North Central London

NHS

Barnet - Camden - Enfield
Haringey - Islington

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

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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.

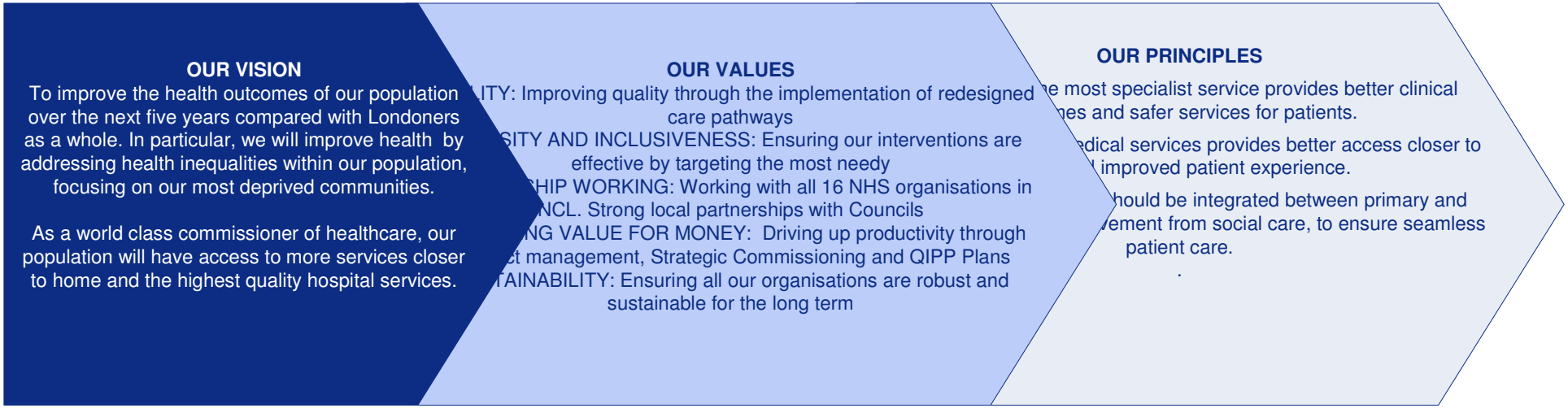
VISION, VALUES AND PRINCIPLES

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.

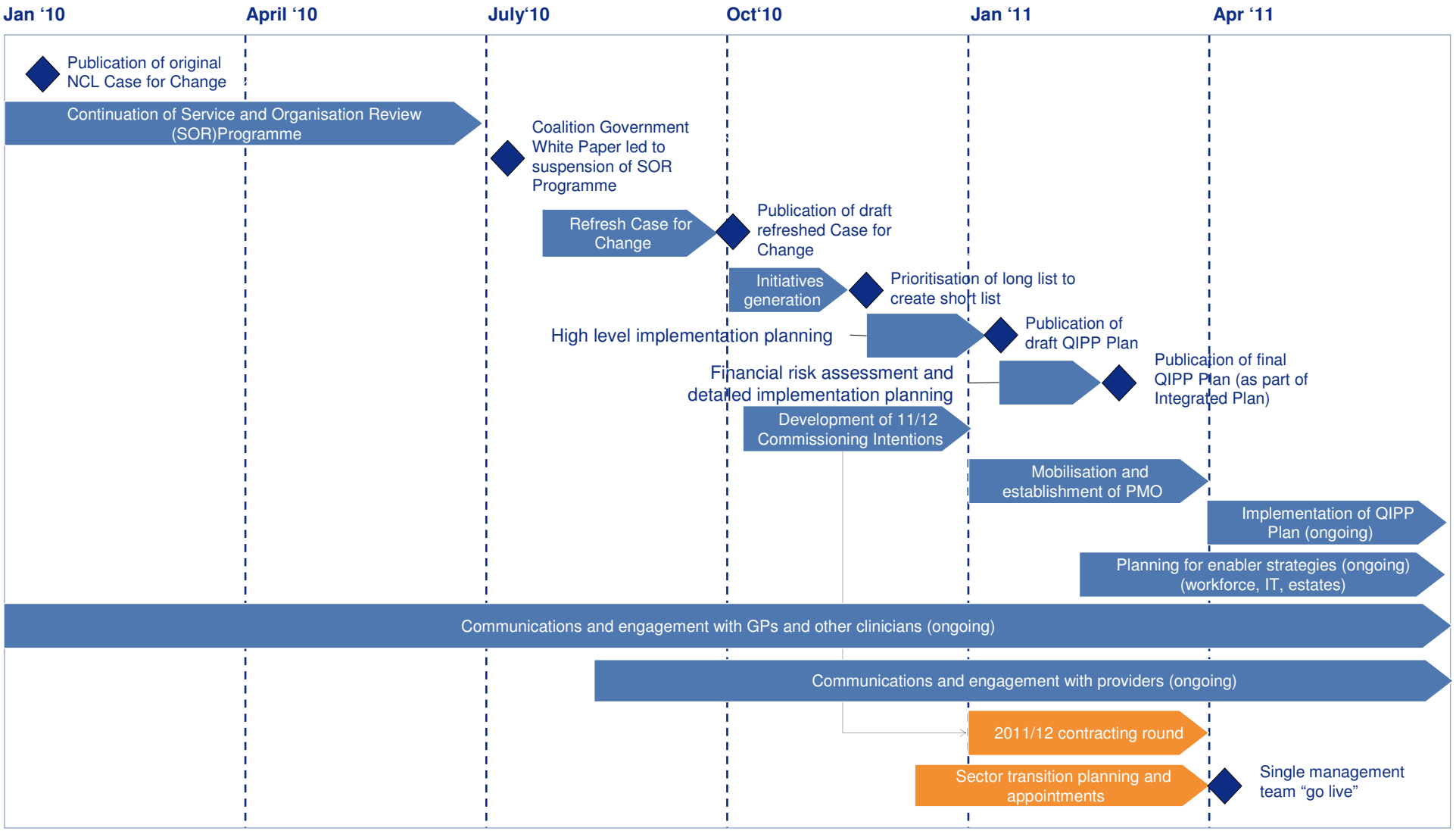
Together:

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 ● Development and evaluation of options for the configuration and provision of health services in NCL	● Detailed review and update of existing underpinning evidence base ● Benchmarking of NCL against peer regions ● Remodelling of financial base case ● Engagement with key stakeholders ● Refresh and publication of draft refreshed Case for Change building on past work ● 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 ● Collaboration with PCTs to ensure all existing QIPP plans are captured in long list ● Development of PiDs ● Application of agreed prioritisation framework to agree short list ● Two clinically led challenge and review panels held ● Consultation and workshops with GP Commissioners ● Development and publication of 11/12 Commissioning Intentions	● Development of detailed delivery and implementation plan for each initiative ● Evaluation and communication of finance and activity impact of initiatives on acute providers at speciality level	● Identification of temporary Programme Management Office resource ● Development and agreement of Programme Management Strategy ● Programme governance structure reviewed (further review will follow NCL transition to single management team)	● Develop overall Communications and Engagement Strategy ● Hold three GP engagement events ● Engagement events with Local Authorities, scrutiny committees, LiNKs and other stakeholders ● Engagement exercise around the BEH Clinical Strategy and Mental Health reconfigurations
Impact	● Reduction in variation in health services ● Increase in quality of patient outcomes ● Improvement in productivity	● Clear commissioner understanding of the issues that the QIPP plan should be designed to address ● Increased understanding of the issues facing the NHS in NCL across a wide stakeholder population ● Alignment of strategic planning objectives with providers	● Priority areas identified by GPs for revised QIPP Plan ● 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 ● Clearer understanding of impact on provider sustainability	● Robust programme management strategy in place ● Appropriate assurance, review and sign off for QIPP Plan	● Shared understanding of the challenges facing the NCL sector ● GP acceptance of the issues and ownership of the emerging plans ● Building consensus on priorities and plans ● Proactively managing media coverage
Key Stakeholders	● PCT Boards ● NCL Board ● All providers ● Clinical, patient and local authority groups ● Scrutiny committees	● Clinical, patient and local authority groups ● All providers	● GP Commissioners ● PCTs ● QIPP Delivery Group ● NCL Delivery Board ● NCL Strategy Committee ● NCL Board	● All providers ● PCTs ● NHS London	● QIPP Delivery Group ● NCL Delivery Board ● NCL Strategy Committee ● NCL Board	● GP Commissioners ● PCT Commissioners ● Clinical community ● Local Authorities ● Scrutiny committees ● LiNks ● 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

Contents

Key Priorities

1.0 CARE CLOSER TO HOME	
Case for Change	• Too many preventable admissions/readmissions are leading to inefficient use of resources • Aim to provide right care in the right place at the right time not yet being realised • Over-reliance on secondary care, particularly by patients with Long Term Conditions • Need to Improved patient experience and outcomes together with clinical productivity
Scope	• Proactive model of care for Long Term Conditions • Improve provision of 'Out of Hospital care • Improving care in nursing homes • Reprovision of selected elective services in a community setting • Admission avoidance and early discharge schemes

