



## NOTICE OF MEETING

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

Contact: Robert Mack

Friday 25 November 2016 10:00 a.m.  
Committee Room 1, Hendon Town Hall, The  
Burroughs, London NW4 4AX

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Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Danny Beales and Alison Kelly (L.B.Camden), Abdul Abdullahi and Anne Marie Pearce (L.B.Enfield), Pippa Connor and Charles Wright (L.B.Haringey), Jean Kaseki and Martin Klute (L.B.Islington),

Support Officers: Anita Vukomanovic, Andy Ellis, Robert Mack, Pete Moore and Vinothan Sangarapillai

### **AGENDA**

- 1. NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - AGENDA PACK (PAGES 1 - 90)**

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Camden

Haringey

ENFIELD  
Council



ISLINGTON

# NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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FRIDAY, 25 NOVEMBER 2016 AT 10.00 AM  
COMMITTEE ROOM 1, HENDON TOWN HALL, THE BURROUGHS, LONDON  
NW4 4AX

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## MEMBERS

Councillor Alison Kelly (LB Camden) (Chair)  
Councillor Pippa Connor (LB Haringey) (Vice-Chair)  
Councillor Martin Klute (LB Islington) (Vice-Chair)  
Councillor Alison Cornelius (LB Barnet)  
Councillor Graham Old (LB Barnet)  
Councillor Richard Olszewski (LB Camden)  
Councillor Abdul Abdullahi (LB Enfield)  
Councillor Anne Marie Pearce (LB Enfield)  
Councillor Charles Wright (LB Haringey)  
Councillor Jean-Roger Kaseki (LB Islington)

Issued on: Thursday, 17<sup>th</sup> November 2016

**NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND  
SCRUTINY COMMITTEE - 25 NOVEMBER 2016**

**THERE ARE NO PART II REPORTS**

**AGENDA**

**Wards**

**1. APOLOGIES**

**2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY  
INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA**

**3. ANNOUNCEMENTS**

**4. NOTIFICATION OF ANY ITEMS OF BUSINESS THE CHAIR  
DECIDES TO TAKE AS URGENT**

**5. MINUTES**

(Pages 5 -  
14)

To consider the minutes of the meeting of the NCL JHOSC held on  
30<sup>th</sup> September 2016.

**6. SUSTAINABILITY AND TRANSFORMATION PLAN (STP)**

(Pages 15 -  
82)

To consider the Sustainability and Transformation Plan.

**7. LUTS CLINIC UPDATE**

(Pages 83 -  
86)

Report of the Whittington Health Director of Strategy and Deputy Chief  
Executive.

To note an update on the LUTS service at the Whittington Hospital.

**8. WORK PLAN**

(Pages 87 -  
90)

To consider the work plan for the Committee.

**9. DATES OF FUTURE MEETINGS**

Future meetings of the JHOSC will be on:

- Friday, 9<sup>th</sup> December 2016 at 9.30am at Camden Town Hall  
(Special meeting to consider the STP);
- Wednesday, 14<sup>th</sup> December 2016 at 5pm at Camden Town Hall  
(Special meeting to consider the STP);
- Friday, 3<sup>rd</sup> February 2017 at 10am at Enfield Civic Centre;
- Friday, 24<sup>th</sup> March 2017 at 10am at Camden Town Hall

**AGENDA ENDS**

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**THE LONDON BOROUGH OF CAMDEN**

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 30TH SEPTEMBER, 2016** at 10.00 am in the Rooms 1 & 2, Haringey Civic Centre, High Road, Wood Green, London N22 8LE

**MEMBERS OF THE COMMITTEE PRESENT**

Alison Kelly (Chair)	LB Camden
Martin Klute (Vice Chair)	LB Islington
Alison Cornelius	LB Barnet
Graham Old	LB Barnet
Abdul Abdullahi	LB Enfield
Anne-Marie Pearce	LB Enfield
Charles Wright	LB Haringey
Jean-Roger Kaseki	LB Islington

**The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee.**

**MINUTES****1. APOLOGIES**

Apologies for absence were received from Councillors Pippa Connor (LB Haringey) and Richard Olszewski (LB Camden).

**2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA**

Councillor Cornelius reported that she was a trustee of care home in Barnet.

**3. ANNOUNCEMENTS**

There were no announcements.

**4. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT**

There were no notifications of urgent business.

**5. MINUTES**

**RESOLVED –**

That the minutes of the meeting of 10 June 2016 be approved.

## **6. DEPUTATIONS**

Deputations were received regarding the LUTS clinic and the Strategic Transformation Plan and are noted at the relevant agenda items below.

## **7. WHITTINGTON LUTS CLINIC**

The Committee received a deputation from a group of patients from the Lower Urinary Tract Services (LUTS) clinic that is run by Whittington Health at Hornsey Clinic. Members of the deputation stated the following:

- The clinic had closed abruptly last year. This had affected 900 patients, many of whom had been adversely affected. The closure had been challenged by patients and, following this, re-opened with certain restrictions. This included not taking any new patients and not treating children. There was also a need for a succession plan on the retirement of the clinic's consultant and this had been raised by patient representative but still required resolution. The consultant had agreed to continue his work for a further two years but the lack of new patients for the clinic was making the identification of a successor to him more difficult;
- There were around 100 patients who were currently awaiting treatment by the clinic and unable to access it due to the current restrictions. This was causing long term damage to their welfare and was, they felt, ethically unacceptable. In addition, it had proven difficult to act on the changes that had been required to develop the paediatric pathway and there were now significant numbers of children awaiting treatment;
- The potential risk of side effects from treatment offered at the clinic had been raised by the Trust as an issue but the rate was very low and the risks that arose from withholding treatment were considerably higher, with 80% of patients deteriorating;
- The actions of Whittington Health in addressing the situation had not been investigated and had been characterised by a lack of transparency. In particular, there had been continual delays by the Trust in revalidating the consultant's General Medical Council validation;
- The patient representatives asked for a commitment by the Trust to;
  - Accept the report of the review that had been commissioned from the Royal College of Physicians (RCP) in full;
  - Provide assurances that they would support the clinic;

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- Lift the restriction on new patients and facilitate an effective succession plan; and
  - Allow the clinic's consultant to resume treating children.
- They felt that the actions of the Trust had been counter productive. The effective and innovative treatment offered by the clinic made it worthy of "centre of excellence" status. The recent issues had been very stressful for the clinic's staff and patients, who deserved better.

Simon Pleydell, the Chief Executive of Whittington Health, responded that the Trust was committed to the future of the clinic and finding a way forward. There were a number of issues that required resolution though. The clinic had been reinstated, but with some restrictions. The RCP had provided some preliminary feedback from its review and this had stated that the Trust should focus on the issues of the sustainability of the service and succession following the retirement of the clinic's consultant from University College London. The consultant had agreed direct employment with Whittington Health to stay on for a limited period though and the clinic was continuing to see patients post his retirement date. The long term aspiration was to locate the service within University College Hospital (UCLH). The final report of the RCP review was imminent and it was the ambition of the Trust to re-open the clinic for new patients.

There were complex governance issues that needed to be resolved. The clinic was a national referral centre that offered treatment that was not available anywhere else. Meetings had taken place with UCLH to determine whether a suitable clinician could be identified who shared the philosophy of the clinic. There was a feeling that the service would be best suited to operating as a tertiary centre as the Whittington was not geared up for dealing with innovative practice. The clinic would begin to take new patients once there was a firm succession and governance plan and the final RCP report had been checked. Modern paediatric care required that clinicians did not care for patients in isolation and discussions were taking place with Great Ormond Street Hospital (GOSH) regarding the development of a suitable pathway.

Siobhan Harrington, the Deputy Chief Executive, stated that the Trust was very sorry for any distress that had been caused to patients by the issues at the clinic. The RCP had completed its work in early May and a delay in them providing their final report had not been anticipated. The clinic was very reliant on a single clinician and the issues regarding its future and sustainability were currently being worked through. It was nevertheless planned to re-open it to new patients.

The Committee welcomed the recognition by the Trust that the clinic was a national centre of excellence. It was acknowledged that the clinic should not be reliant on a single clinician working in isolation but the issues appeared to taking a long time to resolve.

Ms Harrington responded that the Trust was sorry about the delay but it had been found to be very extremely complicated to resolve. It was disappointing that it had

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not yet been possible to finalise a succession plan but there had been some interest from clinicians at UCLH and she was now more optimistic that the right clinical team would be found to ensure the future sustainability of the clinic.

Mr Pleydell stated that the Trust Board's position was that taking on new patients before they fully understood the RCP's position would not be the right thing to do. It was very clear that there was an ethical duty to patients. The RCP report constituted guidance and the Trust Board would have to make the final decision. He noted that the RCP had been struck by compelling evidence from patients.

In respect of the RCP report, Mr Pleydell stated that he was optimistic that it would be positive. As the issue of succession had been mentioned in their interim feedback, it appeared unlikely that the RCP had any serious clinical concerns. The Trust Board would be developing an action plan as well as timescales.

In response to a question, Mr Pleydell stated that the Trust aimed to resolve the matter as quickly as possible. The clinic was unique and this had been recognised by the Care Quality Commission. In the future, decisions regarding services like the clinic were likely to be determined as part of the Sustainability and Transformation Programme (STP).

**RESOLVED:**

That a meeting be arranged between the Chair and Vice Chairs of the Panel and Mr Pleydell when the final report of the RCP review becomes available in order to discuss the way forward.

**ACTION – WHITTINGTON HEALTH (SIMON PLEYDELL)/VINOTHAN SANGARAPILLAI (CAMDEN COMMITTEE SERVICES)**

**8. WHITTINGTON ESTATE STRATEGY**

Mr Pleydell reported that Whittington Health currently operated out of 37 separate sites. The majority of these were no longer fit for purpose and their number and standard made services uneconomic. There was a large backlog of maintenance work and the Trust had not invested in their estates to the same extent as UCLH and the Royal Free. There was concern that, unlike other trusts, the Whittington was currently without a detailed strategic development plan for its estates. He was nevertheless aware of the issues that had arisen from the previous strategy.

A key theme of the STP was to provide better care closer to home and the strategy would seek to progress this. The use of Information Technology would provide opportunities. All proposals would be properly consulted upon.

The Trust was proposing a novel way of dealing with the issue through the procurement of a Strategic Estates Partnership (SEP). A similar approach was now being adopted by Oxleas and Hinchingsbrooke NHS trusts. The Trust's

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intention was to seek a strategic partner to work with to develop separate proposals, which would be subject to individual procurement processes. Proposals would also need to fit within the STP process. There was a need for specific expertise so that action could happen at a fast pace.

In answer to a question, he stated that the SEP would be used to look at all of the different sites that the Trust currently owned and generate ideas in respect of a 10 year strategic plan and packages. It would be involved in the planning and delivery of projects as well as the raising of finance. SEPs had been used by several local authorities but were a new concept within the NHS. The SEP would operate as a separate company tied to the Trust. Work to develop the proposals further was taking place with NHS Improvement and it was envisaged that the procurement process would take place over the next six months.

The Chair stated that the Committee had asked a number of questions in a letter to the Trust and could not feel reassured until they were answered fully. The Committee felt that it might be of benefit if the procurement documentation was made available so that there was clarity on the nature of the partnership.

Mr Pleydell stated that the partners provider appointed would have a number of roles, including identifying suitable sources of working capital. It would also be well positioned to bid for particular projects although these would have to go through the STP planning process. The aim was to find a different way of obtaining procurement advice. Proper processes and scrutiny would be built into all stages of the processes and the normal procurement rules would apply. The procurement was about buying intellectual capacity and producing a range of projects.

The Committee felt that the partner provider's role in developing projects could provide a conflict of interest if they intended to bid for any of the individual projects. Deborah Fowler, representing Healthwatch across north central London, stated that information about arrangements for public and patient involvement would be welcome.

Mr Pleydell stated that there was a need to articulate the benefits of the process to patient care. Current sites were occupied for reasons of convenience rather than as a consequence of any planning process. The target was for the Trust to operate from 10 hubs. However, there were a lot of possible options and it was recognised that it was necessary to gain community support.

**RESOLVED:**

1. That a full response be provided by the Chief Executive of Whittington Health to the issues raised in the recent letter from the Committee regarding the Estates Strategy and that a meeting be arranged between the Chief Executive and the Chair and Vice Chairs to discuss the response further;

**ACTION – WHITTINGTON HEALTH (SIMON PLEYDELL)/VINOOTHAN SANGARAPILLAI (CAMDEN COMMITTEE SERVICES)**

2. That the Whittington Trust be requested to provide evidence that the development of their Estates Strategy is aligned to the STP process; and

**ACTION – WHITTINGTON HEALTH (SIMON PLEYDELL)**

3. That the Whittington Trust be requested to share draft procurement documentation with Councillor Klute, on behalf of the JHOSC, when it becomes available.

**ACTION – WHITTINGTON HEALTH (SIMON PLEYDELL)**

**9. NCL STRATEGIC TRANSFORMATION PROGRAMME AND CASE FOR CHANGE**

The Committee heard from the following:

- Mike Cooke, the Chief Executive of Camden Council;
- Jo Sauvage, the Chair of Islington Clinical Commissioning;
- David Stout, STP Programme Director.

Mr Cooke reported that deadline for the submission of STP plans to NHS England had been put back to 21 October. A lot of development work had been undertaken so far but the plan still required finalisation. When this happened, it would be shared with the local community. There was concern that the plan would be difficult for people to understand so it had been agreed that an easy to read version would also be produced. Involvement and engagement with the community would be arranged in due course.

Ms Sauvage reported that the plan was a challenging piece of work but presented some real opportunities. It had involved clinical leadership from all areas and the commitment that had been shown so far had been very impressive. The case for change described current issues within the health and social care system that required attention and it was ultimately necessary to achieve sustainability. There were a range of ways of working that could be done differently. For example, payment by results had not allowed funding to spread out. However, changes to the system needed to be grounded in the patient experience.

Mr Stout stated that there was a financial challenge that needed to be addressed, with a considerable gap in funding if nothing was done. Although funding had increased, it had not gone up fast enough to keep pace with demand. However, sustainability was not just about money.

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The Committee agreed to receive a deputation from Keep Our NHS Public on this issue and was addressed by John Lipetz, Professor Sue Richards and Alan Morton.

Ms Richards stated that it was hard to disagree with the vision of the STP for north central London. However, there was no evidence that it would be any cheaper than the current arrangements. For example, providing services in the community was not any cheaper. There was immense pressure to squeeze costs. The consensus was that a 4% increase per year from 2010 was needed to sustain NHS services but only 1% had been provided. If health services were funded at the same proportion of gross domestic product as Germany, there would now be £50 billion more available. The financial pressures had been driven by more expensive, high technology treatments and the ageing population. Staff costs had been under pressure and this was part of the reasons for the huge cost of agency staff. Although the proposals appeared to be well worked up, they could not be achieved without substantial budgetary reductions. The current projected financial gap was £800 million by 2020.

There was a lack of formal governance structure for the STPs, which meant that they were outside of the framework of the law. Decisions made would need to be referred back to CCGs for implementation. Local authorities now had greater powers to influence NHS decisions and were not compelled to support the STP process. There were statutory processes that the proposed changes would need to go through and efforts would be made to ensure that these responsibilities were complied with.

Mr Lipitz stated that the proportion of NHS funding that was going to primary care was now smaller than before and funds would need to be re-directed from elsewhere in order to redress the balance. He felt that it was essential that there was full public consultation regarded the proposed changes. Mr Morton felt that the principles behind the STP were laudable but that the process was over ambitious. The issues relating to the LUTS clinic were hugely complex but had only involved one small service. Costs would need to be reduced by 25% to achieve the savings of £800 that were required. In addition, the 7 day NHS would need to be factored in,

Ms Fowler reported that Healthwatch were on the STP Transformation Board. The main purpose of their role was to ensure that there was patient and public involvement in the process. She urged there to be far greater public engagement and that this be done in a creative manner. She was nevertheless appreciative that there was nothing specific to engage on as yet.

Committee Members noted that the current set up was a virtual structure and the plans would require sign off by 19 separate organisations. Concern was expressed at the lack of additional money in the system to bring about the transformation. They asked for further information regarding;

- Transitional funding and what it would be used for;

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- Governance structures and how they would operate;
- The development of digital services; and
- How funding would be provided equitably for each borough and take into account demographic changes.

Mr Cooke stated that several of these issues were national matters and he was therefore not in a position to comment. The essence of the STP was partnership and, whilst there was no formal legitimacy to the process, it was not unlawful. Proposals to develop the governance structure were being developed. In particular, it was important that there was political involvement. Engagement and involvement would take place at an early stage using established systems.

