working with LAS on implementation of their QIPP service development plans to reduce number of patients conveyed to A&Es to 60% of all calls by 2015<br>• Implement Single Point of Access scheme |
| Initiatives / Projects | • Co-location of UCC at NMUH<br>• Establishment of Primary Care front door at Chase Farm and Barnet Hospital<br>• Integration with OOH services; a primary care front door to A&E at The Whittington<br>• Redirection of patients out of hospital to Primary Care services in Barnet and Enfield (Chase Farm)<br>• Implementation of single point of access in Enfield and Barnet<br>• Contribution to LAS QIPP service development plans, including<br>  ○ Increasing conveyance to UCCs in partnership with Primary Care<br>  ○ Increasing the number of alls passed to NHSD for resolution<br>  ○ Increasing the number of motorcycle and pedal bike based paramedics and technicians<br>  ○ Expanding the use of Community First Responders<br>  ○ Implementing further technology and digital projects such as CommandPoint and the electronic patient record |
| Innovation | • Single point of access for all Unscheduled Care services<br>• Jointly agreed model between Primary and Secondary care providers<br>• Explore enhanced pharmacy services to encourage self management in patients |

# Key Priorities



| 2.0 UNSCHEDULED CARE (cont.) | |
|---|---|
| Mode of delivery | • Collaborative service redesign with acute providers<br>• Collaborative service redesign with GPs to incorporate appointments for patients who are redirected from another service area<br>• Open procurement to identify operators of newly commissioned urgent care services to ensure best value for money<br>• LAS transformation programme<br>• Incorporation into contracts of service requirements and activity/finance impacts of unscheduled care initiatives |
| System Levers and Incentives | • Ability to reduce number of existing points of access to concentrate activity to most appropriate locations<br>• Robust service specification incorporated into contracts to enable robust performance management against plans<br>• Ability to negotiate pricing<br>• Trends in patient behavior and choice indicate preferences for certain points of access |
| Key Enablers | • GP leadership and involvement in provision<br>• Robust service specification<br>• Clinical ownership and leadership<br>• Estate and other infrastructure fit for purpose<br>• Appropriate workforce in place to deliver service as specified<br>• Strong collaborative links with Acute Providers |
| Identified savings | • 2011/12 = £1.9m<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • Primary Care QIPP (contracting) – incentivisation of GPs to help keep patients out of hospital where clinically appropriate<br>• Provider landscape and aspirations of current acute providers<br>• Social care service provision and sign up<br>• Alignment with Out of Hours services<br>• GP engagement<br>• Links with Care Closer to Home work stream to ensure a seamless approach to all aspects of unscheduled care |

# Key Priorities



| 2.0 UNSCHEDULED CARE (cont.) | |
|---|---|
| Risks | • Increased access points across economy – thereby increasing activity unnecessarily and driving up spend<br>• Inconsistency of model and service specification offering across the sector perpetuating inequality of access<br>• Variation in quality and access to primary care provision preventing availability of a real alternative to A&E<br>• Patient behavior does not change in line with service changes<br>• Misalignment of priorities between health and social care perpetuates fragmentation of provision<br>• Lack of robust modeling of new service model resulting in estimated financial benefits are unrealistic or unrealised<br>• Introduction of revised A&E tariff invalidates original savings estimates<br>• Volume of patients being redirected is not as great as predicted therefore decreasing the benefits realised<br>• Primary Care unable to manage additional workload from patient achievable<br>• Lack of GP engagement resulting in patchy changes |
| Progress to Date | • Agreement of core principles of approach to unscheduled care across NCL<br>• NCL wide specification for UCC's developed for local adoption<br>• Enfield and Barnet have plans to enter self-assessment to position for SPA pilot by September and have partially completed Directories of Service<br>• Written specification for the model (BEH)<br>• Local consultation held n Islington<br>• Piloting Primary Care front end at Royal Free and Chase Farm Hospitals<br>• Whittington and North Middlesex Primary Care stream schemes incorporated into 2011/12 contract offers<br>• Clinical model has significant clinical buy in |
| Next Steps | • Agree go live dates<br>• Develop further implementation and communication plans where needed<br>• Escalate areas where changes are not progressing and ensure there are plans to mitigate the risks<br>• Carry out preparatory work ready for SPA roll out |

# Key Priorities



| 3.0 MENTAL HEALTH | |
|---|---|
| Case for Change | • Quality and cost of current in-patient service model<br>• Variation in quality and clinical outcomes across services<br>• Need to provide more care in community and reduce length of stay<br>• Link between physical and mental health for people with LTCs<br>• Reliance on acute care fro drug and Alcohol dependant patients |
| Scope | • Inpatient beds (Camden and Islington)<br>• Community Bed provision to replace in-patient capacity (Harlingen)<br>• Out of area placements – repatriation<br>• Dementia services<br>• Long Term Conditions<br>• Alcohol and drug services |
| Initiatives / Projects | • Closure of two wards in CandI to reduce over capacity<br>• Improving capacity and focus of CMHTs<br>• Streamlining substance abuse services<br>• Decommissioning Brain Injury Services<br>• Responding to patients with LTC and mental health issues<br>• Developing and focusing a liaison service |
| Innovation | • Service redesign with a focus on community services<br>• Integrating the physical and mental health needs of patients in care planning |

# Key Priorities



| 3.0 MENTAL HEALTH (cont.) | |
|---|---|
| System Levers and Incentives | • Contractual framework<br>• Under use of current contracted resources e.g. beds<br>• Performance management of current contracts<br>• Titration of service delivery to user need |
| Mode of delivery | • Contract<br>• De-commissioning<br>• Service reconfiguration<br>• Incorporate mental health appropriately into LTC work<br>• Development of service model e.g. liaison services |
| Key Enablers | • Outcomes of consultation (CandI)<br>• Contracting Round<br>• Provider sign up and engagement with system change<br>• Provider capacity to repatriate for specialist services |
| Identified savings | • 2011/12 = £9.3m<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • IAPT capacity and capability<br>• Impact on other teams in the system – e.g. assertive outreach<br>• Fully understanding pop health needs |