Initiatives / Projects	Local PCTs have developed a wide range of pathway redesign initiatives covering three areas:
	1. Admission Avoidance
	  ○ Implementation of virtual wards and early intervention programmes
	  ○ Schemes to reduce preventable admissions from Care Homes
	2. Planned Care (largely focused on shifting a proportion of existing outpatient activity into the community where clinically and financially beneficial)
	  ○ Cardiology
	  ○ Anti-coagulation
	  ○ Dermatology
	  ○ Urology
	  ○ ENT services
	  ○ Ophthalmology
	  ○ Gynaecology
	  ○ Specialist colorectal
	  ○ Oral/dental
	3. Long Term Conditions management schemes

Key Priorities

1.0 CARE CLOSER TO HOME (cont.)	
Innovation	• Use of Teleheath and PACE schemes • Risk stratification and case management approach • Development and systematic and consistent implementation of evidence based pathways • Development and sophisticated use of referral management processes to avoid unnecessary admissions
Mode of delivery	• Pathway redesign to redeliver appropriate activity in community settings • Build support and commitment to adherence to pathways with consortia, providers and the public • Use of contractual levers and performance management processes • Development of protocols and agreement on right sizing of secondary care to combat the “Roemer effect” • Development of incentives and risk/gain sharing schemes • Pathway approach to commissioning based on specified outcomes
System Levers and Incentives	• Contracting • Detailed service specification • Procurement • Incentive Schemes • Performance Management
Key Enablers	• Engagement of consortia, providers and the public • Development of primary care and community services to ensure capacity and capability to support services being transferred out of acute setting • Systematic workforce modernisation to ensure fitness for purpose • Telehealth system implementation • 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 • 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" • Impact of commissioner change and consortia development derailing initiatives • Workforce availability and competence not sufficient to implement new initiatives quickly enough • Under developed use of data undermines commissioners' ability to drive meaningful change • 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" • Impact of commissioner change and consortia development derailing initiatives • Workforce availability and competence not sufficient to implement new initiatives quickly enough • Under developed use of data undermines commissioners' ability to drive meaningful change • Collective impact on provider sustainability has negative effect on provider landscape
Progress to Date	• Engagement with clinicians on care pathway redesign • Delivery plans for initiatives developed • Detailed finance and activity modeling completed and benefits identified • Development of Integrated Care Organisation (ICO) covering two PCTs with support from UCLP to maximise impact and cross sector learning • Inclusion of most developed plans in 2011/12 contract negotiations
Next Steps	• Implement effective performance management processes to assure the Board of implementation progress • Further engagement with GP consortia and wider clinicians to develop and deliver initiatives • Engagement with acute sector to prepare for change • 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 • High levels of A&E attendances for non-urgent conditions resulting in ineffective use of resources and patients travelling unnecessarily • 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 • Remove duplication of services in the system to reduce cost of providing non – urgent care in A&E • Co-location of urgent care services with A&E • 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 • Implement Single Point of Access scheme

Initiatives / Projects	• Co-location of UCC at NMUH
	• Establishment of Primary Care front door at Chase Farm and Barnet Hospital
	• Integration with OOH services; a primary care front door to A&E at The Whittington
	• Redirection of patients out of hospital to Primary Care services in Barnet and Enfield (Chase Farm)
	• Implementation of single point of access in Enfield and Barnet
	• Contribution to LAS QIPP service development plans, including
	  ○ Increasing conveyance to UCCs in partnership with Primary Care
	  ○ Increasing the number of alls passed to NHSD for resolution
	  ○ Increasing the number of motorcycle and pedal bike based paramedics and technicians
	  ○ Expanding the use of Community First Responders
	  ○ Implementing further technology and digital projects such as CommandPoint and the electronic patient record