Ms Sauvage accepted that there was significant variability between boroughs within the north central London area and stated that consideration need to be given on how services could be made more equitable. It was very important that all relevant organisations were involved in discussions and that priorities were addressed. It needed to be ensured that services were sustainable. In addition, social care needed to be better integrated. Significant levels of spending were currently taking place in the wrong place within the system and it therefore needed to be re-built to address this. There would be extensive engagement at the beginning of this process. In terms of digital services, boroughs were at different stages of development and a clear way forward was required. She noted that the integrated 111/Out of Hours service was due to go live on 4 October.

Mr Stout stated that the process constituted a major challenge. The law would not be broken and responsibilities to engage and involve would be taken seriously. Some early engagement had been arranged and the invitations for this had been discussed with Healthwatch. However, this had been done at short notice. The projected gap in funding if no action was taken was £867 million. There was a strategic transformation fund of £105 million that was currently being used to offset provider deficits for the next two years. It was accepted that the current arrangements were not ideal. There was a wish to double run services in the transformation process if possible.

Ms Sauvage stated that the plan would be dealt with either across all five boroughs or locally, as appropriate.

Mr Cooke stated that the Plan for north central London would be published on 21 October and would therefore be available in time for the next meeting of the JHOSC on 25 November.

**RESOLVED:**

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That the meeting of the JHOSC on 25 November 2016 in Barnet be devoted in its entirety to considering the STP plan for north central London in detail and that the remainder of the proposed agenda items for the meeting be deferred.

**10. RESIDENTIAL & NURSING CARE HOMES - SUPPORT INCLUDING PRIMARY CARE SUPPORT**

The Chair expressed her disappointment that the report did not cover all of the issues that she had hoped. Cassie Williams, Assistant Director of Primary Care, Quality and Performance at Haringey CCG, reported that the officer who had been coordinating the report had been forced to take emergency sick leave and she had therefore taken over responsibility for it at short notice. She reported that Enfield had commissioned a multi-disciplinary service which was highly rated but was not based in primary care. Camden, Islington and Enfield provided additional incentives for GPs to engage with care homes. Haringey and Barnet did not provide this and GPs were expected to provide cover as part of their standard contract.

The Barnet Care Homes Enhanced Support Service team was similar to the service that was provided in Enfield. An integrated service was also provided in Islington. Commissioning arrangements were complex though there was a lot of work required to reduce the level of variability between boroughs. A lot of issues arose from funding streams that were available.

The Committee was of the view that performance indicators and outcomes needed to be standardised across the five boroughs. It was also felt that consideration should be given to identifying a lead borough. In addition, learning from good practice needed to be shared. Ms Williams stated that there was a common goal of reducing the number of patients being taken to hospital and she would take the views of the Committee back.

Committee Members requested further details of what arrangements would be out in place once current pilot schemes, such as the CHES team in Barnet, had finished.

**RESOLVED:**

That a further report on progress, including details of the outcomes of current pilot schemes, be submitted to the Committee in 2017.

**11. WORK PROGRAMME**

**RESOLVED:**

That the report be noted.

**12. DATES OF FUTURE MEETINGS**

*North Central London Joint Health Overview and Scrutiny Committee - Friday, 30th September, 2016*

Future meetings of the JHOSC will be on:

- Friday, 25<sup>th</sup> November 2016
- Friday, 3<sup>rd</sup> February 2017
- Friday, 24<sup>th</sup> March 2017

**13. ANY OTHER BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT**

There was no urgent business.

**CHAIR**

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**MINUTES END**

# North Central London Sustainability and Transformation Plan

21 October 2016

DRAFT

## Key information

**Name of footprint and number:** North Central London, no. 28

**Nominated lead of the footprint:** David Sloman, Chief Executive, The Royal Free NHS FT

**Organisations within footprint:**

CCGs: Camden, Barnet, Islington, Haringey, Enfield

LAs: Camden, Barnet, Islington, Haringey, Enfield

Providers: Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS FT, Central London Community Healthcare NHS Trust, Central and North West London NHS FT, Moorfields Eye Hospital NHS FT, North Middlesex University Hospital NHS Trust, Royal Free London NHS FT, Royal National Orthopaedic Hospital NHS Trust, Tavistock and Portman NHS FT, University College London Hospitals NHS FT, Whittington Health NHS Trust

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## 1 Foreword

Welcome to the Sustainability and Transformation Plan (STP) for the health and social care services that serve the population of North Central London (NCL). The aim of the STP is to ensure NCL is a place with the best possible health and wellbeing, where no one gets left behind.

This STP is a work in progress and we welcome your comments and input as we further develop the plans.

For the first time, we have come together as health and social care partners to plan how we will deliver excellent, future-proofed services for our local population over the next 5 years.

We know that the health and social care needs of our local people are changing, and that there are serious issues facing health and care services in NCL. People receive different care depending on where they go to obtain it: waiting times for services and health outcomes vary, and the quality of care and people's experience of health and social services is sometimes not as good as it could be.

On top of this, our financial situation remains challenging. Demand for health and social care continues to grow year on year and the growth in demand is running faster than the growth in funding. If we do nothing, we estimate that we would face an unprecedented financial gap in relation to health services alone of nearly £900m in NCL by 2020/21. In addition, as is well known, the trend is for people to live longer and in turn this is creating pressure on social care services and funding.

We believe the best approach to meeting these challenges is to work together to tackle them head on, working together to find solutions at scale and aligning as a system around the interests of local people rather than solely focusing on our individual organisations. It takes time to build relationships and trust in the context of a system that is fragmented and under increasing pressure, but we are committed to this joint endeavour across the whole partnership.

The STP sets out our commitment to transforming care to deliver the best possible health outcomes for our local population; shifting our model of care so that more people are cared for in out of hospital settings - through prevention, more proactive care, and new models of care delivery – and reducing reliance use of secondary care. We have made significant progress in developing our specific ideas for how we will achieve this. We have set up 13 different workstreams and have worked hard on these over the last few months to develop thinking, building on evidence and involving hundreds of members of staff drawn from every organisation in NCL. We have held public meetings in each of the boroughs to start to develop a dialogue with the local community, although we recognise there is much more to do on engagement in the months ahead.

The plan sets out a mixture of both radical service transformation and incremental improvements we believe we need to make in order to deliver real benefits for our population: increasing the emphasis on prevention; shifting care closer to home to reduce demand on hospitals; reducing variation in quality; improving productivity and reducing waste.

But the plan as it stands does not have all the answers. There are some parts of the plan which we have not had time to develop in detail that require significantly more work. We recognise the sheer scale of the changes that we set out currently in the plan will stretch our capacity to deliver, so we need to stress test the plan to ensure we focus on the most important improvement first. And fundamentally the plan does not yet balance the finances, either next year or by 2020/21. Unless we can do so, we will not be able to afford all of the investments and improvements we aspire to deliver. As a result we know that we may face some really tough decisions about where we can invest for improvement and where we will need to prioritise or make choices.

We need to resolve these questions between now and Christmas. We will ensure we are prioritising the areas which will add the most value (in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money) to focus our energies on achieving maximum benefit. This will include trying to attract as much investment into NCL as possible. We will continue to develop further ideas in the parts of the plan which are not fully developed. And we will review the phasing of our specific priorities for the first 2 years of our plan in the context of the significant financial challenge we face, seeking specifically to identify areas where we can go further and faster, and areas where we can defer our investment or effort.

We recognise there is much more work to do, and it is crucial that our local residents are involved in this. We are at the beginning of truly transforming care for our population, which will require significant input and contribution from the people who use services in NCL. We look forward to working with our local population to make designing and implementing the plan a success as it evolves.

## 2 Executive summary

There are some excellent health and care services in North Central London (NCL). However, services are not consistent and there are examples of poor practice. We also face significant challenges over the next five years and need to shift our model of care so that more people are cared for in out of hospital settings. This Sustainability and Transformation Plan (STP) has been produced by all the main healthcare organisations and local authorities within NCL. It sets out how we are planning to meet the challenges we face and deliver high quality and sustainable services in the years to come.

We know from our track record that we have the capability to deliver excellent services and to deliver significant change. However, we are not currently able to deliver services across NCL consistently to the standards we would like. We also face a number of significant challenges around the health and wellbeing of local people; and the care and quality of our services. Our current system is focussed on dealing with illness, rather than orientated to prevention and helping people to live well. There is a substantial financial challenge facing health organisations in NCL; the health system is already in deficit and, if nothing changes, this will worsen over the next 5 years meaning that by 2020/21 we estimate we will be c.£900m in deficit. Local authorities are also facing significant financial pressures due to demographic changes and policy inflation: by 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£300m.

Our vision is for NCL to be a place with the best possible health and wellbeing, where no one gets left behind. To deliver on our vision, we have designed a programme of transformation with 4 fundamental aspects:

- 1. Prevention:** We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population.
- 2. Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services.
- 3. Productivity:** We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale.
- 4. Enablers:** We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Delivering these plans will result in improved outcomes and experience for our local population, increased quality of services and significant savings.

Despite this, we currently expect that the overall financial position of NHS organisations will be a £75m deficit in 2020/21. We have identified a number of areas for further work between now and Christmas where we believe there may be additional savings to be found that would address this residual gap.

To ensure we are able to deliver as a system, building on the progress we have made to date we will develop a robust governance structure which enables NHS and local government partners to work together in new ways to drive implementation. We will put in place dedicated resources to support delivery. It is crucial that whole system is aligned around delivery of the STP and we will ensure that the development of the 2 year health contracts that are being put in place for 2017/18 - 2018/19 are consistent with the STP strategic framework.

We recognise there is more work to do to finalise the granular detail of our delivery plans and address the residual challenge we are forecasting. To develop our plans in more detail we want to fully engage people who use services and the public in our thinking to ensure they are reflective of their needs. We are committed to being radical in our approach, focusing on improving population health and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

DRAFT

### 3 Context

North Central London (NCL) comprises five Clinical Commissioning Groups (CCGs): Barnet, Camden, Enfield, Haringey and Islington, each of which is coterminous with the local London Boroughs. Approximately 1.45m<sup>1</sup> live in the 5 boroughs. We spend c.£2.5bn on health and c.£800m<sup>2</sup> on adult and children's social care and public health. The population is diverse and highly mobile, with a large number of people living in deprivation<sup>3</sup>.

There are four acute trusts within NCL: The Royal Free London NHS Foundation Trust (sites include Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital in Hampstead), University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, and Whittington Health NHS Trust. There are two single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. Great Ormond Street Hospital for Children NHS Foundation Trust is within the NCL geography, but currently out of the scope of the STP. Community services are provided by Central and North West London NHS Foundation Trust, the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust.

Mental health services are provided by the Tavistock and Portman NHS Foundation Trust, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust. There are 220<sup>4</sup> GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative. There are 497 active social care sites registered across NCL, including 273 registered care homes (47 of which provide nursing)<sup>5</sup>. Care homes are particularly high in numbers in the north of NCL, for example in Enfield where there are 97 registered care homes (in contrast to the 12 care homes registered in Camden)<sup>6</sup>. In addition, there are 214 registered domiciliary care providers<sup>7</sup>.

The organisation of services in NCL makes the area quite unique and this has ramifications for planning: there is a particularly high concentration of specialised services across multiple providers covering a small geographic area. This means many of the patients treated in NCL do not live in NCL and consequentially, a large proportion of the income paid to our providers comes from commissioners outside of the area.

As individual organisations in NCL, we have a history of working together in different ways to meet the needs of our population, and there are numerous excellent examples of collaboration as a result. However, working collectively across all organisations remains a relatively new endeavour and we continue to build the trust required to enable us to do so.

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<sup>1</sup> ONS, Mid-year population estimates, 2015

<sup>2</sup> 2015/16

<sup>3</sup> Office for national statistics, IMD 2015

<sup>4</sup> Latest figures from NHS England, updated since publication of the NCL case for change

<sup>5</sup> Local Authority Care Quality Commission reports, 2016

<sup>6</sup> Local Authority Care Quality Commission reports, 2016

<sup>7</sup> Local Authority Care Quality Commission reports, 2016

We are home to 4 national Vanguards: The Royal Free London NHS Foundation Trust is developing a provider chain model; University College London Hospitals NHS Foundation Trust Vanguard is focused on what can be done to improve the end-to-end experience for people with cancer; Moorfields Eye Hospital NHS Foundation Trust is developing an ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust is one of 13 partners developing a UK-wide chain of orthopaedic providers. NCL is also home to two devolution pilots: one seeking to optimise the use of health and social care estate, and another focused on prevention in Haringey. In primary care, GP practices are already working together in a number of GP Federations to provide extended services to our residents.

In NCL, every borough has its own unique identity and local assets we can build on. Many people lead healthy lives, but if they do get sick we can offer some of the best care in the country. We have a reputation for world class performance in research and the application of innovation and best practice, and we can harness the intellectual capacity of our workforce to ensure the best outcomes are delivered. There are many examples of excellent practice across health and social care in our area, which we intend to use to help ensure that excellent practice can be offered to all our residents.

Our track record demonstrates that we have the capability to deliver excellent services and also to significantly change our services when needed. Our ambition is that everyone is able to get the care they need when they need it. This means ensuring people have the best start in life, and supporting them to live healthy lives. When people do need specialist care, we want them to be able to access it quickly and in the most appropriate setting, and to be fully supported to recover in the setting most suited to their needs.

However, we are not consistently delivering our ambition to the standards we would like. We face significant challenges around the health and wellbeing outcomes for our population, the quality of our services and the financial sustainability of the health and care system. These are outlined in this document and set out in more detail in our case for change<sup>8</sup>.

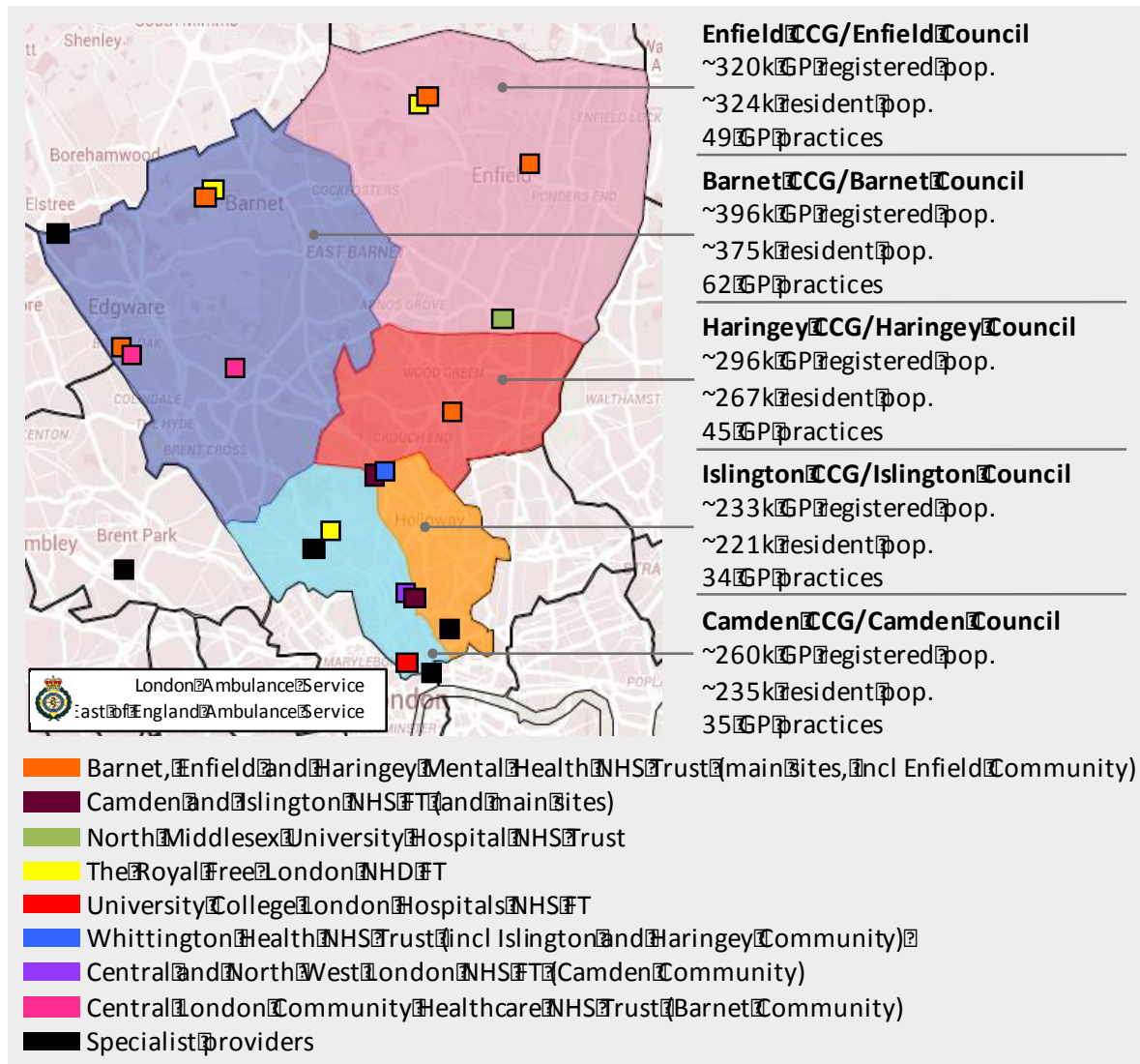
The national requirement to produce an STP is an opportunity for the NCL system to address these challenges together and widen the scope of our collaborative working. This document articulates:

- our collective understanding of the challenges we face
- our vision for health and care in NCL in 2020/21
- the plans to deliver on our vision and address the challenges
- the delivery framework which will enable us to implement our plan
- the impact we expect to achieve through the delivery of our plans
- our plans for securing broader public support and engagement with our proposals
- our next steps for further developing proposals and responding to our residual financial gap.