# Key Priorities



| 3.0 MENTAL HEALTH (cont.) | |
|---|---|
| Risks | • Outcome of consultation<br>• Ability to implement effective capacity modeling<br>• Community workforce competencies<br>• Further scoping and detailed project planning required for some initiatives |
| Progress to Date | • Out to consultation on service change<br>• Robust deliverable with clear outcomes for some initiatives |
| Next Steps | • Conclude consultation and implement proposals – including decommissioning<br>• Undertake scoping and detailed project planning to confirm position |

# Key Priorities



| 4.0 MEDICINES MANAGEMENT | |
|---|---|
| Case for Change | • Big differences in the quality of service being delivered by the NHS<br>– Unexplained variation in primary care prescribing both within and across PCTs<br>– Variation in efficiencies of prescribing spend/patient<br>• Cost of health care is rising more quickly than the amount of money available for our residents<br>– Variation in costs charged by local providers against London and National benchmarking prices<br>Need for assurance that the commissioning and prescribing of medicine across the health economy is line with national guidance and/ or good practice (i.e. NICE, DH) |
| Scope | • Primary care medicines management: Concentrates on the changing of clinical behaviour of GPs by reducing wasteful prescribing, encouraging the use of the most cost-effective medicines and reducing variations in prescribing behaviour<br>• Secondary care medicines management: Using contractual levers to reduce opportunities for inflated drug prices, surcharging, and using drugs outside of agreed indications. More explicit commissioning of high cost drugs. Development of regular challenges to Trusts from SLAM data<br>• Development of Sector clinical and governance leadership including development of area prescribing committee<br>• Developing incentives including possible shared saving schemes with providers |
| Initiatives / Projects | • Secondary care initiatives<br>– Review of High Cost drugs (non PbR)<br>– Review of on costs on PbR excluded drugs at Royal free Hospital and Renal drug tariff costs<br>– Mandating use of 4 Biosimilar drugs<br>• Commissioning good practice (aligning incentives in Primary care) – PCT specific<br>– NHS Enfield – MM scheme focused on 32individual prescribing initiatives<br>– NHS Barnet - MM scheme focused on 28 individual prescribing initiatives<br>– NHS Islington - MM scheme focused on 23 individual prescribing initiatives<br>– NHS Camden – MM scheme focused on 20 individual prescribing initiatives<br>– NHS Haringey - MM scheme focused on 32 individual prescribing initiatives |

# Key Priorities



| 4.0 MEDICINES MANAGEMENT (cont.) | |
|---|---|
| Innovation | • Sector wide approach – sharing of resource between PCTs and sector<br>• Benchmarking good practice across and between sectors and PCTs, developing novel KPIs<br>• Clinically led change management<br>• Incentive scheme approach |
| Mode of delivery | • Contractual mechanisms and levers within acute contracts including the inclusion of drug specification<br>• Monitoring, professional and practical support by PCT pharmacists<br>• Sector wide GP/clinical leadership and championing<br>• Sector wide consistency in programme management |
| System Levers and Incentives | • Contractual terms<br>• Performance management against contracts and raising challenges where appropriate<br>• Financial Incentive schemes for GPs<br>• Consortium peer review and support<br>• Clinical sign up and engagement in both primary and secondary care initiatives, especially where cost effective drug choices are recommended<br>• Risk/gain sharing schemes |
| Key Enablers ( | • Interim realignment of resources to ensure appropriate distribution to support delivery of initiatives (pending formal restructure)<br>• Timely, accurate Data and information, from practice to national level. In secondary care much more data and information requested routinely<br>• Engagement of clinicians to support the initiatives as prescribing responsibility rests with them<br>• Development of GP Consortia<br>• Trust efficiency saving responsibilities<br>• More benchmarking data in secondary care available<br>• Inclusion of drug specification in the acute contracts<br>• Development and management a robust database to manage the high cost drug funding requests |

# Key Priorities

| 4.0 MEDICINES MANAGEMENT (cont.) | |
|---|---|
| Identified savings | • 2011/12 = £6.2m<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • Contracting rounds and negotiation<br>• Acute and primary care trust data provision<br>• Primary Care QIPP initiatives and Trust CIP plans<br>• Restructure of commissioning function<br>• Finances, in particular inflationary uplift<br>• NICE recommendations<br>• Cancer drug tariff negotiations |
| Risks | • Currently not delivering on primary care medicine plans in all PCTs<br>• Relevant data sets analyzed in a timely manner<br>• Evaluation of changes implemented and their impact<br>• Clinical engagement<br>• Resource and Skills; numbers in medicines management workforce<br>• IT support and level of information provided by trusts |
| Progress to Date | • Delivery plans written and incentive schemes proposed in draft<br>• Support materials developed or developing<br>• Metrics developed<br>• Development of Drug schedule which details the management of high cost drugs in acute trusts<br>• Immediate transfer of some resources to Acute work stream<br>• Approval for redistribution of resources as part of next phase of transitional plan |
| Next Steps | • Implement project plans<br>• Redistribution of resources |