Innovation	• Single point of access for all Unscheduled Care services • Jointly agreed model between Primary and Secondary care providers • 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 • Collaborative service redesign with GPs to incorporate appointments for patients who are redirected from another service area • Open procurement to identify operators of newly commissioned urgent care services to ensure best value for money • LAS transformation programme • 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 • Robust service specification incorporated into contracts to enable robust performance management against plans • Ability to negotiate pricing • Trends in patient behavior and choice indicate preferences for certain points of access
Key Enablers	• GP leadership and involvement in provision • Robust service specification • Clinical ownership and leadership • Estate and other infrastructure fit for purpose • Appropriate workforce in place to deliver service as specified • Strong collaborative links with Acute Providers
Identified savings	• 2011/12 = £1.9m • 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 • Provider landscape and aspirations of current acute providers • Social care service provision and sign up • Alignment with Out of Hours services • GP engagement • 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 • Inconsistency of model and service specification offering across the sector perpetuating inequality of access • Variation in quality and access to primary care provision preventing availability of a real alternative to A&E • Patient behavior does not change in line with service changes • Misalignment of priorities between health and social care perpetuates fragmentation of provision • Lack of robust modeling of new service model resulting in estimated financial benefits are unrealistic or unrealised • Introduction of revised A&E tariff invalidates original savings estimates • Volume of patients being redirected is not as great as predicted therefore decreasing the benefits realised • Primary Care unable to manage additional workload from patient achievable • Lack of GP engagement resulting in patchy changes
Progress to Date	• Agreement of core principles of approach to unscheduled care across NCL • NCL wide specification for UCC's developed for local adoption • Enfield and Barnet have plans to enter self-assessment to position for SPA pilot by September and have partially completed Directories of Service • Written specification for the model (BEH) • Local consultation held n Islington • Piloting Primary Care front end at Royal Free and Chase Farm Hospitals • Whittington and North Middlesex Primary Care stream schemes incorporated into 2011/12 contract offers • Clinical model has significant clinical buy in
Next Steps	• Agree go live dates • Develop further implementation and communication plans where needed • Escalate areas where changes are not progressing and ensure there are plans to mitigate the risks • 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 • Variation in quality and clinical outcomes across services • Need to provide more care in community and reduce length of stay • Link between physical and mental health for people with LTCs • Reliance on acute care fro drug and Alcohol dependant patients
Scope	• Inpatient beds (Camden and Islington) • Community Bed provision to replace in-patient capacity (Harlingen) • Out of area placements – repatriation • Dementia services • Long Term Conditions • Alcohol and drug services
Initiatives / Projects	• Closure of two wards in CandI to reduce over capacity • Improving capacity and focus of CMHTs • Streamlining substance abuse services • Decommissioning Brain Injury Services • Responding to patients with LTC and mental health issues • Developing and focusing a liaison service
Innovation	• Service redesign with a focus on community services • 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 • Under use of current contracted resources e.g. beds • Performance management of current contracts • Titration of service delivery to user need
Mode of delivery	• Contract • De-commissioning • Service reconfiguration • Incorporate mental health appropriately into LTC work • Development of service model e.g. liaison services
Key Enablers	• Outcomes of consultation (CandI) • Contracting Round • Provider sign up and engagement with system change • Provider capacity to repatriate for specialist services
Identified savings	• 2011/12 = £9.3m • 4 year cumulative impact = 2011/12 = £[ ]m
Interdependencies	• IAPT capacity and capability • Impact on other teams in the system – e.g. assertive outreach • Fully understanding pop health needs