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<sup>8</sup> <https://www.uclh.nhs.uk/News/Documents/NCL%20case%20for%20change.September%202016.pdf>

Exhibit 1: Overview of NCL



Source: Population figures from 2014 ONS data.

## 4 Case for change: our challenges and priorities

In NCL we share many of the same challenges faced by health and care organisations across the UK (and indeed internationally). We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. Across the system we have aligned behind this work and we all agree on the nature and scale of the challenge, which we have described in our [case for change](#) which was published in September 2016.

### 4.1 Health and wellbeing gap

We have a diverse and highly mobile population. There are people from a range of Black and Minority Ethnic (BME) groups: these groups have differing health needs and health risks. A quarter of our local people do not have English as their main language<sup>9</sup>, which creates challenges for the effective delivery of health and care services. The mobility of our population, with 8% of local people moving into or out of NCL each year<sup>10</sup>, has a significant impact on access to services and delivery.

Poverty is a crucial determinant of health, and is widespread among both adults and children living in the boroughs that make up NCL<sup>11</sup>. Significant inequalities exist, which need to be addressed; for example, men in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas<sup>12</sup>. We face challenges in addressing other wider determinants of health, for example, there are high levels of homelessness and households in temporary housing with all five boroughs in the top 10% for number of households in temporary accommodation<sup>13</sup>. Social isolation also remains a critical issue across the sub-region.

The children of NCL do not always get the best start to life. 30% of children grow up in child poverty and 6% live in households where no one works. 60 children take up smoking every day<sup>14</sup>. Although there have been some improvements recently, London as a whole has the highest rates of obesity nationally: 1 in 3 children are obese in Year 6 (age 11) and we need to do more to tackle this, particularly working with the schools in NCL<sup>15</sup>. Although many of our residents are healthy and people are living for longer, good health does not always persist into old age. Our older people are living the last 20 years of their life in worse health than the England average<sup>16</sup>.

Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk<sup>17</sup>. However, they have not yet developed

<sup>9</sup> NCL case for change, 2016

<sup>10</sup> ONS mid-year population estimates 2014

<sup>11</sup> Census 2011

<sup>12</sup> IMD 2015, ONS

<sup>13</sup> <https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness>

<sup>14</sup> CENSUS 2011

<sup>15</sup> Public health outcomes framework tool, 2015

<sup>16</sup> Office for National Statistics, HSCIC CCG Indicators, 2014-15

<sup>17</sup> Camden and Islington GP Linked Dataset projected to NCL level

a long term health condition. Many of these lifestyle-related clinical problems are risk factors for NCL's biggest killers - circulatory diseases and cancer. These diseases are also the biggest contributors to the differences which exist in life expectancy.

There are high rates of mental illness amongst both adults and children in NCL<sup>18</sup>, and many conditions go undiagnosed<sup>19</sup>. 50% of all mental illness in adults begins before 14 years of age and 75% by 18<sup>20</sup>. Children with mothers with mental ill health are much more likely to develop mental health issues themselves. Three of our boroughs have the highest rates of child mental health admissions in London<sup>21</sup> There are high rates of early death amongst those with mental health conditions<sup>22</sup>, particularly in Haringey and Islington, and the rate of inpatient admissions amongst this population is above the national average. A strong focus on mental health is central to our approach with a clear aim of treating mental and physical ill health in a joined up way and with "parity of esteem."

#### 4.2 Care and quality gap

Currently, our system does not sufficiently invest in those people with a life-style related clinical problem, which would help stop them from developing the long term conditions which in aggregate are a huge burden on our health and care system. Only 3% of health and social care funding is spent on public health in NCL<sup>23</sup>, and that is despite evidence showing that between 2012 and 2014 around 20% (4,628) of deaths in NCL could have been prevented<sup>24</sup>. There is a large opportunity in refocusing our efforts towards prevention and making every contact count. This focus should also address the wider determinants of health such as poverty, housing and employment, all of which have a significant impact on individuals' health and wellbeing.

Disease and illness could be detected and managed much earlier, and managed better in community. It is thought that there are around 20,000 people in NCL who do not know they have diabetes, while 13% of the population are thought to be living with hypertension<sup>25</sup>. It is likely that people are being treated in hospital for long term conditions (LTCs) when they could be better managed by individuals themselves with the support of professionals in the community. Many people with LTCs – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition<sup>26</sup>. This would help avoid the high levels of hospitalisation we experience for the elderly and those with chronic conditions.

One of the disease specific challenges we face is in the provision of cancer care. Late diagnosis of cancers is a particular issue, alongside low levels of screening for cancer and low awareness of the symptoms of cancer in some minority ethnic groups. Waiting times to

<sup>18</sup> QOF data 2014/15

<sup>19</sup> NHS England Dementia Diagnosis Monthly Workbook, April 2016

<sup>20</sup> Dunedin Multidisciplinary Health & Development Research Unit. Welcome to the Dunedin Multidisciplinary Health and Development Research Unit (DMHDRU).

<sup>21</sup> Fingertips, 2014/15

<sup>22</sup> Healthy Lives, Healthy People 2010

<sup>23</sup> Based on 2015/16 public health budget of each NCL council

<sup>24</sup> Public Health Profiles Data Tool, PHE, 2012-14

<sup>25</sup> QOF 2014/15

<sup>26</sup> Office for National Statistics, HSCIC CCG Indicators, 2014-15

see a specialist are long, and so are waiting times for diagnostics. Additionally, referrals to specialists have almost doubled in five years. There is a huge shortfall in diagnostic equipment and workforce, and a lack of services in the community, particularly at weekends. A further issue is that some hospitals are seeing small numbers of patients with some types of cancer, in some cases less than two per week.

There are some challenges in primary care provision, however, this is a mixed picture which creates inequity. There are too few GPs in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person across all areas, but particularly in Camden and Haringey.

There are high levels of A&E attendances across NCL compared to national and peer averages<sup>27</sup>, and very high levels of first outpatient attendances<sup>28</sup>, which indicate potential gaps in primary care provision. Acute providers are not consistently meeting emergency standards.

In the acute setting there are differences in the way that planned care is delivered and this needs to be addressed, with variation based on differences in clinical practice rather than patient need. The number of people seen as outpatients in NCL is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

We are using hospital beds for people who could be cared for at home, or in alternative care settings. 59% of acute bed days are used by people with stays over 10 days, and the majority of these people are elderly. 85% of the mental health bed days in NCL are from patients staying over 30 days. Delayed discharges are also high in some hospitals. Staying longer than necessary in hospital is not good for people's health, especially the elderly whose health and wellbeing can deteriorate rapidly in an acute environment.<sup>29</sup>

We face challenges in mental health provision. People do not always have easy access to information and community based support, and community mental health services are under huge pressure. There is also no high quality health-based place of safety in NCL. Many people receive their first diagnosis of mental illness in Emergency Departments. High numbers of people are admitted to hospital – many under the Mental Health Act. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care: most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight<sup>30</sup>. There is limited perinatal community service in NCL, in the northern boroughs there is no specialist team and in the southern boroughs the service does not meet national standards<sup>31</sup>.

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<sup>27</sup> RightCare Atlas of Variation in Healthcare, September 2015

<sup>28</sup> NHS England Activity Data 2014-15

<sup>29</sup> Philip et al. (2013) Reducing hospital bed use by frail older people: results from a systematic review of the literature. International Journal of integrated care.

<sup>30</sup> Mental health crisis care ED audit, NHS England (London), 2015

<sup>31</sup> Maternal Mental Health Everyone's Business

Our use of information and technology does not currently support integrated health and social care across NCL. There is a variable level of digital maturity across providers and most being below the national average for digital capabilities, particularly their capability to share information with others.

Some of our buildings are not fit for purpose and there are opportunities to use our estates better. 11 sites in NCL have facilities management costs at least 10% more than the Carter benchmark (£319 p sq. m), with a further 3 sites within 10% of the benchmark. 8 sites have a higher proportion of unutilised space than the 2.5% benchmark contained within the Carter report, and over half of the sites analysed were found to have a higher proportion of non-clinical space than the Carter benchmark (35%).

We have significant workforce challenges across health and social care, including a high turnover across a range of professions, an over reliance on agency staff and HR policies which are not transferable across organisations.

There is consensus across the system that the current approach to commissioning and providing health and social care services across NCL could be better aligned to support the implementation of our emerging vision for the STP. In particular, the delivery of a population health approach and genuinely integrated care is significantly constrained by:

- the rigid separation of commissioning and providing responsibilities within the NHS
- the limited existing integration between health and social care
- the fragmentation of providers of health and care into many sovereign organisations
- increased financial risks across CCGs and providers
- stretched capacity and capability in the current organisational form.

We need to design new commissioning and delivery models that enable us to deliver transformed care in a way that is sustainable.

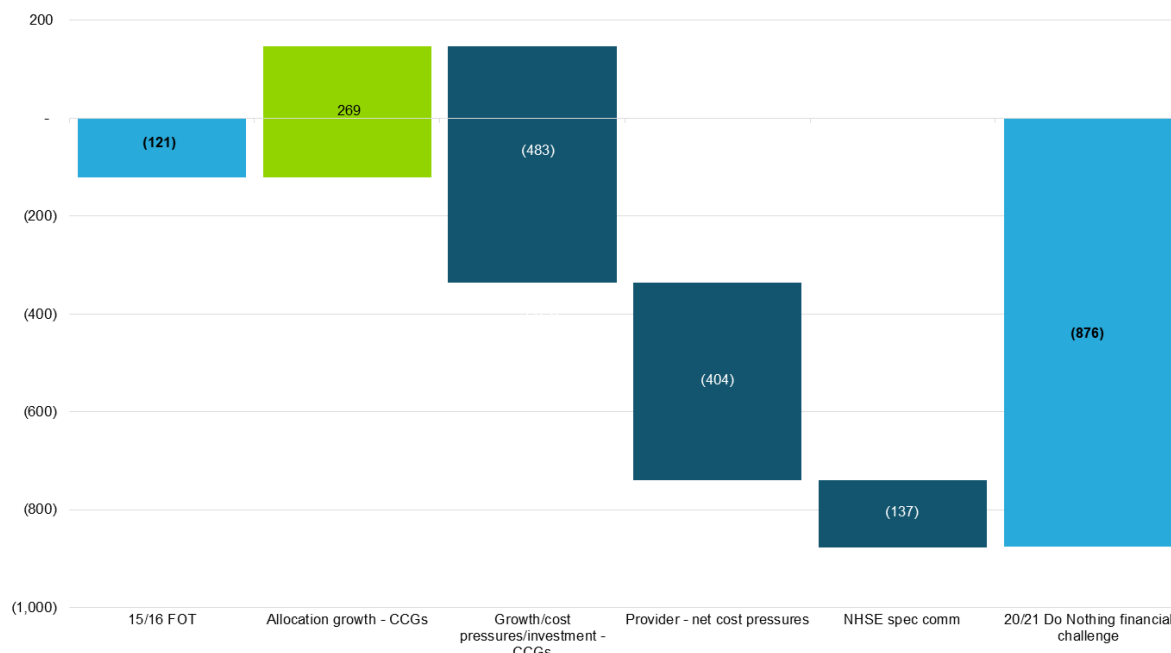
#### 4.3 Baseline financial gap

Our population is growing and demand is rising: people access health care more often, and are – positively – living longer, but often with one or more long term conditions. Meanwhile, the NHS's costs are rising more than inflation across the UK economy (to which allocations are linked). The upshot of this is that not only is the system responding to greater demand, but also that the sum cost of activity is growing faster than allocations.

Put simply, funding increases in NCL of £269m over the next 5 years will not meet the likely increases in numbers of local people and growth in demand for health services of c.£483m, plus increases in the cost of delivering health care of c.£404m.

This means that there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers were already £121m in deficit in 2015/16 and, if nothing changes, this will grow to £876m in deficit by 2020/21.

Exhibit 2: The 'do nothing' financial gap for NCL



The 'do nothing' specialised commissioning financial challenge is estimated at £137m (this estimate is currently being validated). This excludes Great Ormond Street Hospital NHS Trust and the Royal National Orthopaedic Hospital NHS Foundation Trust which would add a further £49m and £10m respectively. The specialised commissioning challenge is driven by advances in science; an increasingly ageing population with LTCs; and rising public expectation and choice for specialised treatment. In addition there are increasing financial pressures for specialised services, including the increasing volume of expensive new drugs. Spending on specialised services has increased at much greater a rate than other parts of the NHS, and this is expected to continue.

The current combined net budgets for the 5 boroughs in NCL is £760m for Adults and Children's Social Care (CSC) and Public Health services. However, we know that between 2010/11 and 2020/21 the average reduction in borough spending power will be 35%. Adult Social Care (ASC) budget reductions during this period will total at least £154.5m. This reduction in funding requires that a significant savings programme be delivered.

The collective 2016/17 forecast budget pressures for the 5 boroughs in ASC and CSC is £39m (£26m ASC, £13m CSC). Both ASC and CSC will continue face considerable pressures from demographic growth, inflation and increasingly complex care needs. By 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£308m, which is equivalent to a 28% reduction on the current Councils' total budget. Councils may have the option to raise a 2% precept for social care in future years, but this will be subject to political agreement and will not come close to closing the gap.

## 5 Vision

***Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind.***

Developing our vision in NCL has taken time, and we have harnessed our high quality clinical and practitioner leadership at every stage of the process. The vision for NCL initially drew on existing local work which was underway before the STP process started. Leaders across the system then iterated the vision at an event in September 2016. This process, alongside the series of borough-based public engagement events in September and October, has ensured that our vision is collectively owned across the system. We are committed to fulfilling our vision through this plan, and have identified a set of core principles to support our ambition.

### **Our core principles**

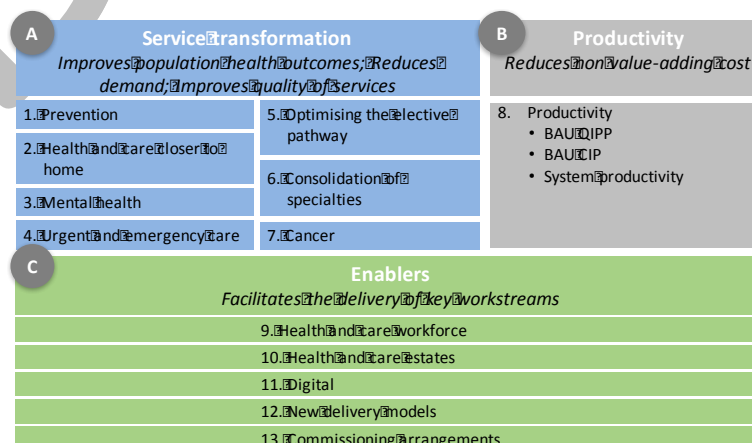
- We will work in a new way as a whole system; sharing risk, resources and reward.
- Health and social care will be integrated as a critical enabler to the delivery of seamless, joined up care.
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research based delivery models that move innovation in laboratories to frontline delivery as quickly as possible.
- We will make the best the standard for everyone, by reducing variation across NCL.
- In terms of health we will give children the best start in life, and work with people to help them remain independent and manage their own health and wellbeing.
- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible.
- We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate.
- To do all of this we will do things radically differently through optimising the use of technology.
- This will be delivered by a unified, high quality workforce for NCL.