# Key Priorities

| 5.0 QIPP IN PRIMARY CARE | |
|---|---|
| Case for Change | • Inconsistent and irregular processes for maintaining patient lists resulting in inaccurate financial allocations to GP practices<br>• Adherence to historical patterns of funding allocation for enhanced level services without clearly defined outcomes or assurance of value for money<br>• Variation in quality and performance in primary care services due to inconsistent approaches to contract management across the sector<br>• High level of use of acute services where primary care services are more appropriate and cost effective |
| Scope | • Primary Care Dentistry<br>• General Medical Services<br>• Community Pharmacy |
| Initiatives / Projects | • Reducing list inflation in General Practice through an annual process agreed across the sector aiming to remove 2.5% of patient population each year (31,750). Work for each PCT will be focused each year to ensure the target level of patient removal and maintenance of accurate lists<br>• Primary Care Enhanced Services review in General Practice including a review of PMS growth. This will be achieved by i) Removal of uncommitted funding from PCT LES baselines where present ii) Re-basing of PCT enhanced service budgets based on the 2010/11 year end position and decommissioning if significant under-spends, iii) Conversion of services back to national DES models, with DES funding, where they have locally been commissioned as LES extensions e.g. extended hours , iv) Application of a % top slice of 2.5% to 4% over 4 years to PCT enhanced service tariffs based on the Operating Framework principal of tariff deflation with clear impact assessment per PCT and per service, v) Application of a decommissioning principal based on GP practice performance against each enhanced service, phased over 4 years from 2.5% t0 7.5%, vi) Review of LESs specifically commissioned to address demand management at Enfield and Haringey PCTs where targets for reduction in acute activity need to be set and monitored to ensure VFM<br>• Primary Care performance management based on the principal of standardizing the processes for identifying and remedying poor performance through robust contract and performance management<br>• Referral /demand management arrangements to retain patients in primary care and reduce secondary care activity based on identification of the reasons for referral and subsequent development of training protocols to change GP referral behavior |

# Key Priorities



| 5.0 QIPP IN PRIMARY CARE (cont.) | |
|---|---|
| Innovation | • Incorporation of National contract developments e.g. Dental QOF and NHSL GP Balanced Scorecard to identify, monitor and remedy poor performance ensuring a return of quality on national contract investment<br>• Innovative approach to identifying top 10 reasons for referral as opposed to top 10 referral specialties as a means of modifying GP referral behavior<br>• Innovative models of ensuring VFM is achieved on enhanced service investment and commissioning |
| Mode of delivery | • Development of robust, up to date balanced scorecards and performance dashboards to benchmark performance across the sector<br>• Development of referral thresholds/guidance for top 10 reasons for referral with information to practices to demonstrate referral activity against average<br>• Disinvestment in low value enhanced services and refocus of enhanced service outcomes to reductions in acute activity where applicable<br>• Re-commissioning of DES models where extended LES models have previously been commissioned without delivering outcomes<br>• Development of regular annual list cleaning programmes |
| System Levers and Incentives | • Performance management of contracts – use of national contractual levers and productivity information upon which investment and disinvestment decisions can be made<br>• Clinical engagement with Commissioning Consortia and Local Representative Committees (LMC/LDC/LPC)<br>• Clinical leadership of the entire QIPP programme<br>• Commissioning for outcomes with enhanced services and performance review |
| Key Enablers | • Engagement of clinicians through consultation with sector LMC representatives, GP representative for overarching QIPP programme and with Camden and Islington GPs based on level of LES commissioning in these boroughs<br>• Early engagement with borough DOFs to ensure agreement to financial contribution from each PCT<br>• Early engagement with GP IT teams, borough GP Primary Care Directors and borough finance teams to validate current levels of commissioning, performance and savings potential<br>• Agreement for robust performance monitoring processes with consistent approach to use of national contract levers |

# Key Priorities



| 5.0 QIPP IN PRIMARY CARE (cont.) | |
|---|---|
| Identified savings | • 2011/12 = £2.1m<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • Care closer to home initiatives where intermediate care services maybe commissioned at borough level that overlap with GP enhanced services also commissioned<br>• Unscheduled care initiatives where outcomes of GP demand management LESs e.g. as at NHS Enfield and NHS Haringey are focused on reductions in A&E attendance and outpatient activity where this activity may be counted elsewhere<br>• Individual PCT referral management centers where reductions in acute activity may be double counted with outcomes associated with commissioned LESs |
| Risks | • Clinical disengagement and inability to manage peers<br>• National contractual change e.g. Dental contract, changes to GMS contract leading to inflexibility in financial control and in year changes to balanced scorecards and performance dashboards<br>• Ability of primary care providers to address the required level of change and recognize the necessary contribution of primary care to financial recovery targets<br>• Ability to provide referral information in adequate detail on a regular basis at GP and secondary care level<br>• Reduced capacity in primary care teams to deliver QIPP initiative outcomes |
| Progress to Date | • Outline programme has been developed for each initiative<br>• LMC acceptance of key principals for Enhanced Service funding review<br>• List Cleaning options are identified |
| Next Steps | • All Delivery plans are to be discussed with GP colleagues and a Programme Board set up with sub groups for each initiative to take forward each implementation plan |

# Key Priorities



| 6.0 MATERNITY | |
|---|---|
| Case for Change | • Choice of care provider including antenatal care setting and place of birth – destination of choice for non NCL patients<br>• Wide health inequalities<br>• Variation in quality of service and care pathways based on risk stratification benchmarking and patient experience<br>• Identified gaps in service provision<br>• Sustainable Medical and Midwifery workforce, including adequate junior staff and consultant cover<br>• Number and age profiled of midwives |
| Scope | • Care pathway development<br>• Improving clinical quality and patient experience and current service provision<br>• Further assessment of gaps in service provision |
| Initiatives / Projects | • Spine pathway<br>• Improving Early access to maternity services<br>• Intrapartum (deliveries) and inpatient activity not related to activity<br>• Scoping of perinatal mental health services<br>• Improving quality standards and patient experience in maternity services |
| Innovation | • Implementing recognised best practice across the sector- leveling up |
| Mode of delivery | • Pathway re-design<br>• Whole pathway approach across the sector<br>• Contractual terms and conditions<br>• Service specification |