Key Priorities

3.0 MENTAL HEALTH (cont.)	
Risks	• Outcome of consultation • Ability to implement effective capacity modeling • Community workforce competencies • Further scoping and detailed project planning required for some initiatives
Progress to Date	• Out to consultation on service change • Robust deliverable with clear outcomes for some initiatives
Next Steps	• Conclude consultation and implement proposals – including decommissioning • 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 – Unexplained variation in primary care prescribing both within and across PCTs – Variation in efficiencies of prescribing spend/patient • Cost of health care is rising more quickly than the amount of money available for our residents – Variation in costs charged by local providers against London and National benchmarking prices 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 • 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 • Development of Sector clinical and governance leadership including development of area prescribing committee • Developing incentives including possible shared saving schemes with providers
Initiatives / Projects	• Secondary care initiatives – Review of High Cost drugs (non PbR) – Review of on costs on PbR excluded drugs at Royal free Hospital and Renal drug tariff costs – Mandating use of 4 Biosimilar drugs • Commissioning good practice (aligning incentives in Primary care) – PCT specific – NHS Enfield – MM scheme focused on 32individual prescribing initiatives – NHS Barnet - MM scheme focused on 28 individual prescribing initiatives – NHS Islington - MM scheme focused on 23 individual prescribing initiatives – NHS Camden – MM scheme focused on 20 individual prescribing initiatives – 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 • Benchmarking good practice across and between sectors and PCTs, developing novel KPIs • Clinically led change management • Incentive scheme approach
Mode of delivery	• Contractual mechanisms and levers within acute contracts including the inclusion of drug specification • Monitoring, professional and practical support by PCT pharmacists • Sector wide GP/clinical leadership and championing • Sector wide consistency in programme management
System Levers and Incentives	• Contractual terms • Performance management against contracts and raising challenges where appropriate • Financial Incentive schemes for GPs • Consortium peer review and support • Clinical sign up and engagement in both primary and secondary care initiatives, especially where cost effective drug choices are recommended • Risk/gain sharing schemes
Key Enablers (	• Interim realignment of resources to ensure appropriate distribution to support delivery of initiatives (pending formal restructure) • Timely, accurate Data and information, from practice to national level. In secondary care much more data and information requested routinely • Engagement of clinicians to support the initiatives as prescribing responsibility rests with them • Development of GP Consortia • Trust efficiency saving responsibilities • More benchmarking data in secondary care available • Inclusion of drug specification in the acute contracts • 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 • 4 year cumulative impact = 2011/12 = £[ ]m
Interdependencies	• Contracting rounds and negotiation • Acute and primary care trust data provision • Primary Care QIPP initiatives and Trust CIP plans • Restructure of commissioning function • Finances, in particular inflationary uplift • NICE recommendations • Cancer drug tariff negotiations
Risks	• Currently not delivering on primary care medicine plans in all PCTs • Relevant data sets analyzed in a timely manner • Evaluation of changes implemented and their impact • Clinical engagement • Resource and Skills; numbers in medicines management workforce • IT support and level of information provided by trusts
Progress to Date	• Delivery plans written and incentive schemes proposed in draft • Support materials developed or developing • Metrics developed • Development of Drug schedule which details the management of high cost drugs in acute trusts • Immediate transfer of some resources to Acute work stream • Approval for redistribution of resources as part of next phase of transitional plan
Next Steps	• Implement project plans • 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 • Adherence to historical patterns of funding allocation for enhanced level services without clearly defined outcomes or assurance of value for money • Variation in quality and performance in primary care services due to inconsistent approaches to contract management across the sector • High level of use of acute services where primary care services are more appropriate and cost effective
Scope	• Primary Care Dentistry • General Medical Services • 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 • 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 • Primary Care performance management based on the principal of standardizing the processes for identifying and remedying poor performance through robust contract and performance management • 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 • Innovative approach to identifying top 10 reasons for referral as opposed to top 10 referral specialties as a means of modifying GP referral behavior • 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 • Development of referral thresholds/guidance for top 10 reasons for referral with information to practices to demonstrate referral activity against average • Disinvestment in low value enhanced services and refocus of enhanced service outcomes to reductions in acute activity where applicable • Re-commissioning of DES models where extended LES models have previously been commissioned without delivering outcomes • 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 • Clinical engagement with Commissioning Consortia and Local Representative Committees (LMC/LDC/LPC) • Clinical leadership of the entire QIPP programme • 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 • Early engagement with borough DOFs to ensure agreement to financial contribution from each PCT • 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 • 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 • 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 • 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 • 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 • 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 • Ability of primary care providers to address the required level of change and recognize the necessary contribution of primary care to financial recovery targets • Ability to provide referral information in adequate detail on a regular basis at GP and secondary care level • Reduced capacity in primary care teams to deliver QIPP initiative outcomes
Progress to Date	• Outline programme has been developed for each initiative • LMC acceptance of key principals for Enhanced Service funding review • 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 • Wide health inequalities • Variation in quality of service and care pathways based on risk stratification benchmarking and patient experience • Identified gaps in service provision • Sustainable Medical and Midwifery workforce, including adequate junior staff and consultant cover • Number and age profiled of midwives
Scope	• Care pathway development • Improving clinical quality and patient experience and current service provision • Further assessment of gaps in service provision
Initiatives / Projects	• Spine pathway • Improving Early access to maternity services • Intrapartum (deliveries) and inpatient activity not related to activity • Scoping of perinatal mental health services • 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 • Whole pathway approach across the sector • Contractual terms and conditions • Service specification