## 6 Strategic framework

To deliver on our vision and achieve the triple aim as set out in the Five Year Forward View (to increase health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency), we have designed a programme of transformation with 4 aspects:

1. **Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in NCL is preventable. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population, which will reduce health inequalities, and help prevent demand for more expensive health and care services in the longer term.
2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services. This involves taking a “population health” approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Social care plays a key role in service transformation.
3. **Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the Carter Review and working together across organisations to identify opportunities to deliver better productivity at scale.
4. **Enablers:** We will focus on delivering capacity in key areas that will support the delivery of transformed care across NCL. This includes digital, workforce, estates, and new commissioning and delivery models.

Exhibit 3: The NCL STP strategic framework



## 6.1 Prevention

We will embed prevention and early intervention across the whole health and care system and deliver effective preventative interventions at scale. As a result, we will improve population health outcomes and reduce health inequalities by harnessing assets within and across communities for example, from Council services, including social care and the voluntary and community sector. This will positively impacting on the lives of residents, their families, and our communities.

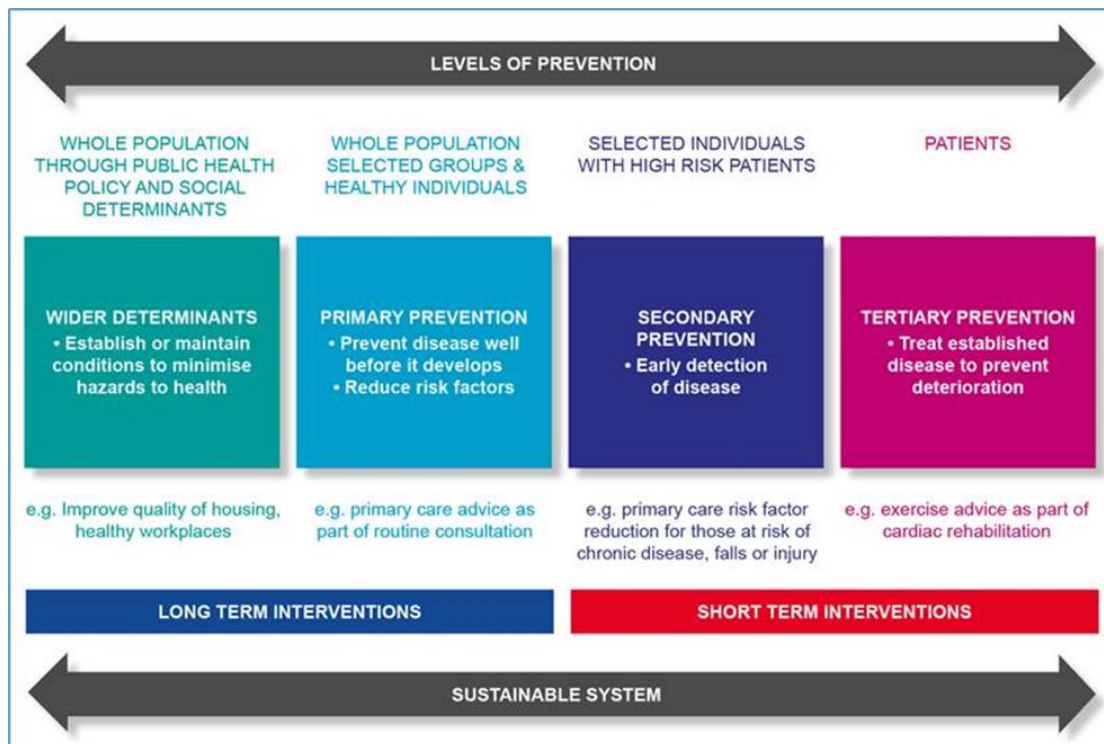
Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many unscheduled hospital admissions in the last 6 months. In future, on admission to hospital Afrin will be referred to an alcohol assertive outreach worker (AAOT) by the hospital alcohol liaison worker. This support will enable him to put in place foundations that will help him towards abstinence and recovery. Afrin will be supported to give up drinking, with input from an addictions doctor at a community alcohol service. A slow reduction plan, that is achievable and minimises the risk of seizures which in the past have led to hospital admission, will be put in place. Afrin will have regular 1-2-1 appointments with his AAOT, which will include psychological help.

Our prevention plans focus on interventions and system change across the whole spectrum of prevention (exhibit 4), where there is strong evidence of effectiveness and return on investment within the 5 year period of the STP<sup>32</sup>. In addition, we have identified opportunities where we could rapidly build upon successful local initiatives across NCL to achieve economies of scale.

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<sup>32</sup> Interventions have been identified from the Public Health England (PHE) Supporting Pack for STPs and the return on investment work undertaken for Healthy London Partnerships by Optimity.

Exhibit 4: Approach to prevention



We will concentrate our efforts on:

- **Creating a 'workforce for prevention'** so that every member of the local public sector workforce in NCL is a champion for prevention.  
*Specific interventions: Making Every Contact Count (MECC); Mental Health First Aid (MHFA); dementia awareness*
- **Ensuring that the places where residents and employees live and work promote good health.** This will include: reversing the upwards trend in childhood obesity; supporting people with mental ill health and other long term conditions to stay in work; pioneering new approaches to tackling gambling, alcohol misuse and smoking; and supporting the workforce across NCL (including our own staff) to become healthier.  
*Specific interventions: Haringey Devolution Pilot; improving employment opportunities for people with mental ill health through individual placement support (IPS); Healthy Workplace Charter; Healthy Early Years / Healthy Schools accreditation*
- **Supporting residents, families and communities to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing.** This will all reduce hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths. We will protect and ensure high quality universal services for vulnerable families by starting direct conversations with schools to proactively identify who these families are, and collaborating to map across primary care, social care, early years, therapies, paediatrics and secondary care. We will ensure that smoking cessation programmes are embedded across

maternity services and services for children and young people, targeting parents and older children. Drawing on the experience of our local authorities in running large scale campaigns, we will design and deliver a campaign across NCL to address a variety of wellbeing or long term conditions through a single preventative message with common NCL branding.

*Specific interventions: smoking cessation; alcohol screening, liaison and outreach teams; weight management programmes; diabetes prevention programme; multifactorial falls intervention; long-acting reversible contraception; community resilience; increased access to mental health services for children and new mothers; London's digital mental health programme.*

- **Diagnosing residents with clinical risk factors and long term conditions much earlier to increase life expectancy.** Once diagnosed, empowering them to manage their own condition(s) alongside proactive management by health professionals to prevent the development of further conditions and complications.

*Specific interventions: increasing awareness and case finding (including national cancer screening and HIV testing) and appropriate medications to control conditions for people with high blood pressure, diabetes, atrial fibrillation; self-care and structured self-management for long term conditions; reablement offers in social care and care navigation.*

We will build upon on the individual strengths that each part of the public sector in NCL can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and the London Fire Brigade in, for example, preventing falls. We also recognise the key contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

## 6.2 Service transformation

To meet the changing needs of our population we will transform the way that we deliver services, shifting the balance of care from reactive to proactive. This will be through ensuring people achieve the best start in life, developing our care closer to home model, creating a holistic approach to mental health services, improving urgent and emergency care, optimising the elective pathway, consolidating of specialties where appropriate and transforming cancer services to improve the end-to-end experience. Social care plays a key role in all aspects of service transformation.

### 6.2.1 Achieving the best start in life

Children make up between 25% and 30% of the population across the NCL footprint which means that service transformation must include a specific focus on our children and young people. We recognise that providing children with the best start in life is critical for their development and health long term. We have identified interventions across the pathway,

from prevention to acute care, that are focussed specifically on improving health and outcomes for children and young people.

In the context of a considerable body of research suggesting that fetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, we will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy. In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improvement of diet in women of reproductive age has the potential to reduce the health needs of children. We will leverage the work of our NCL Maternity Network to ensure that our local maternity system implements the findings of the national Maternity review: Better Births. We are keen to take part in the National Maternity Transformation programme as an Early Adopter.

We will promote active travel, sport and play for children in schools, for example involving schools to deliver the *Take 10, Active 15, Walk a daily mile* initiatives that other parts of the country have adopted to support this. By 2020/21, our aim is that 4 out of 5 'early years' settings and schools in NCL will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

Tai, 14, suffers from severe depression. With the involvement of Tai, his family, and his CAMHS practitioners, Tai has been admitted into a Tier 4 unit on a planner basis. Previously, it was likely that Tai would have been placed far from home. In future, with the local commissioning of Tier 4 he will be able to be placed close to home. This will enable better linkage with the local CAMHS community team, which will have also been enhanced. Together, these factors will mean Tai has a better experience of care and stays in hospital for a shorter length of time. When Tai is discharged back into the community, he will have an enhanced care plan to support him to keep well.

We will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families. We will capitalise on the universal services of MIND, Place2Be and voluntary sector initiatives like *Hope Tottenham* that are already established and working directly with families and young people. As part of our Child and Adolescent Mental Health Services (CAMHS) and perinatal initiative led through the mental health workstream, we will:

1. **Develop a shared dataset for CAMHS** to enable comparison and shared learning across the 5 boroughs
2. **Tackle eating disorders** by establishing dedicated eating disorder teams in line with the waiting time standard, service model and guidance
3. **Upskill our workforce** to meet the mental health and psychological wellbeing needs of children and young people, including developing a children and young people's IAPT workforce capability programme

4. **Build on our Transforming Care initiative** by supporting children and young people with challenging behaviour in the community in order to prevent the need for residential admission
5. **Improve perinatal mental health services** by developing a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL
6. **Implement a Child House model** following best practice to support abused children
7. **Create a 24/7 crisis pathway for children and young people**, including local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of S136
8. **Develop a co-commissioning model for youth justice** working with NHS England.

The principles of THRIVE will be used as an overarching approach to our CAMHS work, with the aim that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

#### 6.2.2 Health and care closer to home

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. We already have many high quality services outside acute settings across NCL, but our health and care closer to home model will focus on scaling these services up, reducing variation and making this the default approach to care. Social care will play a key role in the design, development and expansion of the future model.

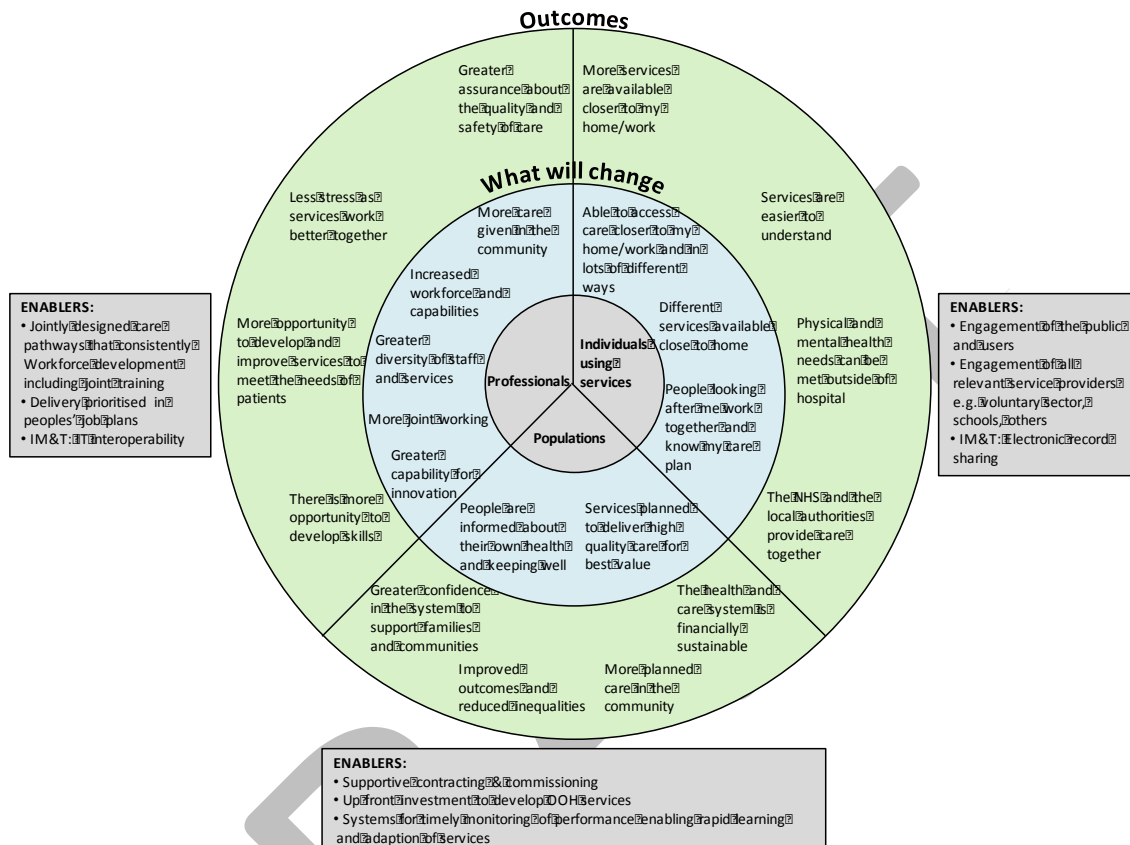
Ms Sahni is 87 and has four chronic health problems. Previously, she had to book separate appointments with different primary care professionals to have all of the relevant check-ups and appointments that she required. In future, Ms Sahni will be in a special “stream” of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the Integrated Care Centre located at her GP surgery. There will also be a care navigator in the team who can help to sort things out for her at home, including community support when she needs it.

We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed.

At the heart of the care closer to home model is a ‘place-based’ population health system of care delivery which draws together social, community, primary and specialist services. This will be underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. We will deliver the right care at the right time to the whole population. The care closer to home model is one of the key vehicles by

which we will contribute towards the overall delivery of the Better Health for London outcomes.

*Exhibit 5: Delivery of the Better Health for London outcomes through the health and care closer to home model*



Specific interventions that make up the scope of the care closer to home model include:

- **Developing 'Care Closer to Home Integrated Networks' (CHINs):** CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focussed on the strengths of residents, families and communities; improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes. We have already piloted CHINs, for example the Barnet Integrated Local Team (BILT)<sup>33</sup> hub which provides coordinated care for older residents with complex medical and social care needs, as well as providing support

<sup>33</sup> Barnet integrated Care Locality Team, 2016

to carers. The BILT hub has been open since April 2016 and is a joint funded health and social care pilot.

- **Extending access to primary care:** patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- **Supporting healthier choices:** in line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by 9-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across NCL; scaling up weight management programmes with integrated physical and wellbeing activities; and reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception.
- **Improving access through technology and pathways:** telephone triage, virtual consultations and online booking systems will be available for all patients.
- **Supporting patients through social prescribing and patient education:** the care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.
- **24/7 access to specialist opinion in primary care:** primary care will be able to provide more complex patients with a number of options for specialist opinion outside of the hospital itself. These range from: 1) advice only 2) an urgent 'hot clinic' appointment in an out-patient clinic 3) assessment in an ambulatory emergency care facility and 4) admission to an acute assessment unit. In addition, consultant-led clinical assessment and treatment services offered in CHINs will enable more patients to be managed in the primary care setting. Specialties to be considered include gynaecology; ENT; urology; dermatology; musculo-skeletal; and ophthalmology.
- **GP front door model in Emergency Departments:** we will review the existing provision across NCL of GP led triage, treatment and streaming for all ambulatory patients will be provided at the front door of Emergency Departments. GPs and nurses on the door make decisions about where the patient is best treated – which could be in the urgent care centre or emergency department, or redirection to alternative services.
- **Falls emergency response team and multifactorial intervention:** multifactorial interventions combining regular exercise, modifications to people's homes and regular review of medications will prevent people from falling in the first place. If they do fall, falls partnership ambulance vehicles will be available with advanced, multi-disciplinary practitioners. In addition, a specific falls service will support patients to remain at home after a fall.
- **Enhanced rapid response (ERR):** a rapid response team will prevent an admission to hospital for those in crisis, providing enhanced therapy, nursing and social work support to support people to stay in their own home.