# Key Priorities



| 6.0 MATERNITY | |
|---|---|
| Case for Change | • No agreed definition of what constitutes low and high risk care for women<br>• Complex flows of women into and out of services. Women 'shop around' for the best maternity care which can lead to duplication of resource. Many women who choose to have care provided by an NCL trust, do not live in the sector.<br>• Significant numbers of women still do not receive a health and social needs assessment by the 12th completed week of pregnancy. Earlier access to services has been proven to improve outcomes for mother and baby<br>• Wide health and social inequalities in NCL<br>• Variation in quality of service and care pathways based on risk stratification benchmarking & patient experience. Lack of continuity of care during antenatal and postnatal periods<br>• Inadequate junior staff and consultant cover on labour wards (not all units in line with 'Safer Childbirth' recommendations)<br>• Number and age profile of midwives mean difficulties with recruitment and retention of staff. Vacancy rates are high in comparison to national average |
| Scope | • Maternity pathway development and model of care for NCL<br>• Standardised care protocols for NCL<br>• Improving clinical quality and patient experience and current service provision through benchmarking<br>• Further assessment of gaps in service provision<br>• Development of new payment systems for maternity services to ensure best value for money (payment for a pathway rather than for individual contacts). In order to do this, providers will need to collect data systematically in detail for a period of 6 months to establish a full activity baseline |
| Initiatives / Projects | • Development of a maternity 'Spine pathway' for all women and 'offshoot' pathways for higher risk women<br>• Improving early access to maternity services including a network approach to booking women for care<br>• Intrapartum (deliveries) and inpatient activity not related to delivery (for example, reducing antenatal admissions, reducing c -sections and increasing the number of deliveries outside of obstetric setting)<br>• Scoping of perinatal mental health services<br>• Improving quality, standards and patient experience in maternity services |
| Innovation | • Implementing recognised best practice in NCL to reduce variation in quality and outcomes<br>• Linking with UCL Partners' work on maternity through the NCL Maternity Network<br>• Piloting new models of care to assess suitability for adoption NCL-wide |
| Mode of delivery | • Pathway re-design for low and high risk women (whole pathway approach across the sector)<br>• Contractual terms and conditions- using the contract to deliver better value for money<br>• Updated Service Specification to reflect new pathways and model of care<br>• Monitoring and benchmarking through NCL Maternity Network |

# Key Priorities



| 6.0 MATERNITY (cont.) | |
|---|---|
| System Levers and Incentives | • Involvement of managers and clinicians from all providers and GPs in NCL Maternity Network established with remit to redesign services<br>• Contracting and performance management to current service specification in 11/12 and beyond<br>• Patient experience and choice (regular monitoring and benchmarking through maternity network sub group)<br>• National standards and guidance on best practice- NCL will strive to provide the best service by working together<br>• Clinical Negligence Scheme for Trusts for maternity services provides an incentive for trusts to develop detailed protocols of care. The network clinical leads will standardise these across NCL<br>• New maternity payment system to be developed which will incentivise trusts to provide care in more efficient ways |
| Key Enablers | • The Maternity Network Board (all CEOs of acute trusts have signed up to working together strategically)<br>• Public, provider and commissioner engagement through network and Maternity Service Liaison Committee<br>• Workforce strategy and development of new ways of working, piloted through the Maternity Network<br>• Public facing information which is clear and explains the work of the network and the pathways that are produced |
| Identified savings | • 2011/12 = none<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • National work on tariff for maternity services<br>• Financial modeling and establishment of agreed baseline position<br>• Recruitment of dedicated clinical leadership<br>• Primary and community care capacity and quality<br>• London wide approaches to improving maternity services |

# Key Priorities

| 6.0 MATERNITY (cont.) | |
|---|---|
| Risks | • Inability to recruit high calibre clinical leads<br>• Access to appropriate, detailed data sets as record of activity and pricing varies between providers, therefore commissioners do not have an accurate activity baseline. Estimating savings is challenging at present<br>• Pace of change (too slow)<br>• Workforce issues will negatively impact on NCL's ability to redesign the model of care<br>• Availability of community facilities suitable for providing maternity care closer to home<br>• GPs may not agree maternity shared care arrangements across NCL<br>• Need to develop new payment system for maternity based on a pathway of care. This will require significant finance input and resource. There is a risk that trusts will not agree to the new payment approach |
| Progress to Date | • Clear programme objectives established and work streams identified<br>• NCL Maternity Network, which will drive the maternity QIPP programme, has now been established (first meeting held in December 2010) and meeting dates/membership confirmed for 11/12<br>• Excellent engagement from maternity service providers and clinicians in NCL<br>• Maternity services specification developed for inclusion in contracts. This will be amended in 11/12 as a result of QIPP initiatives<br>• Job descriptions for clinical leads have been written and signed off by network board (awaiting funding confirmation before these are issued) |
| Next Steps | • Recruit a lead obstetrician, GP and midwife for network<br>• Formulation of full project plans for all initiatives<br>• Development of information recording requirements for first six months of 2011/12 to operate in shadow form to provide consistent picture of activity on which to build service change. This needs to be negotiated and agreed with trusts<br>• Establish NCL Maternity Network sub groups/working groups to progress the work |

# Key Priorities

| 7.0 LPT, DECOMMISSIONING AND THRESHOLDS | |
|---|---|
| Case for Change | • Variation in clinical thresholds across a range of services<br>• Pressing need to ensure limited financial resources are focused on the most effective care |
| Scope | • Streaming back office approaches to managing exceptional treatment requests<br>• Determining appropriate and consistent clinical thresholds<br>• Decommissioning activity of limited clinical value |
| Initiatives / Projects | • Extension of existing low priority treatment policy (originally implemented in 2010/11)<br>• Sector centralisation of intrauterine insemination<br>• Determining revised clinical thresholds for bariatric surgery<br>• Decommissioning of navigational catheters<br>• Decommissioning of acute terminations<br>• Decommissioning of acute vasectomies<br>• Reducing unnecessary cataract activity<br>• Terminate sexual health promotion contracts<br>• Not routinely funding Cyberknife treatment<br>• Recommissioning Chronic Fatigue Syndrome services using a single pathway |
| Innovation | • Supports consistency of approach across the NCL sector in a number of services – strengthening our business as usual approach to contracting |
| Mode of delivery | • Development of agreed clinical thresholds to reduce volumes of activity<br>• Prior approval for treatment authorisation to ensure only the right patients are treated<br>• Guidance for clinicians to empower them to help enforce thresholds and LPT policies<br>• Performance monitoring against agreed outcomes<br>• Monitoring of activity to ensure reduction and take early action in cases of overperformance |