Key Priorities

6.0 MATERNITY

Case for Change	• No agreed definition of what constitutes low and high risk care for women • 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. • 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 • Wide health and social inequalities in NCL • 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 • Inadequate junior staff and consultant cover on labour wards (not all units in line with 'Safer Childbirth' recommendations) • 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 • Standardised care protocols for NCL • Improving clinical quality and patient experience and current service provision through benchmarking • Further assessment of gaps in service provision • 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 • Improving early access to maternity services including a network approach to booking women for care • 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) • Scoping of perinatal mental health services • Improving quality, standards and patient experience in maternity services
Innovation	• Implementing recognised best practice in NCL to reduce variation in quality and outcomes • Linking with UCL Partners' work on maternity through the NCL Maternity Network • 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) • Contractual terms and conditions- using the contract to deliver better value for money • Updated Service Specification to reflect new pathways and model of care • 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 • Contracting and performance management to current service specification in 11/12 and beyond • Patient experience and choice (regular monitoring and benchmarking through maternity network sub group) • National standards and guidance on best practice- NCL will strive to provide the best service by working together • 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 • 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) • Public, provider and commissioner engagement through network and Maternity Service Liaison Committee • Workforce strategy and development of new ways of working, piloted through the Maternity Network • Public facing information which is clear and explains the work of the network and the pathways that are produced
Identified savings	• 2011/12 = none • 4 year cumulative impact = 2011/12 = £[ ]m
Interdependencies	• National work on tariff for maternity services • Financial modeling and establishment of agreed baseline position • Recruitment of dedicated clinical leadership • Primary and community care capacity and quality • London wide approaches to improving maternity services

Key Priorities

6.0 MATERNITY (cont.)	
Risks	• Inability to recruit high calibre clinical leads • 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 • Pace of change (too slow) • Workforce issues will negatively impact on NCL's ability to redesign the model of care • Availability of community facilities suitable for providing maternity care closer to home • GPs may not agree maternity shared care arrangements across NCL • 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 • 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 • Excellent engagement from maternity service providers and clinicians in NCL • Maternity services specification developed for inclusion in contracts. This will be amended in 11/12 as a result of QIPP initiatives • 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 • Formulation of full project plans for all initiatives • 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 • 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 • Pressing need to ensure limited financial resources are focused on the most effective care
Scope	• Streaming back office approaches to managing exceptional treatment requests • Determining appropriate and consistent clinical thresholds • Decommissioning activity of limited clinical value
Initiatives / Projects	• Extension of existing low priority treatment policy (originally implemented in 2010/11) • Sector centralisation of intrauterine insemination • Determining revised clinical thresholds for bariatric surgery • Decommissioning of navigational catheters • Decommissioning of acute terminations • Decommissioning of acute vasectomies • Reducing unnecessary cataract activity • Terminate sexual health promotion contracts • Not routinely funding Cyberknife treatment • 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 • Prior approval for treatment authorisation to ensure only the right patients are treated • Guidance for clinicians to empower them to help enforce thresholds and LPT policies • Performance monitoring against agreed outcomes • 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 • Contracting framework
Key Enablers	• Clinical leadership to support and lead change in practice • Public agreement to support following of protocols
Identified savings	• 2011/12 = £17.9m • 4 year cumulative impact = 2011/12 = £[ ]m
Interdependencies	• Alignment of senior management views and sign up to proposals • Recruitment to sector treatment funding process support team
Risks	• Political /public reaction overturns commissioning decisions • Lack of consensus between PCTs makes sector-wide approach to implementation a challenge • Lack of support from key stakeholders e.g. GPs lead to protocols not being respected • Sector team is not able to manage volume of prior approval requests • 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 • Exceptional Treatment Request policy agreed in principle by commissioners
Next Steps	• Implementation of proposals that have been agreed • Further development of some proposals to enable value to be determined and decision making on whether to proceed to take place • Set up of NCL sector-wide treatment funding panel

Key Priorities

8.0 CANCER

Case for Change	• Late diagnosis • Increased rates of cancer • Lower than, or on par with, England and London survival rates for breast and colorectal patients • Inequitable access to treatment • Variation in quality of care • Low uptake of screening services • Inequalities within the sector in relation to both incidence and outcomes • Not achieved full compliance with IOG standards in all organisations for all tumour sites
Scope	• Specialist services – London model of care • Commissioning and contracting frameworks and tariff • Service redesign and new pathway development • Cancer follow up • Cancer inpatient efficiency - length of stay • Risk stratification
Initiatives / Projects	• Optimisation of routine follow up for breast , colorectal and prostate patients • Implementation of brain and lung commissioning pathways • Development of colorectal, breast and prostate commissioning pathways • Implementation of bowel screening age extension • Development and implementation of 23 hour breast cancer surgery (excluding immediate reconstruction and reconstruction) • Development and implementation of an enhanced recovery programme for colorectal cancer • Development of new models of community chemotherapy provision • Improving efficiency of chemotherapy services • Introduction of a recurring admission patient alert system in accident and emergency departments • Raising public awareness of signs and symptoms linked to earlier diagnosis • Reconfiguration of MDTs for common and specialist cancers (provider network designation) • 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 • Integrated service delivery across whole pathway of care
Mode of delivery	• Service redesign • Cancer provider network designation • Decommissioning of determined unwarranted outpatient activity • Detailed service specification • Roll out of technology • Provider collaboration • Procurement
System Levers and Incentives	• Contracting and performance monitoring framework • Specifying and commissioning services on a whole pathway basis • Commissioner led designation of cancer provider networks • Alternative pricing approaches for pathways
Key Enablers	• Effective provider network • Capacity in the system – e.g. . Facilities • Patient sign – up • Positive press reportage • Workforce redesign • Effective clinical governance systems and processes • Effective data sets • GP and provider support
Identified savings	• 2011/12 = none • 4 year cumulative impact = 2011/12 = £[ ]m