- **Acute care at home:** where there is a medical need, acute clinical care will be provided at home by a MDT to provide the best possible patient experience and outcomes, and enable the patient to benefit from holistic integrated care.
- **Frailty units:** a dedicated service, such as that already in place at the Whittington, that will be focussed on rapid assessment, treatment and rapid discharge of frail older people that could potentially be co-located within the Emergency Department. This will enable ambulatory care for people aged over 65. These would be rolled out across NCL.
- **Enhanced care home support:** provided to stabilise and / or treat residents in the care home where appropriate thereby reducing the level of conveyances, unplanned attendances and admissions to secondary care. The care closer to home model will prevent emergency readmissions from care homes through development of a care home bundle, including a proactive approach to prevention and early identification of complications.
- **End of life care:** we will support people at the end of life to receive the care that they need to enable them to die in their place of choice via rolling out the Co-ordinate My Care (CMC) care planning programme, and ensuring the new Integrated Urgent Care service (see section 6.2.4) has access to CMC plans.

Achieving care closer to home will need to be underpinned by strong resilient communities that are able to support residents live independently at home, where that support is needed. The support may be needed from families, carers, neighbours or from voluntary and community groups all of whom have central roles to play.

We plan to bring together the funding currently used for Locally Commissioned Services (LCS) and the premium spent on Personal Medical Services (over and above GMS) and establish one LCS contract framework for the whole of NCL. This LCS contract will have agreed outcomes which are shared with the Health And Care Closer to Home Networks (CHINs) and the Quality Improvement Support Teams (QISTs) so that all local GPs are provided with the necessary funding and incentives to fully engage with these vital components of the health and care closer to home work. Delivery of this whole system alignment is partly dependent on NHS England (London) delegating commissioning of the PMS premium to the CCGs which is currently under discussion with all key parties.

In support of delivering our health and care closer to home model, Islington CCG has expressed an interest in becoming an Integrated Personal Commissioning (IPC) site in order to improve health and wellbeing outcomes through personalised commissioning, improved care and support planning and developing an asset based approach to support solutions.

The IPC site will:

- improve outcomes for patients with care delivered closer to home, and aim to reduce unplanned admissions
- realign service provision in light of new service developments related to IPC and Personal Health Budgets
- review existing contracts to assess impact and identify opportunities for realignment based on a number of other developments such as New Care Models and IPC.

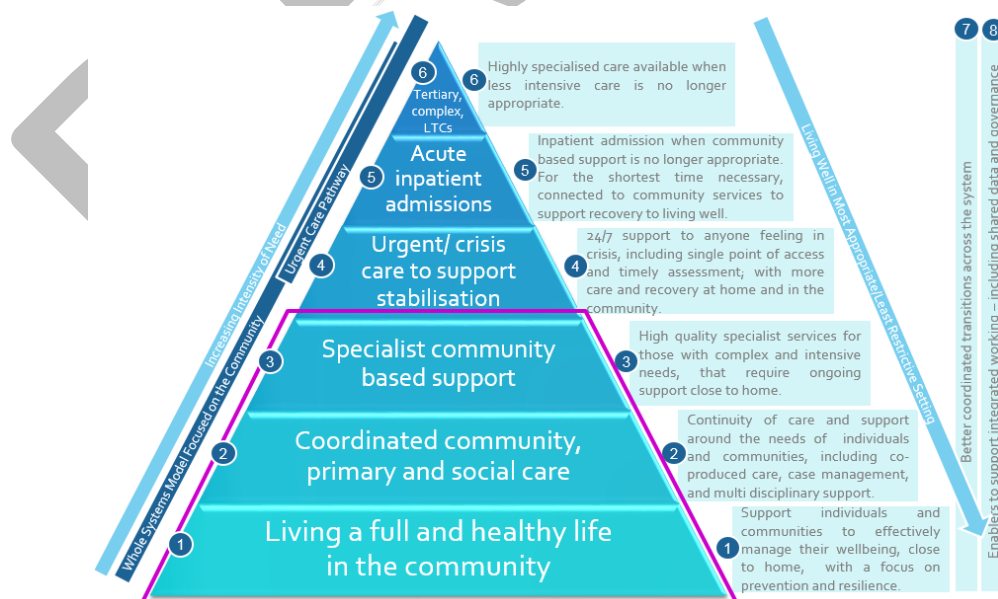
Improving outcomes will be the crucial measure of success of the care closer to home model. Using national and international evidence, we have estimated that some of the outcomes that our health and care closer to home model could potentially deliver are:

- 70% of people at the end of their life will have a care plan to support them to die in their place of choice
- 4% decrease in unplanned pregnancies
- a reduction in alcohol consumption with 10% fewer alcohol-related hospital admissions
- up to 150,000 fewer emergency department attendances
- 63,000 fewer non-elective admissions
- 35,000 fewer outpatient attendances
- 10% reduction in falls-related hospital admissions
- a halving of the numbers of late HIV diagnoses
- 50,000 weight management referrals leading to a reduction in excess weight
- 66% of people with high blood pressure have it diagnosed and controlled
- 55% of people with atrial fibrillation are receiving anti-coagulants
- 69% of people with diabetes have controlled blood glucose.

### 6.2.3 Mental health

We will develop a ‘stepped’ model of care (see exhibit 6) supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs.<sup>34</sup> We recognise the key role and accountabilities of social care for people with long-standing mental ill health and drawing on this will be central to the success of the stepped model.

Exhibit 6: The mental health ‘stepped’ model of care



<sup>34</sup> As identified in the Mental Health Taskforce Report

We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. This will improve overall mental health outcomes across NCL, reduce inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will achieve the key mental health access standards:

- more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within 2 weeks of referral
- 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, with 95% treated within 18 weeks.

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home, Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal. In future, the hospital will have Core 24 liaison psychiatry meaning that the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Initiatives will cover mental health support for all age groups and include:

- **Improving community resilience:** both for the general population, and those at risk of developing mental ill health or of it becoming more severe. For the general population this includes a promotional drive aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma. For the at risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support<sup>35</sup>; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies.<sup>36</sup> This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscent therapy and engaging with local shops to raise awareness.
- **Increasing access to primary care mental health services:** ensuring more accessible mental health support is delivered locally within primary care services, developed as part of the CHINs; enabling both physical health and mental health needs to be

<sup>35</sup> Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within NCL)

<sup>36</sup> Five Year Forward View - Reduce suicide by 10%

supported together<sup>37</sup>. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services<sup>38</sup>, and more care to be offered through CHINs rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need.<sup>39</sup>

- **Improving the acute mental health pathway:** building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPOS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to ensure effective discharge, enabling more people to live well in the community.
- **Developing a Female Psychiatric Intensive Care Unit (PICU):** we will ensure local provision of inpatient services to female patients requiring psychiatric intensive care, where currently there is none. This will enable patients to remain close to their communities, with a more streamlined and effective pathway ensuring a focus on recovery.<sup>40</sup>
- **Investing in mental health liaison services:** scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments, ensuring that more people in Emergency Departments and on inpatient wards with physical health problems have their mental health needs assessed and supported.
- **CAMHS and perinatal:** initiatives as set out in section 6.2.1.
- **Investing in a dementia friendly NCL:** looking at prevention and early intervention, supporting people to remain at home longer and supporting carers to ensure that we meet national standards around dementia, including a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

An important enabler of a number our initiatives is the redevelopment of both the Barnet, Enfield and Haringey Mental Health Trust St Ann's site and the Camden and Islington Foundation Trust St Pancras site (in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site).

The proposed developments of the St Ann's and St Pancras sites would:

- transform the current inadequate acute mental health inpatient environments on both sites
- provide more therapeutic and recovery focussed surroundings for patients and staff
- improve clinical efficiency and greater integration of physical and mental health care
- release estate across the trusts, to enable development of community-based integrated physical and mental health facilities
- develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence

<sup>37</sup> FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within NCL)

<sup>38</sup> Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within NCL)

<sup>39</sup> Five Year Forward View

<sup>40</sup> Five Year Forward View - inappropriate out of area treatments for acute mental health care should be eliminated in all areas by 2020/21.

- provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

#### 6.2.4 Urgent and emergency care<sup>41</sup>

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations. The first 2 years will focus on reducing variation in our services and the latter years will focus on transformation of the urgent and emergency care system, aligning closely with the care closer to home model.

Mary is 83 years old and lives at home with her husband. Mary had a fall at home and injured her ankle. Her husband was unable to help her get up so he called 999 for an ambulance. Mary was taken to the nearest A&E and admitted to hospital, where she is diagnosed with a urinary tract infection (UTI). She was reviewed by the consultant: a plan was put in place for treatment of her UTI and physiotherapy was recommended for her ankle. Over the weekend, Mary's UTI improved, but there was no consultant to review her condition or physiotherapist to provide her care, so Mary was unable to go home. When going to the toilet in the night, Mary fell again and stayed in hospital for a further 2 weeks. Mary became increasingly less mobile and more frail and dependent.

In future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the Acute Care at Home service with request for a 12 hour response. Mary will then be visited at home by the falls team the next day who will design a package of care for Mary including reablement, allowing Mary to stay at home. The falls team will be able to detect if there is anything unusual about Mary's behaviour, and make a rapid appointment with her GP if they suspect a UTI. Mary will then get the antibiotics she needs to resolve this at an early stage.

Our aims are to:

- **Create a consistent UEC service across NCL:** all UEC services in NCL will meet National and London-wide quality standards<sup>42</sup> which will promote consistency in clinical assessment and the adoption of best practice. Patients will be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service.
- **Develop and implement a high quality integrated UEC service:** all urgent care services across NCL (including NHS 111, GP out of hours, Urgent Care Centres) will work together to offer consistent care. These services will be renamed 'Integrated

<sup>41</sup> This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system.

<sup>42</sup> As defined by the NHS E UEC designation process

Urgent Care'. We have commissioned a joined up new Integrated Urgent Care service provided by one provider, LCW, which goes live in October 2016. This service combines the NHS 111 and GP Out-of-Hours (OOH) services, and allows patients to access a wider skill mix of specialised clinicians in a new NHS 111 clinical hub.

- **Develop high quality, responsive 7-day hospital UEC services:** people will be supported to leave hospital as quickly as possible through building close links between acute care providers and social care. We will support shorter hospital stays by operating a simplified discharge or integrated 'discharge to assess' model: planning post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This will be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this.
- **Develop high quality, responsive 7-day community services:** where possible, people will be supported and treated at home by community and ambulance services. For those people who do require ambulance transfer, the ambulance services will be able to use any UEC services that meets the patient's need.
- **Develop high quality ambulatory care services across NCL:** we will develop a service that reduces avoidable, unplanned admissions to hospital, such as that already in place at the Whittington. All UEC services will create consistent ambulatory care pathways that support people to have their care on a planned basis, wherever possible. This will provide same day emergency care to support patients to be assessed, diagnosed, treated and able to go home the same day without an overnight admission. This model will be rolled out across NCL.

The focus on urgent and emergency care services will reduce the number of unplanned admissions to hospital and support people to go home from hospital as soon as possible. This will improve patient experience, improve outcomes and make sure that people have their care on a planned basis wherever possible.

#### 6.2.5 Social care

Social care is a crucial part of many of our workstreams, particularly care closer to home, Transforming Care, and mental health, as well as children's and public health interventions. We are considering how local authorities can work with the workforce leads across NCL to design and develop proposals specifically for social care, including a focus on the sustainability of provider workforce, the sustainability of the registered workforce and stimulating the personal assistant workforce. We will ensure that our plans factor in practical steps that we can take as partners to address provider failure and the huge risks around capacity and quality in the domiciliary market.

The role of social workers will be essential to delivering on our model for health and care closer to home, in addition to the role of home care workers, personal assistants, blended role between district nurses and care workers. The workforce workstream will consider these career pathways, making careers in these areas more attractive to support increased sustainability of the workforce. We will quantify any investment that might be needed in workforce from a social care point of view e.g. increasing numbers of domiciliary care

workers and, drawing on learning from elsewhere, we will quantify the return on investment.

Social care is also built into our mental health model, including a broader dimension of public service support such as employment support workers. Learning disabilities is a key area of focus given that half of social care spend is on this group, and that children with special educational needs and learning disabilities have worse long term outcomes in both health and education. We need to start supporting those with learning disabilities from early childhood to ensure early detection and appropriate intervention. Many of our interventions, including health visiting, early years, community paediatrics, CAMHS, and working directly with schools will ensure that we better support these children. We plan to scale up our Transforming Care work to implement enhanced community provision; reduce inpatient capacity; upgrade accommodation and support for those with learning disabilities; and roll out care and treatment reviews in line with published policy to reduce long lengths of stay in hospitals and improve independence.

As part of our STP we will explore collaboration and consolidation opportunities between local authorities in areas such as the hospital discharge pathway and the mental health enablement process. We will consider what can be commissioned differently and/or at scale - particularly across health and social care, for example nursing homes. We will focus on ramping up the use of data analysis and risk stratification; working cohesively with public health across the patch; leveraging telecare; and sharing of ideas and learning about best practice in terms of health and social care integration. Our pan-NCL bed state analysis will consider non-health beds, including the 6,440 care home beds in NCL, so that we gain an in-depth understanding of why people end up in these beds and how best their needs could be met elsewhere (as well as the resources it would take to do this).

We recognise the co-dependencies between health and social care: any change in either sector may have a significant impact on the other. As we continue to develop our plans, we will ensure local authorities are involved throughout so that we can mitigate any risks around this together, and transform the system so that it is truly integrated.

#### 6.2.6 Optimising the elective (planned care) pathway

Building on the opportunities identified through RightCare, we will reduce unwarranted variation in elective (planned) care across providers in NCL. This will include reducing variation in the length of stay in hospital and the number of outpatient appointments received by patients with similar needs. Optimised pathways will ensure patient safety, quality and outcomes, and efficient care delivery.

Previously, John (who is 75 and has pain in his knee) made an appointment with his GP. The GP referred him to the hospital where he was seen in outpatients and sent for an MRI scan. A consultant established that John needed a knee replacement. John was about to go on a trip to visit family in the USA for 2 months, so the consultant sent him back to his GP. When he returned John saw the GP again as well as the consultant, who sent him to preoperative assessment. He was found to have high blood pressure, and was sent back to the GP for treatment. Once his blood pressure was under control, John was listed and then admitted for surgery. He spent about 5 days in hospital, and then returned home.

In the future, John will see an extended scope physiotherapist at the GP surgery for his knee pain. The physio will arrange the MRI, and discuss the results with John. The physio will identify that John has raised blood pressure while completing his electronic referral template to the consultant at the hospital, and liaise with the GP to make sure this is treated before he is referred. John will have his hospital appointment and pre-operative assessment on the same day, and will be given all the information he needs to prepare for after the operation.

We will draw on local examples of best practice, such as the South West London Elective Orthopaedic Centre; and international best practice, such as Intermountain's hip replacement pathway redesign, which reduced the cost of total hip replacement by a quarter.<sup>43</sup> Building on the evidence, we will redesign pathways with local clinicians, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics.

We will leverage the following opportunities for improvement to elective pathways:

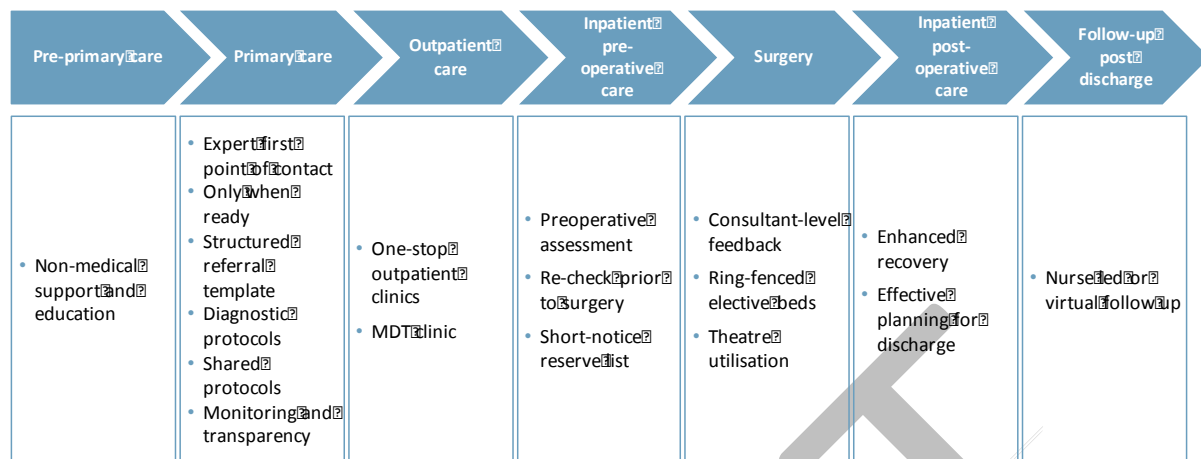
- expert first point of contact: making sure people have access to the right expertise from their first appointment in primary care
- one-stop services: so that people do not need to attend multiple outpatient appointments before their procedure
- efficient surgical pathways: to ensure maximum use of staff and theatres
- timely discharge planning: to reduce unnecessary time in hospital.