# Key Priorities



| 7.0 LPT, DECOMMISSIONING AND THRESHOLDS (cont.) | |
|---|---|
| System Levers and Incentives | • Market<br>• Contracting framework |
| Key Enablers | • Clinical leadership to support and lead change in practice<br>• Public agreement to support following of protocols |
| Identified savings | • 2011/12 = £17.9m<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • Alignment of senior management views and sign up to proposals<br>• Recruitment to sector treatment funding process support team |
| Risks | • Political /public reaction overturns commissioning decisions<br>• Lack of consensus between PCTs makes sector-wide approach to implementation a challenge<br>• Lack of support from key stakeholders e.g. GPs lead to protocols not being respected<br>• Sector team is not able to manage volume of prior approval requests<br>• Community providers do not have adequate capacity to accommodate decommissioned activity from actue sector |
| Progress to Date | • Clear worked up proposals with specified outputs and outcomes for initiatives to be kicked off in 2011/12<br>• Exceptional Treatment Request policy agreed in principle by commissioners |
| Next Steps | • Implementation of proposals that have been agreed<br>• Further development of some proposals to enable value to be determined and decision making on whether to proceed to take place<br>• Set up of NCL sector-wide treatment funding panel |

# Key Priorities

| 8.0 CANCER | |
|---|---|
| Case for Change | • Late diagnosis<br>• Increased rates of cancer<br>• Lower than, or on par with, England and London survival rates for breast and colorectal patients<br>• Inequitable access to treatment<br>• Variation in quality of care<br>• Low uptake of screening services<br>• Inequalities within the sector in relation to both incidence and outcomes<br>• Not achieved full compliance with IOG standards in all organisations for all tumour sites |
| Scope | • Specialist services – London model of care<br>• Commissioning and contracting frameworks and tariff<br>• Service redesign and new pathway development<br>• Cancer follow up<br>• Cancer inpatient efficiency - length of stay<br>• Risk stratification |
| Initiatives / Projects | • Optimisation of routine follow up for breast , colorectal and prostate patients<br>• Implementation of brain and lung commissioning pathways<br>• Development of colorectal, breast and prostate commissioning pathways<br>• Implementation of bowel screening age extension<br>• Development and implementation of 23 hour breast cancer surgery (excluding immediate reconstruction and reconstruction)<br>• Development and implementation of an enhanced recovery programme for colorectal cancer<br>• Development of new models of community chemotherapy provision<br>• Improving efficiency of chemotherapy services<br>• Introduction of a recurring admission patient alert system in accident and emergency departments<br>• Raising public awareness of signs and symptoms linked to earlier diagnosis<br>• Reconfiguration of MDTs for common and specialist cancers (provider network designation)<br>• Reconfiguration of cytology screening services to meet minimum volumes of 35,000 per year and review of colposcopy services |

# Key Priorities

| 8.0 CANCER (cont.) | |
|---|---|
| Innovation | • Development of whole pathway commissioning with provider network responsible for delivering improvement in outcomes and experience of care<br>• Integrated service delivery across whole pathway of care |
| Mode of delivery | • Service redesign<br>• Cancer provider network designation<br>• Decommissioning of determined unwarranted outpatient activity<br>• Detailed service specification<br>• Roll out of technology<br>• Provider collaboration<br>• Procurement |
| System Levers and Incentives | • Contracting and performance monitoring framework<br>• Specifying and commissioning services on a whole pathway basis<br>• Commissioner led designation of cancer provider networks<br>• Alternative pricing approaches for pathways |
| Key Enablers | • Effective provider network<br>• Capacity in the system – e.g. . Facilities<br>• Patient sign – up<br>• Positive press reportage<br>• Workforce redesign<br>• Effective clinical governance systems and processes<br>• Effective data sets<br>• GP and provider support |
| Identified savings | • 2011/12 = none<br>• 4 year cumulative impact = 2011/12 = £[ ]m |

# Key Priorities



| 8.0 CANCER (cont.) | |
|---|---|
| Interdependencies | • London model of care programme<br>• Configuration of provider landscape |
| Risks (KF added this) | • Media attention<br>• Negative public perception<br>• Funding of networks beyond 2011/12<br>• Complexity of delivering whole systems change |
| Progress to Date | • Well defined plans with key objectives<br>• Development of long term cancer commissioning strategy<br>• Provider Network and Cancer Network commissioning team established<br>• Service specification, QIPP schemes and metrics included in 2011/12 contract offers |
| Next Steps | • Progress to implementation of scoped projects |