Key Priorities

8.0 CANCER (cont.)	
Interdependencies	• London model of care programme • Configuration of provider landscape
Risks (KF added this)	• Media attention • Negative public perception • Funding of networks beyond 2011/12 • Complexity of delivering whole systems change
Progress to Date	• Well defined plans with key objectives • Development of long term cancer commissioning strategy • Provider Network and Cancer Network commissioning team established • 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 • Need to reduce treatment delays • Need to improve timely access to key cardiac interventions • Slow uptake of evidence based innovative procedures • Workforce constraints relating to the availability of junior doctors
Scope	• Redesign and implement revised pathways to move appropriate services closer to home • Using evidence-based practice to reduce variation and inequitable access to cardiac and stroke services • Admissions avoidance • Reduction of length of stay • Centralisation of specialist services • Detection and treatment of stroke risk factors
Initiatives / Projects	• Creation of a single specialist vascular centre for NCL • Heart Failure diagnosis – cost effective use of tests, which leads to more appropriate use of heart failure specialist services • Re- admission avoidance for people with heart failure • Implementation of service redesign for patients in need of complex arrhythmia procedures to produce a more equitable service provision • Non- ST elevation acute coronary syndrome pathway redesign, reducing length of stay and double admissions during the same non-elective episode • Cardiac surgery – reducing the average length of stay for non elective surgery through the use of an electronic referral system • Work towards a door to needle time of 30 minutes for thrombolysis of stroke patients • Improve diagnosis of atrial fibrillation and anti-coagulation following a stroke • Unbundle London Stroke tariff to fund Early Supported Discharge (ESD) services • Creation of a HASU ESD coordination role to provide cost-effective stroke discharge services across NCL • Deliver 6 month post-discharge reviews of all stroke patients • Embed stroke rehabilitation standards and data collection into community contracts

Key Priorities

9.0 CARDIO-VASCULAR DISEASE (cont.)

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

Key Priorities

9.0 CARDIO-VASCULAR DISEASE (cont.)	
Risks	• Capacity to deliver scope of programme • Resistance to the centralisation of vascular services • Ability to provide ongoing funding following pilot phases • Longer term sustainability of outcomes, if no mechanism for ongoing monitoring in place
Progress to Date	• NCL localisation of London wide redesign work • Service specifications for cardiac services included in contract documentation for 2011/12 • Service specifications for vascular services prepared and shared with providers • A collaborative approach with providers to achieving the changes to vascular services • Robust scoping of project deliverables • 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 • Families would most often prefer to go somewhere other than A&E if services were open and close to home • 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 • 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 • Variation in quality and provision of tertiary pediatric services • Fewer larger centres to focus on complex needs • Creation of North London Tertiary Provider network to bring deliver capacity small specialties
Scope	• Acute paediatric inpatient services (medical and surgical) • Paediatric outpatient and community services • Proposed service model for London for tertiary services
Initiatives / Projects	• To be confirmed for tertiary services following consultation on the proposals for London • 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 • 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 • 4 year cumulative impact = TBC
Interdependencies	• Further London wide redesign proposals • Impact of the London health economy response to the tertiary services proposals • NCL Unscheduled Care QIPP work stream • Local authority children's services
Risks	• Future disposition of tertiary services disadvantages local providers • Financial and clinical implications for providers' acute paediatric proposed model of care • Public and stakeholder reactions to any proposed changes • Alignment of health and social care plans
Progress to Date	• London tertiary proposals out to consultation • Discussions underway within the Paediatric Network regarding future models of care
Next Steps	• Proposals for tertiary services finalised following consultation • Detailed plan developed for acute paediatrics network