To deliver on the above, a series of interventions will be put in place at each stage of the elective pathway. These are illustrated in exhibit 7.

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<sup>43</sup> James and Savitz (2011). How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts . Health Affairs

Exhibit 7: Interventions that support optimised elective pathways



For orthopaedics, implementation of these high level interventions includes:  
 interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicians at the initial appointment. Structured referral templates are currently used by some providers and commissioners in NCL to good effect, but would be used more widely as part of the optimised elective pathway.
- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatments as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue

regarding the quality of referrals and continuously improve their own referral practices.

- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physios and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied:** patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced elective beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for elective patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

In addition to the improvements being worked through for orthopaedics, further specialties have been identified for focused pathway design. These are:

- Urology
- General surgery
- Colorectal surgery
- Hepatobiliary and pancreatic surgery
- Upper gastrointestinal surgery
- Gynaecology
- Gynaecological oncology
- Ear, Nose and Throat (ENT)

- Vascular surgery
- Breast surgery
- Musculoskeletal (MSK)
- Ophthalmology
- General medicine
- Gastroenterology
- Endocrinology

As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience through:

- improved access to information and support to help people manage conditions without surgical intervention
- support for people to access to the right professional expertise the first time, rather than being referred between several different professionals
- improved access to surgical interventions as capacity will be freed up
- patients receive a single outpatient appointment rather than needing to make several attendances
- less time spent in hospital, meaning less chance of acquiring infections and reducing the risk of lost independence
- ensuring access to the right post-operative support, helping patients get back to normal life more quickly.

Reducing variation will also improve staff experience, including ensuring access to the right professional expertise when needed, better access to high quality diagnostics, improved relationships between professionals in different care settings and increasing sharing and learning from best practice across the local professional communities.

#### 6.2.7 Consolidation of specialties

We will identify clinical areas that might benefit from being organised differently (e.g. managing multiple services as a single service), networking across providers, or providers collaborating and / or configuring in a new way in order to deliver high impact changes to major services. While changes of this sort can be challenging to implement and controversial with the public, we should not shy away from considering making changes

In London, two thirds of early deaths in people under 75 are from cancer and heart disease, there is a high risk of heart disease among the local population and the number of people diagnosed with cancer is growing. Specialists, technology and research are spread across too many hospitals to provide the best round-the-clock care to all patients. If we were to improve local survival rates for heart disease and all cancers in line with at least the rate for England, over 1,200 lives could be saved each year. (Source: UCLH news, 14 March 2014)

UCLH, Barts Health, the Royal Free and a number of other north London trusts implemented a significant service reconfiguration to address these issues. Cardiovascular care services provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital were combined to create an integrated cardiovascular centre in the new building at St Bartholomew's. For 5 complex or rare cancers, specialist treatment is provided in centres of excellence across the area. Services for other types of cancer and general cancer services, such as diagnostics and chemotherapy, continued to be provided locally.

where we are sure that significant improvements in the quality of care can be achieved.

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in NCL. Recent examples where we have successfully done this include:

- Cardiac / cancer (see case example box)
- Neurosurgery
- Pathology Joint Venture
- Renal medicine
- Hepatology and hepatobiliary surgery
- Neurosurgery
- Vascular surgery
- Ear, Nose and Throat (ENT)
- Bone Marrow transplantation
- Upper gastrointestinal
- Malignant gynaecology
- Cardiology
- Major trauma services
- Stroke services
- Plastic surgery
- Respiratory sub-specialties
- Cancer services including: pancreatic cancer, renal cancer, skin cancer, prostate cancer, head and neck cancer

However, we recognise that there may be other service areas which are or will become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. First and foremost, we agree that improving quality should be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes. Where there is a 'burning platform' and it is widely accepted that a service needs urgent attention (for example, in addressing issues of workforce sustainability), consolidation will be explored as an option. Releasing cost savings to support overall system sustainability is another driver for exploring potential consolidation opportunities.

This work is at an early stage. No decisions have been made, but we have identified services where we will review whether some form of consolidation may be worth consideration. It is recognised that fundamental, large scale reorganisation may take longer than the 5 year strategic horizon of the STP. As such, we have made no assumptions of financial benefit from this work.

To understand where we should focus further work, senior clinicians have systematically assessed services based on whether consolidation or alternative networking is required and / or could be beneficial. This has enabled us to identify a long list of services potentially in scope for further work over the 5 year period, for example:

- Emergency surgery (out of hours)
- Maternity services, in the context of the Better Births initiative (see section 6.2.1)

- Elective orthopaedics
- Mental health crisis care and place of safety
- Mental health acute inpatient services
- Histopathology
- General dermatology services

Over the next year each of these services will be reviewed in light of whether they would benefit from consolidation or networking. We are in the process of developing proposals to bring together some mental health inpatient services in order to drive significant improvements in quality and patient experience as set out in the mental health workstream (see section 6.2.3). In addition, work is under way to understand potential opportunities for consolidation of mental health places of safety.

#### 6.2.8 Cancer

We will save lives and improve patient experience for those with cancer in NCL and beyond. Commissioners and providers across NCL joined together to form our Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, with the aim of achieving earlier cancer diagnosis, ensuring effective use of cancer outcomes information and adoption of recognised best practice across the full spectrum of cancer pathways.

Previously Margaret, aged 60, went to see her GP with persistent epigastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of next 3 weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He also started Margaret on a tablet (lansoprazole) to try to reduce inflammation from the acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to the Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her 4 days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it is picked up early she will be able to access potentially curative keyhole surgery.

Our cancer workstream is derived from the Vanguard agenda and encompasses a range of improvements to current practice. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across NCL, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models and deliver a programme to improve awareness of cancer symptoms in primary care.
- **New models of care:** we are developing the case for a single provider model for

radiotherapy in NCL, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and also links with the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality kitemark for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer will be available by the end of September 2016.

- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we will produce balanced scorecards which can be made available to MDTs, providers and commissioners through a free to access web based platform.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

#### 6.2.9 Specialised commissioning

Specialised services are those provided in relatively few hospitals / providers, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. In NCL, the main providers of specialised acute services are University College London Hospitals NHS Foundation Trust (with income totaling £317m) and the Royal Free London NHS Foundation Trust (with income totaling £273m). A further 10 providers receive an additional £128m in income for the delivery of specialised services. This includes three specialist hospitals: Royal National Orthopaedic Hospital NHS Trust, Moorfields Eye Hospital NHS Foundation Trust, and Great Ormond Street Hospital NHS Trust. Barnet, Enfield and Haringey Mental Health NHS Trust and the Tavistock and Portman NHS Foundation Trust provides specialised mental health services. As well as caring for the local population, the specialised services provided by hospitals in north central London are also accessed by a population from outside of NCL.

We recognise that planning for specialised services can have an impact across the region (and potentially nationally), and are therefore working closely with NHS England, London region to develop plans in this area. At a pan-London level, 11 priority transformation initiatives for specialised services have been identified. These are:

- Paediatrics
- Cardiovascular
- Neuroscience and stroke
- Renal
- Cancer
- Adult mental health
- Child and Adolescent Mental Health Services (CAMHS)
- Trauma

- Women and children
- Blood and infection
- Medicines optimisation

On review of these pan-London initiatives, our clinical leadership identified 5 areas which resonated strongly as opportunities where we could lead the way in transforming specialised services. We are in the process of progressing plans in the following 5 areas:

- **High cost drugs:** this involves reviewing and strengthening adherence to starting and stopping rules for all high cost drugs. There is already work ongoing in NCL in this area, which has revealed that clinicians are good at starting people on these drugs but poor at stopping them. We will set clear criteria around the use of high cost drugs at an NCL level. In addition, we will reduce the spend on cancer drugs through the Cancer Vanguard Pharma Challenge process, which includes programmes on biosimilars, home administration and system intelligence.
- **Elective spinal surgery:** we will rapidly progress work on assessment, pre-surgical pathways and stratification to ensure patients are directed to the best possible place. This will help us balance demand and capacity more effectively.
- **End of life chemotherapy:** we will undertake a comprehensive review of chemotherapy usage close to the end of life. Using the evidence on when to stop end of life chemotherapy, we will develop protocols around this. We will work across the whole pathway on this issue, and link stopping acute chemotherapy to end of life discussions in primary care, working closely with the Cancer Vanguard to deliver this.
- **Imaging:** we will contain growth in imaging costs by eliminating the need for re-acquisition due to inadequate or unavailable scans. For patients, this will increase the speed of diagnosis and result in a reduction in duplicated contrast or radiation exposure. Implementing a networking approach to imaging will help us to deliver on this, as well as use of information management and technology to enable providers to share information on the scans which have already taken place.
- **Spinal cord injury:** we will redesign the pathway locally to address patients are currently waiting in Intensive Care Unit (ICU) beds to access specialist spinal cord injury rehabilitation services. Waiting in ICU beds can cause the onset of other symptoms leading to worse outcomes for patients and high costs for the system.

We recognise that our planning on specialised services is less developed than many other parts of the STP. We will continue to work with the specialised commissioning team in NHS England, London Region to develop more detailed plans in this area.

## 6.3 Productivity

### 6.3.1 Commissioner productivity (BAU QIPP)

We will continue to deliver significant “business as usual” efficiencies throughout the 5 year period. Business as usual (BAU) QIPP (Quality, Innovation, Productivity and Prevention) comprises savings commissioners expect to deliver as part of their normal activities. These are efficiencies in areas of CCG spend not covered by our other workstreams and include opportunities in the following areas:

- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services was c.£133m in 2015/16. There is an assumption of increased efficiency equivalent to 1.5% per annum supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care was c.£90m in 2015/16. There is an assumption of increased efficiency equivalent to 2.1% per annum supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing was c.£205m in 15/16. There is an assumption of increased efficiency equivalent to 2.5% per annum including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness. This is in the context of assumed growth of 5-7% per annum.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.

### 6.3.2 Provider productivity (BAU CIP) and system productivity

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity.

We have identified opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from improvements to contracting between CCGs and trusts which will be realised system wide.

Specific initiatives to improve productivity include:

- **Workforce:** we will establish a shared recruitment and bank function across providers meaning that staff can be deployed between providers in the system; as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.
- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management.
- **Back office:** we will create centralised functions for payroll and pensions, finance and estates in order to reduce our overheads and improve service resilience. In addition we will:
  - Consolidate IT services to reduce costs whilst improving the resilience and quality of services

- Enhance the existing share procurement arrangements to reduce non-pay costs
- Pool our legal budgets and resources, considering options to consolidate outsourced resources or appoint an in-house legal team.
- **Operational and clinical variation:** we will collectively reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the elective workstream.
- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.

## 6.4 Enablers

### 6.4.1 Digital

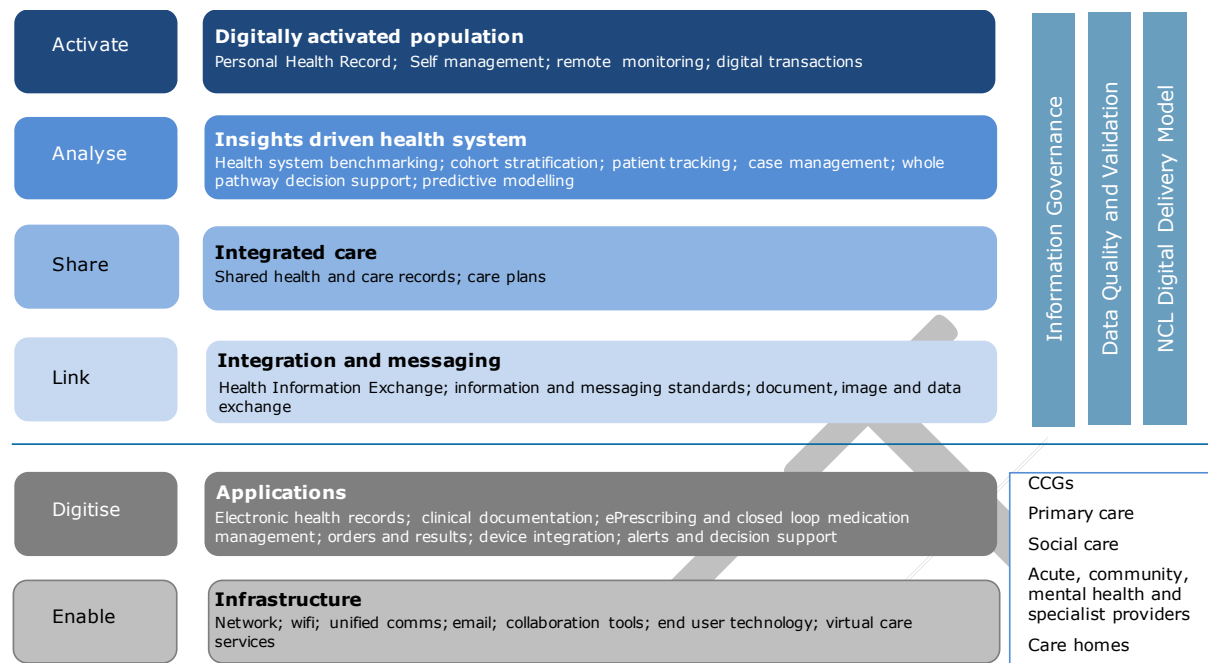
We will use digital technologies and information to move from our current models of care to deliver proactive, predictive, participatory, person-centred care for the population we serve.

There is significant and immediate opportunity for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. Our ambition is to become a national leader in population health management enabled by informatics, to reduce variation and cost and improve care.

We will prioritise and increase pace of appropriate digital technology adoption within our organisations, realigning the demand on our services by reducing the emphasis on traditional face to face care models. In addition, we will explore new digital alternatives that will transform our services, with the aim of moving care closer to home, enabling virtual consultations and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will utilise opportunities for real-time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients.

Our digital programme proposes the creation of an NCL Population Health Management System (exhibit 8), which supports prevention, service transformation and productivity, and would enable us to meet the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

Exhibit 8: NCL Population Health System Management



The 6 workstreams that make up our digital strategy are:

- **Activate:** We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.
- **Analyse:** We will use data collected at the point of care to identify populations at risk, monitor the effectiveness of interventions on patients with established disease and deliver whole systems intelligence so that the needs of our entire population can be predicted and met.
- **Link:** We will enable information to be shared across the health and care systems seamlessly.
- **Share:** We will create and share care records and plans that enable integrated care delivery across organisations.
- **Digitise:** We will support our providers to move away from paper to fully digital care processes; including documentation, ordering, prescribing and decision support tools that help to make care safer.
- **Enable:** We will provide infrastructure which enables our care professionals to work and communicate effectively, anywhere at any time, and facilitate new and enhanced models of care closer to home.

To deliver on our digital strategy we will need to invest £159m, with a further £21m in 2020/21 (see section 8.3).

#### 6.4.2 Estates

Our vision is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population. The priorities for development of our estates strategy are:

- to respond to clinical requirements and changes in demand by putting in place a fit for purpose estate
- to increase the operational efficiency of the estate
- to enhance delivery capability
- to enable the delivery of a portfolio of estates transformation projects.

There are a number of barriers to achieving this, including:

- the complexity of the estates system in NCL, including the number of organisations and the differences in governance, objectives and incentives between each organisation, which often results in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for trusts to retain capital receipts, budget “annuality” and the difficulty of accessing capital investment for re-provision
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government).

We are working as part of the London devolution programme to pilot devolved powers in relation to the health and care estate. As part of this, we are asking for:

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative NCL / national process (or devolved to sub-regional or London-level)
- development of enhanced and revised definitions of value for money, which consider social value, wider community benefit and system sustainability at the sub-regional level
- new approaches for the accounting treatment of multi-year projects for non-foundation trust providers, in support of our plans
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation
- support to agree the London-level and NCL delivery options to enhance our work
- ability to pay off PFIs using money raised from capital sales and/or a commitment by national partners to renegotiation of such agreements, where they have been identified as a significant barrier to financial sustainability and/or the facility is less than 50% utilised and no other utilisation solution will address the issue.