# Key Priorities

| 9.0 CARDIO-VASCULAR DISEASE | |
|---|---|
| Case for Change | • Need to improve patient outcomes and patient experience<br>• Need to reduce treatment delays<br>• Need to improve timely access to key cardiac interventions<br>• Slow uptake of evidence based innovative procedures<br>• Workforce constraints relating to the availability of junior doctors |
| Scope | • Redesign and implement revised pathways to move appropriate services closer to home<br>• Using evidence-based practice to reduce variation and inequitable access to cardiac and stroke services<br>• Admissions avoidance<br>• Reduction of length of stay<br>• Centralisation of specialist services<br>• Detection and treatment of stroke risk factors |
| Initiatives / Projects | • Creation of a single specialist vascular centre for NCL<br>• Heart Failure diagnosis – cost effective use of tests, which leads to more appropriate use of heart failure specialist services<br>• Re- admission avoidance for people with heart failure<br>• Implementation of service redesign for patients in need of complex arrhythmia procedures to produce a more equitable service provision<br>• Non- ST elevation acute coronary syndrome pathway redesign, reducing length of stay and double admissions during the same non-elective episode<br>• Cardiac surgery – reducing the average length of stay for non elective surgery through the use of an electronic referral system<br>• Work towards a door to needle time of 30 minutes for thrombolysis of stroke patients<br>• Improve diagnosis of atrial fibrillation and anti-coagulation following a stroke<br>• Unbundle London Stroke tariff to fund Early Supported Discharge (ESD) services<br>• Creation of a HASU ESD coordination role to provide cost-effective stroke discharge services across NCL<br>• Deliver 6 month post-discharge reviews of all stroke patients<br>• Embed stroke rehabilitation standards and data collection into community contracts |

# Key Priorities

| 9.0 CARDIO-VASCULAR DISEASE (cont.) | |
|---|---|
| Innovation | • Early adoption of new technologies<br>• Changing the provider landscape to create more targeted access to specialist and tertiary services<br>• Earlier diagnosis and triage of Heart Failure and NSTEACS patients, with quicker access to specialists services and reduced length of stay for NSTEACS patients<br>• Providing fast track diagnostic services supporting primary care<br>• Providing Early Supported Discharge (ESD) services cost-effectively from hyper-acute and acute stroke units<br>• Developing post-acute stroke services |
| Mode of delivery | • Care Pathway redesign<br>• Service specifications<br>• Contract and performance monitoring and contractual terms and conditions<br>• Provider designation (if required for vascular services)<br>• Creation of new roles and workforce redesign |
| System Levers and Incentives | • Contracts<br>• Specifying pathways across tertiary, acute and primary care |
| Key Enablers | • New technologies<br>• Workforce redesign<br>• Effective patient data transfer between primary and secondary care<br>• Existence of Cardiac and Stroke Network to manage implementation<br>• National funding |
| Identified savings | • 2011/12 = £0.1m<br>• 4 year cumulative impact = 2011/12 = £[ ]m |
| Interdependencies | • Contracting and business as usual initiatives<br>• IT and informatics<br>• London cardiovascular model of care |

# Key Priorities



| 9.0 CARDIO-VASCULAR DISEASE (cont.) | |
|---|---|
| Risks | • Capacity to deliver scope of programme<br>• Resistance to the centralisation of vascular services<br>• Ability to provide ongoing funding following pilot phases<br>• Longer term sustainability of outcomes, if no mechanism for ongoing monitoring in place |
| Progress to Date | • NCL localisation of London wide redesign work<br>• Service specifications for cardiac services included in contract documentation for 2011/12<br>• Service specifications for vascular services prepared and shared with providers<br>• A collaborative approach with providers to achieving the changes to vascular services<br>• Robust scoping of project deliverables<br>• Pilots being undertaken |
| Next Steps | • Full implementation of proposals in 2011/12 for agreed initiatives |

# Key Priorities



| 10.0 PAEDIATRICS | |
|---|---|
| Case for Change | • High volumes of children and young people attend A&E, presenting with a range of emergency and non-emergency conditions<br>• Families would most often prefer to go somewhere other than A&E if services were open and close to home<br>• Children attending A&E in NCL are often assessed by junior staff who are not paediatric specialists resulting in higher levels of admissions which should be avoided<br>• Some healthcare providers in NCL only undertake very small numbers of inpatient paediatric surgery and are therefore not meeting the standards expected by the Royal Colleges, or by recognised best practice<br>• Variation in quality and provision of tertiary pediatric services<br>• Fewer larger centres to focus on complex needs<br>• Creation of North London Tertiary Provider network to bring deliver capacity small specialties |
| Scope | • Acute paediatric inpatient services (medical and surgical)<br>• Paediatric outpatient and community services<br>• Proposed service model for London for tertiary services |
| Initiatives / Projects | • To be confirmed for tertiary services following consultation on the proposals for London<br>• NCL Paediatric Network to identify appropriate future service configuration for NCL and agree pace of change |
| Innovation | • TBC |
| Mode of delivery | • London Tertiary Paediatric Network<br>• NCL local Paediatric Network |

# Key Priorities



| 10.0 PAEDIATRICS (cont) | |
|---|---|
| System Levers and Incentives | • London wide proposals for tertiary service with clear implications for services and providers in NCL |
| Key Enablers | • Clinical leadership and engagement |
| Identified savings | • 2011/12 = TBC<br>• 4 year cumulative impact = TBC |
| Interdependencies | • Further London wide redesign proposals<br>• Impact of the London health economy response to the tertiary services proposals<br>• NCL Unscheduled Care QIPP work stream<br>• Local authority children's services |
| Risks | • Future disposition of tertiary services disadvantages local providers<br>• Financial and clinical implications for providers' acute paediatric proposed model of care<br>• Public and stakeholder reactions to any proposed changes<br>• Alignment of health and social care plans |
| Progress to Date | • London tertiary proposals out to consultation<br>• Discussions underway within the Paediatric Network regarding future models of care |
| Next Steps | • Proposals for tertiary services finalised following consultation<br>• Detailed plan developed for acute paediatrics network |

# Key Priorities

| 11.0 ACUTE PRODUCTIVITY | |
|---|---|
| Case for Change | • More efficient operation of acute providers<br>• Addressing the financial gap inherent in NCL sector |
| Scope | • Acute contract metrics relating to elective and emergency inpatients, outpatients, A&E attendances and Diagnostics |
| Initiatives / Projects | Specific metrics with penalty clauses to be built into contract relating to:<br>• 18 weeks management<br>• A&E conversion rate<br>• A&E attendance when left without seen a clinician<br>• A&E minor ailments resulting in admission<br>• Admissions via A&E with a zero length of stay<br>• C2C Paid as Follow up<br>• Day case coding to OP procedure<br>• Excess bed days<br>• Non Emergency Re-admission 30 days<br>• Non Emergency Re-admission 30 days to another provider<br>• OP attendances whilst an inpatient<br>• Pre Operative excess bed days.<br>• Procedures requiring prior approval |