Key Priorities

11.0 ACUTE PRODUCTIVITY	
Case for Change	• More efficient operation of acute providers • 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: • 18 weeks management • A&E conversion rate • A&E attendance when left without seen a clinician • A&E minor ailments resulting in admission • Admissions via A&E with a zero length of stay • C2C Paid as Follow up • Day case coding to OP procedure • Excess bed days • Non Emergency Re-admission 30 days • Non Emergency Re-admission 30 days to another provider • OP attendances whilst an inpatient • Pre Operative excess bed days. • 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 • 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 • High quality staff to deliver and negotiate contract changes in a consistent way that create the necessary detailed and enforceable contract terms • A workforce with the necessary skills and capacity to monitor and enforce contract terms fully during the year
Identified savings	• 2011/12 = £46.7m • 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 • The case is not supported if taken to arbitration • Necessary capacity and skill set of staff to monitor and enforce contract metrics is not available • Knock on effect creates additional unplanned activity in other settings
Progress to Date	• Key metrics have been defined and benchmarked • 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 • 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 • Understanding the role that preventable risk factors play in the morbidity and mortality of the NCL • 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 • Local authority input and partnership working with NHS partners
Initiatives / Projects	• CVD, Cancer and Mental Health include; • NHS Health Checks, vascular risk underpinned by weight management, healthy eating and tobacco control programmes • Cancer screening continues to be a priority area for continued delivery with strategic links to interventions • Smoking cessation, impacting on reduced COPD prevalence. • Increasing childhood immunisation rates • Joint Alcohol Harm Reduction Strategies set out work plans to reduce alcohol related A&E attendances • Improved Access to Psychological Therapies aims to tackle common mental health disorders such as anxiety and depression • 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 • Developing service models as a result of insight from social marketing and engaging local communities • 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 • GP Consortia t • The local authority led Health and Wellbeing Boards and future public health workforce • 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 • New NHS and Public Health Outcome Frameworks • Wider role of the GP
Key Enablers	• Healthy Lives and Healthy People; • Public Health White Paper • NHS and Public Health Outcome
Identified savings	• 2011/12 = TBC • 4 year cumulative impact = TBC
Interdependencies	• NHS and Public Health outcome frameworks
Risks (KF added this)	• Transfer of public health to local authorities • Uncertainty and concern about the capacity of local teams to deliver all the proposed public health functions • 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 • New structures of Health and Wellbeing Boards • 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 ● Care provided in more local care settings	● Right person right care right place right time	● Improved clarity of care point location ● Improved quality
2.0 Unscheduled Care	● Reduction in short stay admissions ● Reduce duplication of diagnostics	● Reduced travel and shorter waits ● Reduced likelihood of admission ● Right treatment first time ● Care delivered in a more appropriate setting	● Access care closer to home	● Reduced number of access points in the system ● Skilled and competent workforce in right setting
3.0 Mental Health	● Earlier intervention in SMI	● Reduced out of area treatments – minimising social exclusion ● 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 ● 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 ● Above average performance against clinical outcomes for all Directed Enhanced Services (DES) ● More accurate & targeted screening for the right patients at the right time ● 0-5yr old increase in early clinical diagnoses & prevention for dental conditions ● Increased number of community pharmacy Medicines Usage Reviews increasing medicines compliance	● Increase in % patient satisfaction for GPs up to sector average ● Increase in % patients satisfied with dental treatment received up to London average ● Increase in % patients satisfied with time they have to wait for a dental appointment up to London average ● 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 ● Increase in dental vital sign performance ● Commissioning capacity of UDAs (Units of Dental Activity) to be aligned to sector targets so increasing patient access ● Increased access for new dental patients ● 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 • Improving shared care arrangements between GPs and maternity services • Meeting 'Maternity Matters' standards • Midwife assessment (booking) by 12th week is low • High intervention rates	• Need to develop more patient centric services, avoiding unnecessary appointments • Women still not aware of available choices. • 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 • 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. • Birth rate predictions make planning difficult • Insufficient middle grade and consultant staff. • 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 • Improving shared care arrangements between GPs and maternity services • Meeting 'Maternity Matters' standards • Midwife assessment (booking) by 12th week is low • High intervention rates
7.0 LPT, Decommissioning and Thresholds	• Reduction in clinically ineffective procedures (right care)	• Clarity of service provision available • 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 • Improved survival rates • Improved clinical outcomes	• Effective co-ordinated care pathways • Reduced readmission rates • Shorter lengths of stay	• Increasing take up of access to screening • Earlier access to diagnostics and screening	• Treatment provided earlier • Improved clinical outcomes • Care provided in line with outcome focused pathways, leading to less variation • Compliance with recognised standards
9.0 Cardiovascular	• Reduce variation within NCL sector • 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 ● 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 ● 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		