We anticipate the following benefits:

- a whole system approach to estates development across NCL, with different partners working together on projects and developing a shared view of the required investment and development to support clinical change
- the ability to undertake better local health economy planning, including establishing estates requirements
- increased affordability of estates change across NCL
- greater incentives to dispose of surplus property, releasing land for housing
- focused action on the development of the estates requirements to deliver care closer to home
- greater efficiency and flexibility in the estate, reducing voids and improving utilisation and co-location which will support financial savings

Across the sites of Moorfields, St Pancras, St Ann's we are beginning to evidence qualitative benefits of working together to deliver estates value and improvement. The sector for a number of years has had unresolved estates issues relating to poor mental health inpatient accommodation and potentially saleable and high value estate at St Pancras Hospital. The 3 providers are working together on this strategic estates project which aligns estates priorities between all 3 trusts.

The proposed programme, which is still subject to consultation, would see sales proceeds from surplus assets used to deliver new purpose built mental health accommodation, and the eventual relocation of Moorfields Eye Hospital to the St Pancras site. Clinical improvements would be prioritised through the building of a new Institute of Mental Health and an integrated Eye Hospital and Institute of Ophthalmology at the current St Pancras Hospital site.

The three trusts are currently refining their outline business cases, with Board decisions due in late 2016 and early 2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

- development of a new world class research, education and clinical care facility housing an integrated Moorfields Eye Hospital and UCLH's Institute of Ophthalmology, transforming ophthalmology facilities that are at present a constraint on continuous improvement
- improvements to the estate to meet CQC "must dos" including new mental health inpatients facilities for Camden and Islington NHS Foundation Trust (including the integration of physical and mental health and social care through an integrated practice unit at St Pancras). Also, new facilities for Barnet, Enfield & Haringey Mental Health Trust at St Ann's Hospital, Tottenham
- a world class UCLH Institute of Mental Health and associated patient care and educational facilities at St Pancras Hospital
- potential to deliver c.1,500 new housing units in London, significantly contributing to the NHS target for release of land for residential development
- improvements to environmental sustainability, as the new builds will deliver a balance between BREEAM ratings for 'green' initiatives, the cost of the capital build requirements to deliver them and the whole life cycle benefits in terms of costs and

a more sustainable future for our planet. We will design, build and operate in a manner that supports recycling and use of low carbon technology.

The schemes are planned at a total capital cost of c.£400m (see section 8.3) with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that £326m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

Progressing this scheme may lead to a platform for sector wide capital prioritisation and create an improved incentive framework for asset disposal and enhanced utilisation, which will give rise to a locally originated capital funding stream.

In line with the findings of Healthcare for London in 2014, our analysis shows that significant capital work is required across NCL to improve the primary care estate. The primary and community estate needs improvement in a number of areas:

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- whilst some capital to enable delivery may be available through the estates technology and transformation fund (ETTF), it is unlikely that this will cover the full set of requirements of £111m. Devolved powers will enable us to secure capital to deliver these much needed improvements and reduce the running costs of this estate.

Exhibit 9: NCL CHIN estate planning

## Estates requirements for Care Closer to Home and CHINs

NCL CCG CHIN current locational planning (NB Early stage and subject to full consultation)		
<b>Barnet CCG</b>	North East South West	Vale Drive Health Centre: The site identified is a LIFT building and hence it will improve utilisation Finchley Memorial Hospital: A LIFT building which is a natural hub and this will improve utilisation Grove Mead and/or new Colindale HC: A new health centre/CHIN is planned for Colindale (ETTF & S106) Edgware Community Hospital: ECH is another natural activity hub and also an underutilised site at present
<b>Camden CCG</b>	North North East South West	Hampstead Group: An extension to an existing practice is planned to create a health centre/CHIN (ETTF) Kentish Town Health Centre: A LIFT building which is a natural hub and this will improve utilisation Somers Town: An existing practice that is well placed to serve as a CHIN West Hampstead: An existing practice that is well placed to serve as a CHIN
<b>Enfield CCG</b>	North East South East South West North West	A number of potential GP practices require further consideration in order to deliver Care Closer to Home services (CHINS), in support of implementing the GPFV. We are engaging with our local GP Federation(s) and GP practices on emerging options in order to agree the future direction informed by their suitability, viability and location to deliver the service requirements for CHINS in the future.
<b>Haringey CCG</b>	North East South East South West North West	Somerset Gardens: An ETTF scheme aims to extend an existing practice in the White Hart Lane re-gen area Tynemouth: A well placed existing practice currently providing extended access Hornsey Central (Queenswood): A LIFT building which is a natural hub and this will improve utilisation Bounds Green: A well placed existing practice currently providing extended access
<b>Islington CCG</b>	North Central South	Archway: An ETTF scheme to develop a new build health centre/CHIN Islington Central: A well placed and effective existing practice which can serve as a CHIN Ritchie Street: A well placed and effective existing practice which is able to serve as a CHIN

### 6.4.3 Workforce

We aim to ensure that NCL becomes the place of choice to train, work and live healthy lives. This includes co-creating, communicating and collaboratively delivering a compelling offer to attract, develop retain and sustain a community of people who work in health and care in NCL. Our workforce needs to move further towards a person-centred approach and this means developing a whole range of new skills, training modalities and new roles.

Our vision is for staff to be part of the wider NCL workforce, not just part of a single organisation. Through this we will achieve efficiencies in employment by managing services collectively across the footprint. We will create sustainable career pathways to attract, develop and support a workforce fit for purpose in the changing health and care landscape. We will work with NCL organisations across all care settings (including social care) to support their collaborative efforts to be excellent employers – employers of choice, committed to looking after the wellbeing of staff whilst also preparing them to begin delivering the new care models. This will support NCL organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages. Career pathways will not be limited to a single care setting and will offer our staff opportunities to experience a wide range of different opportunities which fit their own aspirations. This process will allow us to work towards the development of an integrated employment model and a personal career passport for staff to develop their career over the long-term within NCL.

We aim to improve employee wellbeing and reduce avoidable sickness absence cost-effectively, therefore increasing lifetime productivity. We will focus on implementing the healthy workplace charter in NHS organisations, local authorities and in small and medium sized businesses.

Through equipping the existing workforce with new skills and ways of working, we will both ensure that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will support some of those people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model. We will similarly enhance the capabilities of those currently working in social, community and primary care. We will equip all our existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and the enhancement of emotional resilience in themselves, their teams and their patients. All frontline NHS and local authority staff will be trained online in Making Every Contact Count (MECC), with key frontline staff also receiving face-to-face training. All non-medical frontline staff will receive training in Mental Health First Aid (MHFA). All NHS and social care staff will be trained in basic dementia awareness, with more advanced training for frontline staff who are more likely to encounter people living with dementia.

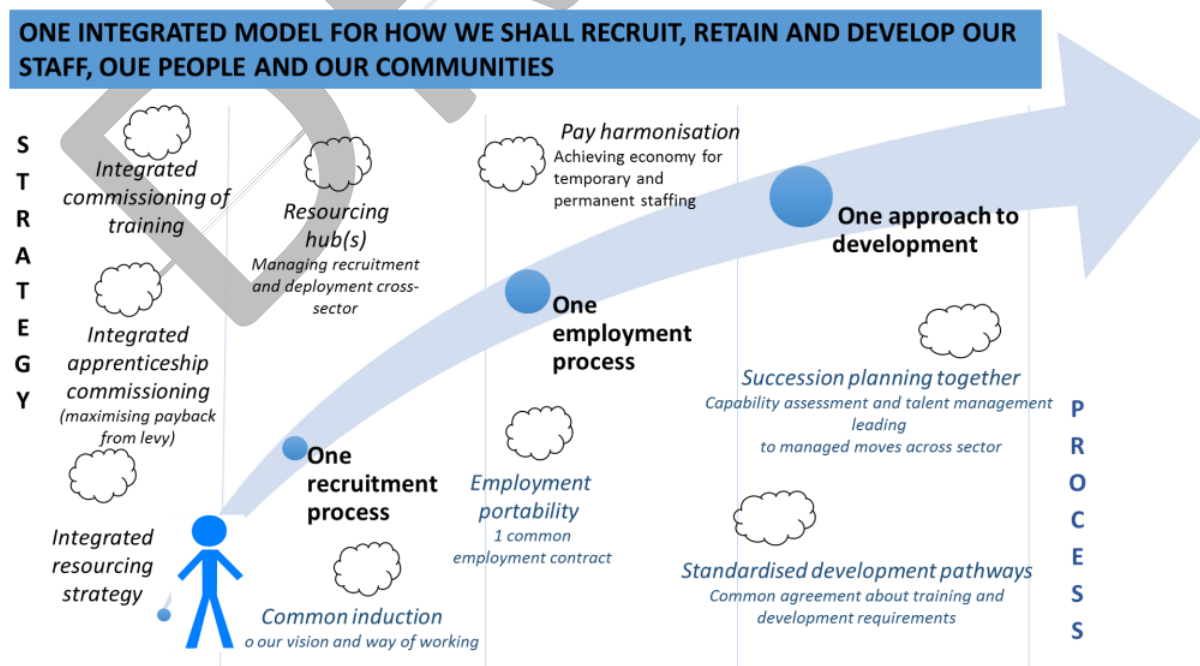
While most of the people who will be engaged in delivering the NCL vision are already with us, working in roles which will need to adapt or change in some way, we will also support the establishment of a small number of new roles, such as physician's associates, care

navigators and advanced clinical practitioners. We will undertake expert strategic workforce planning and redesign, and commission training for skill enhancement, role diversification and new role implementation.

To enable transformation, we will deliver system-level organisational development, supporting system leaders as individuals and as teams through the transformation journey to enable personal resilience and courageous action. In addition, we will train everyone in a single approach to continuous quality improvement to create a culture of continuous improvement to deliver clinical excellence and quality care.

Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness. Building on our 'wider workforce' vision and aligning with initiatives such as the Alzheimer's Society ambition for London to be a dementia friendly city by 2020, we will support the training of groups such as barbers, hairdressers, librarians and teachers to gather a better understanding of dementia and other long term conditions. Across NCL, we have already built five strong Community Education Provider Networks (CEPNs), and these will provide an effective vehicle for delivery of this aim. We will review the provision of learning and development across NCL to ensure we make the best use of existing assets to encompass the wider healthcare community including patients and carers. Our immediate aims will be to standardise and streamline statutory and mandatory training, align induction and share in-house learning and development capacity.

Exhibit 10: Integrated workforce model



#### 6.4.4 New commissioning and delivery models

As part of the STP development process, and in response to the changing healthcare landscape in NCL, the 5 CCGs have been exploring ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. We have concluded that a more formalised degree of cooperation between the 5 CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such as the Royal Free Vanguard.
- increasing financial risk
- stretched capability and capacity.

Our work has covered the development of a proposal for joint governance of strategic commissioning decisions (see section 9.2.1); the development of a common commissioning strategy and financial strategy; and, a review of CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next 2 years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

The governing bodies of each of the CCGs have agreed to the need for new executive management arrangements including shared roles across the CCGs: an Accountable Officer; a Chief Finance Officer; a Director of Strategy; and, a Director of Performance. Additionally, in order to ensure the continued role of each CCG in respect to its local commissioning and joint work with local government, local Directors with responsibility for local functions and services have been proposed.

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described in section 9.2.1, to ensure that health commissioning in NCL delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements will be further considered by governing bodies in November with the expectation that the new leadership will be in place no later than 1 April 2017.

In parallel, commissioners and providers across the system have been working together to define our direction of travel in terms of new delivery models. We already have significant work we can build on relating to this, including the Royal Free London's provider chain model; the UCLH Cancer Vanguard; the Moorfields Eye Hospital ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust chain of orthopaedic providers.

We have consulted with the leaders of all organisations across the system to get views on the different options for new delivery models, and the broad consensus includes moving towards:

- whole system working with a population rather than individual organisational focus
- a deeper level of provider collaboration, including collaboration between primary care, community services, acute services, mental health services and social care services.
- the establishment of some form of 'new delivery vehicle' or 'new delivery system' to support this provider collaboration.
- a transfer over time of some elements of what we currently consider commissioning functions (for example, pathway redesign) into these new delivery vehicles.
- a move towards some sort of population based capitated budget for the new delivery vehicles.
- the retention of a strategic commissioning function responsible for holding the delivery vehicles to account, with accountability for outcomes rather than inputs based on principles of commissioning for value.

Further work needs to be done to resolve issues and differences of view around the following:

- the organisational form for the new delivery vehicles
- the optimal population size for population health management
- the geography over which new delivery vehicles should operate
- the form and governance of the strategic commissioning function
- which commissioning functions should remain with the strategic commissioning function and which should be undertaken through the new delivery vehicle.
- the scope of the new delivery vehicles
- unresolved issues such as how to manage patient choice, specialised services and other flows outside of the delivery vehicle and a full understanding of the legal framework which might impact on implementation
- speed of implementation.

Discussions continue across health and care commissioners and providers in NCL to establish agreement about the nature and scale of new delivery vehicles. Different care models are still being considered, and this work is being steered through the STP governance framework.

## 6.5 Measuring our success

We have established the anticipated impact of each of our workstreams to ensure we remain on track to close the key gaps as set out in our case for change. However, to ensure that the breadth of our workstreams collectively meet the scale of our ambition, 11 overarching outcomes have been developed by the London Health Commission for the Better Health for London strategy. These have been adapted for NCL and endorsed by the clinical cabinet for our STP. We will know if we have been successful by measuring impact against these outcomes over the next 4 years.

### Exhibit 11: NCL STP outcomes

	Ensure that all children are school-ready by age 5. Achieve a 10% reduction in the proportion of children obese by Year 6 and reverse the trend in those who are overweight
	Help all our residents to be active and eat healthily, with 70% achieving recommended activity levels
	Reduce working days lost due to sickness absence
	Reduce smoking rates in adults to 13% in line with the lowest major global city.
	Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 25%
	Increase the proportion of people who feel supported to manage their long-term condition to the top quartile nationally
	Transform general practice in NCL so residents have access to their GP teams 8am-8pm, and primary care is delivered in modern purpose-built/designed facilities
	Work towards having the lowest death rates for the top 3 killers: cardiovascular disease, cancer, respiratory disease and close the gap in care between those admitted to hospital on weekdays and at weekends
	Fully engage our residents in the design of their services, and achieve a 10 point increase on the poll data regarding engagement in designing services.
	Put NCL at the centre of the global evolution in digital health and ensure this improves patient outcomes
	We want to reduce air pollution across NCL to allow our residents to live in healthier environments

## 7 Delivery plans

A delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements and the key risks to successful delivery. We will finalise the details of the delivery plans over the next few months as we agree the detailed phasing and investment timetables.

The delivery plans will be live documents and will continue to be iterated as the programme develops. In addition, each workstream is required to develop a full programme initiation document which will provide a reference point for every workstream to ensure planned delivery is on track, and to support the effective management of interdependencies between workstreams.

## 8 Bridging the financial gap

The financial analysis that we have undertaken (see exhibit 2) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in NCL and the growth in funding that the NHS expects to receive over the 5 years of the STP. Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, this would leave us with an estimated £876m deficit in 2020/2021.

The STP in NCL has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 12) – whilst this addresses more than 90% of the financial gap, we recognise that further work is needed.

The key elements of the plan are set out in detail elsewhere in this document. Exhibit 12 shows how these contribute to the improvement in the annual financial position of the NCL system over 5 years. The key areas of work are:

- **Care closer to home:** savings of £114m have been estimated from improving access to primary care; proactively identifying need and early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; providing community-based and ambulatory-based care; and reducing delays to discharge.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £10m.
- **Mental health outreach and liaison:** this is estimated to result in savings of £6m.
- **Optimising the elective pathway:** savings of £55m have been estimated from benchmarking against best practice; working closely with clinicians; optimising flow through theatres (increasing throughput); and reducing length of stay - in addition to the excellent work that our hospitals and other providers do to improve productivity each year.
- Additional plans are being developed relating to the **UCLH Cancer Vanguard** scheme and **Royal Free Hospital Chain Vanguard** which are estimated to deliver £35m.
- **System level productivity** savings of £98m are planned to be achieved alongside the 'business as usual' cost improvements across providers in NCL of £218m and local commissioner business as usual efficiencies (QIPP) of £57m.
- We have identified a potential saving of £24m per year through 'buying out' a number of **Private Finance Initiative** hospitals, bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, recognising that there are a number of constraints.
- Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the NCL proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. NCL hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst

also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

- Further work is ongoing in relation to developing a fuller understanding of the social care financial position and pressures. At present no financial values have been included as advised by NHS England, but this has not prevented the STP from working very closely across both health and social care. In particular the NHS within NCL is seeking to learn from local authority colleagues best practice in relation to reducing cost whilst improving the experience of people who use services and the public.