# Key Priorities



| 11.0 ACUTE PRODUCTIVITY (cont.) | |
|---|---|
| Innovation | • Standardising and enforcing contract changes consistently to implement metrics and promote more efficient ways of working |
| Mode of delivery | • Incentives and penalties written into contract<br>• Robust monitoring and enforcement of contract terms |
| System Levers and Incentives | • Contractual Terms |
| Key Enablers | • A strong evidence base to support the change in the terms of the contract, and continuing access to comparative benchmarking<br>• High quality staff to deliver and negotiate contract changes in a consistent way that create the necessary detailed and enforceable contract terms<br>• A workforce with the necessary skills and capacity to monitor and enforce contract terms fully during the year |
| Identified savings | • 2011/12 = £46.7m<br>• 4 year cumulative impact = £[ ]m |
| Interdependencies | • 2011/12 acute contract negotiations |

# Key Priorities



| 11.0 ACUTE PRODUCTIVITY (cont.) | |
|---|---|
| Risks | • Unable to agree terms in all provider contracts<br>• The case is not supported if taken to arbitration<br>• Necessary capacity and skill set of staff to monitor and enforce contract metrics is not available<br>• Knock on effect creates additional unplanned activity in other settings |
| Progress to Date | • Key metrics have been defined and benchmarked<br>• The intention to include metrics with penalty clauses in contracts have been raised with providers through a market day |
| Next Steps | • Issue providers with the detail of the metrics to be included<br>• Work up detailed contract terms relating to each metric, negotiate and agree in contract |

# Key Priorities



| 12.0 STAYING HEALTHY | |
|---|---|
| Case for Change | • Reduce premature mortality and all age all cause mortality in addition to improving the prevention, diagnosis and treatment of long term conditions<br>• Understanding the role that preventable risk factors play in the morbidity and mortality of the NCL<br>• Smoking is the single largest cause of deaths in NCL, including lung cancer and COPD as well as being a key risk factor for CVD, particularly CHD |
| Scope | • NCL population especially those people with Long term conditions<br>• Local authority input and partnership working with NHS partners |
| Initiatives / Projects | • CVD, Cancer and Mental Health include;<br>• NHS Health Checks, vascular risk underpinned by weight management, healthy eating and tobacco control programmes<br>• Cancer screening continues to be a priority area for continued delivery with strategic links to interventions<br>• Smoking cessation, impacting on reduced COPD prevalence.<br>• Increasing childhood immunisation rates<br>• Joint Alcohol Harm Reduction Strategies set out work plans to reduce alcohol related A&E attendances<br>• Improved Access to Psychological Therapies aims to tackle common mental health disorders such as anxiety and depression<br>• Local projects focused on reducing teenage pregnancy rates |
| Innovation | • NHS Health Checks through multi dimensional community based models of delivery and targeted work within Primary Care<br>• Developing service models as a result of insight from social marketing and engaging local communities<br>• Utilising health intelligence data to further understand the underlying determinants of health and associated impact upon long term conditions |
| Mode of delivery | • Effective partnership working with multi disciplinary teams to ensure sustained focus and maintain scale and traction required for long term change<br>• GP Consortia t<br>• The local authority led Health and Wellbeing Boards and future public health workforce<br>• One size and model will not fit all and local areas will need to continue to understand the needs of their population |

# Key Priorities



| 12.0 STAYING HEALTHY (cont.) | |
|---|---|
| System Levers and Incentives | • Incentives such as LES, DES, LIS to promote the uptake of services and prevention activities<br>• New NHS and Public Health Outcome Frameworks<br>• Wider role of the GP |
| Key Enablers | • Healthy Lives and Healthy People;<br>• Public Health White Paper<br>• NHS and Public Health Outcome |
| Identified savings | • 2011/12 = TBC<br>• 4 year cumulative impact = TBC |
| Interdependencies | • NHS and Public Health outcome frameworks |
| Risks (KF added this) | • Transfer of public health to local authorities<br>• Uncertainty and concern about the capacity of local teams to deliver all the proposed public health functions<br>• Prioritisation of staying healthy in the future commissioning arrangements |
| Progress to Date | • Initiatives identified for implementation |
| Next Steps | • Local planning of how the new commissioning functions and public health landscape need to work together<br>• New structures of Health and Wellbeing Boards<br>• Maintaining an assessment of population need and effective multidisciplinary partnerships |

# Contents

# Delivery Impact – Impact on Patients



| WORK STREAM | CLINICAL OUTCOMES | PATIENT EXPERIENCE | ACCESS | SAFETY |
|---|---|---|---|---|
| 1.0 Care Closer to Home | ● Fewer crises situations requiring emergency intervention leading to improved quality of life and better outcomes | ● Able to more easily navigate the health system<br>● Care provided in more local care settings | ● Right person right care right place right time | ● Improved clarity of care point location<br>● Improved quality |
| 2.0 Unscheduled Care | ● Reduction in short stay admissions<br>● Reduce duplication of diagnostics | ● Reduced travel and shorter waits<br>● Reduced likelihood of admission<br>● Right treatment first time<br>● Care delivered in a more appropriate setting | ● Access care closer to home | ● Reduced number of access points in the system<br>● Skilled and competent workforce in right setting |
| 3.0 Mental Health | ● Earlier intervention in SMI | ● Reduced out of area treatments – minimising social exclusion<br>● Proactive identification of patients with dementia, drug and alcohol issues – less hospital based care | ● Appropriate in-patient capacity | ● Improved liaison between acute and community based care to improve case management |
| 4.0 Medicines Management | ● Improved formulary compliance<br>● Right prescribing | ● N/A | ● Potentially limits choice of drugs | ● Right prescribing – reduced inappropriate prescribing |
| 5.0 QIPP in Primary Care | ● Improved performance against the 20 QOF clinical domains<br>● Above average performance against clinical outcomes for all Directed Enhanced Services (DES)<br>● More accurate & targeted screening for the right patients at the right time<br>● 0-5yr old increase in early clinical diagnoses & prevention for dental conditions<br>● Increased number of community pharmacy Medicines Usage Reviews increasing medicines compliance | ● Increase in % patient satisfaction for GPs up to sector average<br>● Increase in % patients satisfied with dental treatment received up to London average<br>● Increase in % patients satisfied with time they have to wait for a dental appointment up to London average<br>● Increase in % return of community pharmacy patient satisfaction surveys | ● Increase in the number of available GP appointments with an associated reduction in A&E attendance<br>● Increase in dental vital sign performance<br>● Commissioning capacity of UDAs (Units of Dental Activity) to be aligned to sector targets so increasing patient access<br>● Increased access for new dental patients<br>● Increase in number of 100h pharmacies across the sector increasing access to medicines, clinical advice & Minor Ailment services | ● Tight monitoring of national contractual patient safety issues within each contractual framework GMS/ GDS/ Community Pharmacy contracts |

# Delivery Impact – Impact on Patients (contd.)



| WORK STREAM | CLINICAL OUTCOMES | PATIENT EXPERIENCE | ACCESS | SAFETY |
|---|---|---|---|---|
| 6.0 Maternity | • Clarify low and high risk pathways so care is always appropriate to need, leading to better outcomes for mother and baby<br>• Improving shared care arrangements between GPs and maternity services<br>• Meeting 'Maternity Matters' standards<br>• Midwife assessment (booking) by 12th week is low<br>• High intervention rates | • Need to develop more patient centric services, avoiding unnecessary appointments<br>• Women still not aware of available choices.<br>• Higher levels of satisfaction with care during labour and antenatal care although CQC 2010 survey results show that women have a poorer experience of maternity care than on average in England<br>• Need to ensure care is provided close to home, in non-medicalised environment where possible | • Workforce issues, specifically age of midwives, consultant presence on wards and junior cover.<br>• Birth rate predictions make planning difficult<br>• Insufficient middle grade and consultant staff.<br>• Difficult to establish a baseline due to historical contracting arrangements and non-standardised reporting of maternity care | • Clarify low and high risk pathways so care is always appropriate to need, leading to better outcomes for mother and baby<br>• Improving shared care arrangements between GPs and maternity services<br>• Meeting 'Maternity Matters' standards<br>• Midwife assessment (booking) by 12th week is low<br>• High intervention rates |
| 7.0 LPT, Decommissioning and Thresholds | • Reduction in clinically ineffective procedures (right care) | • Clarity of service provision available<br>• Decommissioning delayed due to authorisation process | • Restricted treatments for patients with certain conditions | • Reduction in risks to patients from ineffective procedures |
| 8.0 Cancer | • Earlier diagnosis, prevention and screening<br>• Improved survival rates<br>• Improved clinical outcomes | • Effective co-ordinated care pathways<br>• Reduced readmission rates<br>• Shorter lengths of stay | • Increasing take up of access to screening<br>• Earlier access to diagnostics and screening | • Treatment provided earlier<br>• Improved clinical outcomes<br>• Care provided in line with outcome focused pathways, leading to less variation<br>• Compliance with recognised standards |
| 9.0 Cardiovascular | • Reduce variation within NCL sector<br>• Improved use of new techniques | • Improve support services and continuity of care throughout pathway | • Right care right place | • Right care right place right person |

# Delivery Impact – Impact on Patients (contd.)



| WORK STREAM | CLINICAL OUTCOMES | PATIENT EXPERIENCE | ACCESS | SAFETY |
|---|---|---|---|---|
| 10.0 Paediatrics | ● Scoping to understand and agree what can be achieved to reduce variation and improve quality in acute services<br>● Improved outcomes for patients requiring tertiary care | ● Scoping to understand and agree what can be achieved to improve patient experience | ● Scoping to understand and agree what can be achieved to get access right for acute services | ● Scoping to understand and agree how safety of services can be increased for acute services<br>● Consistency of tertiary service delivery standards |
| 11.0 Acute Productivity | ● Levelling up to the best practice in NHS | ● Care delivery streamlined | ● Right person right place right time | ● Performance management through effective metrics |
| 12.0 Staying Healthy | ● Improved outcomes as measures in place to encourage healthier lifestyles for local population | ● Improved as more positive interactions with local NHS | | |

# Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London Sector

## 25 March 2010

### 1. Support and Administrative Issues

1.1 The JHOSC has previously discussed its support needs and discussed these with NHS North Central London (NCL). Following the last discussion, the attached letter was received from NHS NCL.

1.2 Officers from boroughs included in the JHOSC have met to discuss this and administrative support for JHOSC. The view of officers was that the offer from NCL to provide officer time from within its public health team for specific pieces of work is welcome and could provide a useful means of providing evidence on best practice and outcomes. The drafting of a work plan based around NHS NCLs work streams would facilitate the best use of this resource as sufficient time will need to be provided to enable them to undertake the work required.

1.3 In terms of administrative support, the current level of activity by the JHOSC is viewed as being containable on the basis that each borough provides “payment in kind” by sharing the workload equally. This involves each borough taking a turn in hosting meetings and providing a minute taker. Support to the Chair and the Vice Chair will come from the borough from which these come from.

### 2. Recommendations:

2.1 That, in order to make best use of the support offered by NHS NCL, a forward plan for the JHOSC be developed based around workstreams within the QIPP.

2.2 That administrative support be resourced for the JHOSC by “payment in kind” with each participating boroughs contributing equally on the basis outlined.

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