These improvements cannot be achieved without investment. The plan is based on investment of £64m in prevention and care closer to home, and £4m in elective care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the clinical cabinet of clinical leaders within NCL we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £53m 'risk adjustment' in the financial analysis.

### 8.1 Normalised forecast outturn by year

Each year there will be a number of one-off costs and income streams to the commissioners and providers within NCL. Our 5 year financial analysis is initially based upon the "normalised" (or underlying) financial position in 2016/17 which is then projected forward. We estimate that 2016/17 outturn will be a normalised deficit of £216m (£101m on an in-year basis). Significant one-off figures within this include UCLH's transitional funding that it is receiving to compensate for the financial impact of moving cardiac services to the new, world class centre at Barts hospital, and the Royal Free's transitional funding in relation to the merger with Barnet and Chase Farm. The underlying figure also includes a £40m adjustment which is an estimate of the combined risk to the NHS provider and commissioner forecast outturn. This has arisen as a result of potentially different assumptions between NHS commissioners and providers about the value of work undertaken by the end of 2016/17. We have reached an agreed view on forecast outturn activity and will continue to work urgently to ensure consistency of payment assumptions between different parts of the NHS within NCL. All parties have agreed a more 'open book' approach to contract agreements that will ensure a consistent, system-based approach.

The STP plan shows a gradual improvement in the financial position over the 5 years of the STP (exhibit 13). The normalised position improves year on year. This pattern is in part caused by the requirement for majority of the investment in the early years of the STP, with benefits accruing in the later years.

## 8.2 2017/18 forecast operating plan

In 2017/18 we estimate that our in-year position will be a £95m deficit for NCL against a draft system control total of £13m surplus (which we anticipate will change over the coming weeks due to a number of technical issues). This incorporates significant investment during the year on service transformation and delivery of the Five Year Forward View:

- investment in service transformation: £25m. This relates to the care closer to home (£23.5m), elective (£0.8m) and outpatient (£0.4m) workstreams
- other recurrent investment by CCGs and trusts – included within the CCG and trust cost movements it is estimated at £25m in 17/18 to deliver elements of the 5YFV priorities
- other non-recurrent costs (estimated at £20m in 17/18) for investment in Vanguard costs, IT digital costs, and STP programme costs.

In line with NHSE guidance we have also assumed that we will receive our 'fair share' of the national Sustainability and Transformation Fund (£105m) in 2017/18. This compares to the £52m currently notified to NHS providers, and additional a further £53m improves our revised forecast operating plan position to a deficit of £62m – see exhibit 14.

## 8.3 Capital expenditure

We recognise that the national capital budget for the NHS is highly constrained over the course of this parliament, and will continue to work hard to minimise the need for significant capital investment unless there is a strong return on investment. NCL also has a number of creative proposals that will seek to maximise disposal proceeds from sites no longer required, and use these to reinvest in the priority areas of the STP as well as the potential to provide additional, much-needed housing for the residents of NCL.

There are a number of large capital schemes that are already approved and underway within the STP and, whilst far from being 'business as usual' these are included in the 'do nothing' scenario as their approval pre-dates the STP work. Total capital, before specific STP-related investment, is £1.2bn over the 5 years. This includes:

- **UCLH new clinical facilities:** haematology-oncology and short stay surgery – (£137m); Proton-beam therapy (£130m), ENT and dental facility to consolidate two existing hospitals onto the main University College Hospital campus (£98m) and other more minor schemes. UCLH have approved DH funding of £278m (£51m public dividend capital (PDC) and £227m DH Loan) as well as anticipated, ring-fenced disposal proceeds to finance these developments
- **Royal Free - Chase Farm redevelopment:** (£183m), which includes £93m of approved DH funding (£80m PDC and £13m DH Loan).

In addition to these major developments there is of course significant business as usual capital investment such as equipment replacement and building maintenance, funded through depreciation, cash reserves and other sources of funding (including disposals).

The additional gross capital requirements to implement the transformation programme set out in the STP totals £542m, with a much smaller net investment requirement after taking into account disposals, donations and grants:

- **Estates redevelopment:** relating to our St Pancras/St Anns/Moorfields proposals: £404m, assumed to be funded through disposals (£326m), DH loans (£39m) and Donations (£37m), of which **£272m** (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above. This scheme, including an assumption of DH loan funding, has yet to be agreed, and will be subject to normal Business Case processes through NHS Improvement.
- **Primary Care for Care Closer to Home and 5YFV investment: £111m** assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- **IT investment: £159m** with a further £21m in 2021/22. All assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation Fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in NCL to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to assume that such investment is not required and will not deliver value simply because of the stage in development of these plans that NCL is currently in.

The estates redevelopment relating to St Pancras, St Ann's and Moorfields, and the estates devolution work, offers an exciting and compelling vision as to how existing assets, disposals, redevelopment and construction of new facilities can be financially efficient as well as delivering significant benefits to patients, service users and the wider population.

In addition, we will continue to engage as an STP with the work being led by Sir Robert Naylor in relation to property strategy across the NHS, to further understand how being a pilot area in this can help NCL make best use of its current assets to support the delivery of our STP vision.

#### 8.4 Next steps to address the financial gap

We are very clear that we have more to do to close the financial gaps for the remainder of 2016/17 and across the next 4 years of the STP.

We will therefore undertake a period of further intensive work over the next 8 weeks both to improve confidence in delivery of current estimates, whilst concurrently working on other areas to further improve the position. As far as possible we will aim to do this by

Christmas, so that our operating plan submission improves on this submission. However, we do believe that there is a risk that the gap will not be fully closed in every year whilst ensuring that we continue to prioritise quality of and access to services, particularly as we balance the need to invest in the early years to deliver transformational benefits in later years. It is also essential that STPs and their constituent organisations and leadership are given the regulatory headroom to develop longer term plans, and that the 'new models of care' being developed give clarity of financial accountability to support the financial challenges that the STP faces.

We have identified a number of immediate actions to improve our current financial position, which include:

- early delivery of high impact care closer to home interventions
- accelerated delivery of stretch targets for high impact elective pathways
- increased effort in terms of delivering efficiencies through provider productivity schemes
- reducing any non-value added contracting costs
- implementation of pay harmonisation and shared principles around usage of bank and agency staff
- leveraging existing capacity in NHS providers to reduce outsourcing of activity to the independent sector
- other non-recurrent savings measures
- assessing and incorporating the impact of 2017/18 tariff changes.

There are also a number of areas that we will explore further as we believe there may be significant savings to be found. These include:

- maximising clinical productivity across providers, for example introducing shared clinical rotas
- developing alternative pathways for the London Ambulance Service to avoid conveyance to Emergency Departments
- rolling out standardised pathways to all specialities
- identifying opportunities to reduce the length of stay for patients receiving specialist services
- reviewing any plans that require capital and have not yet been agreed to establish the most cost effective way to deliver agreed outcomes
- rapid implementation of cancer initiatives, including early diagnosis, new models of care, end of life interventions and research and innovation
- re-providing cost effective services for the c.20% of people we estimate are currently in hospital beds but are medically fit to leave
- putting in place a peer review challenge approach across all areas of spend to identify further opportunities to reduce or avoid spend, and to aid collective delivery of plans.

Exhibit 12: Bridging the financial gap to 2020/21

Adjusted NCL 'Do something' financial gap

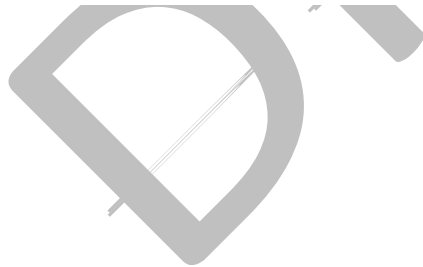
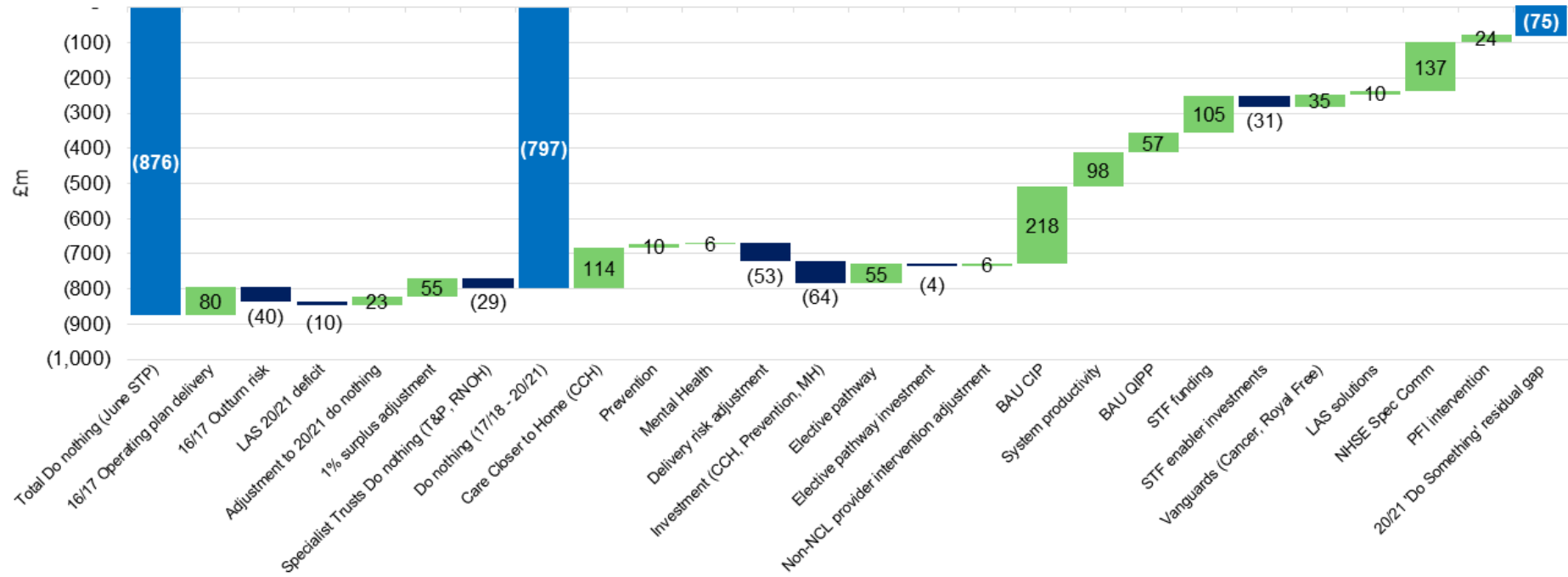
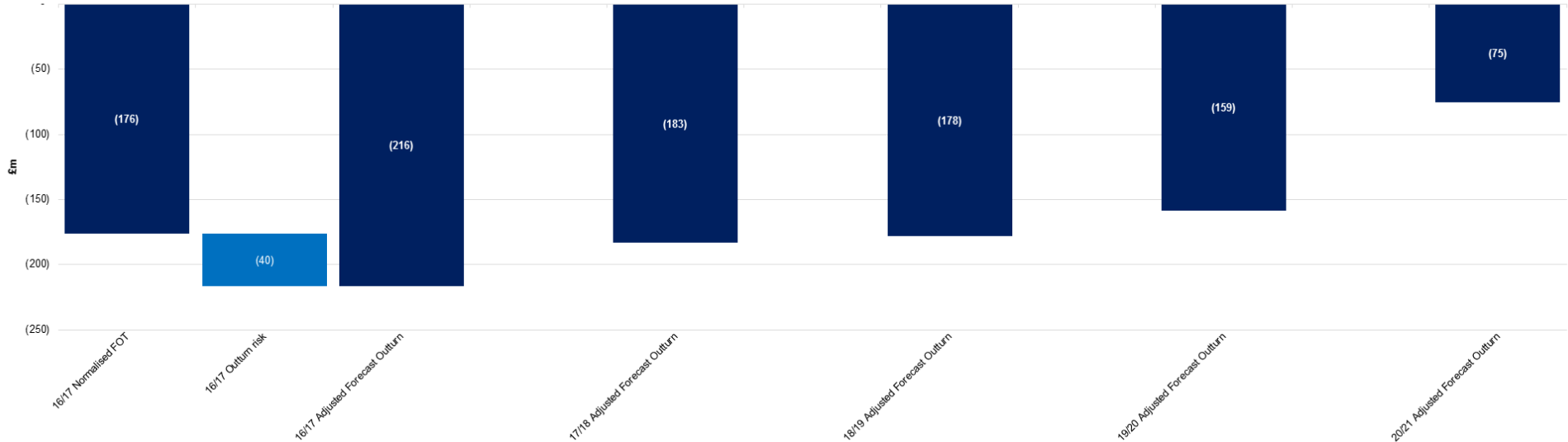


Exhibit 13: Normalised forecast outturn by year

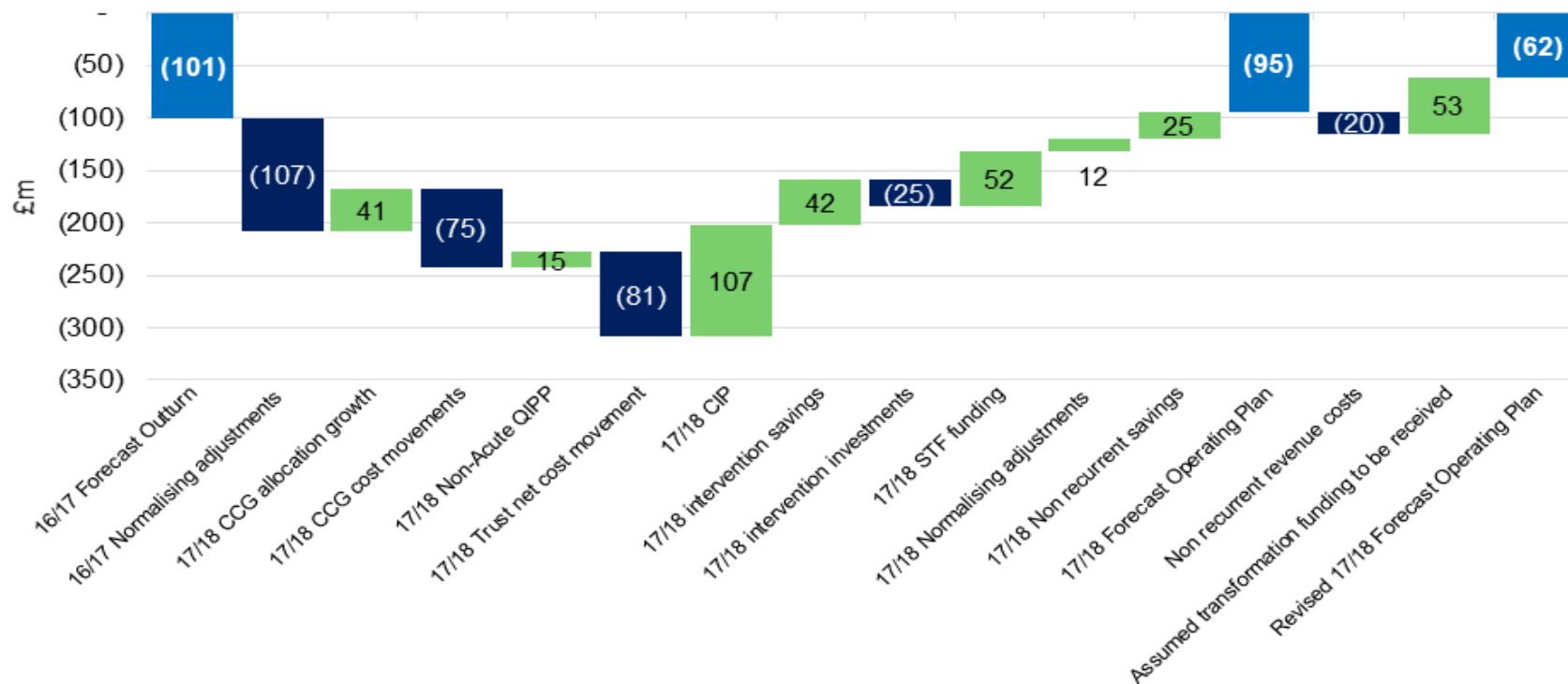
Draft NCL normalised forecast outturn 16/17 - 20/21



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Exhibit 14: Forecast 2016/17 outturn control total to 2017/18 forecast operating plan

### 16/17 Forecast Outturn Control Total to 17/18 Forecast Operating Plan



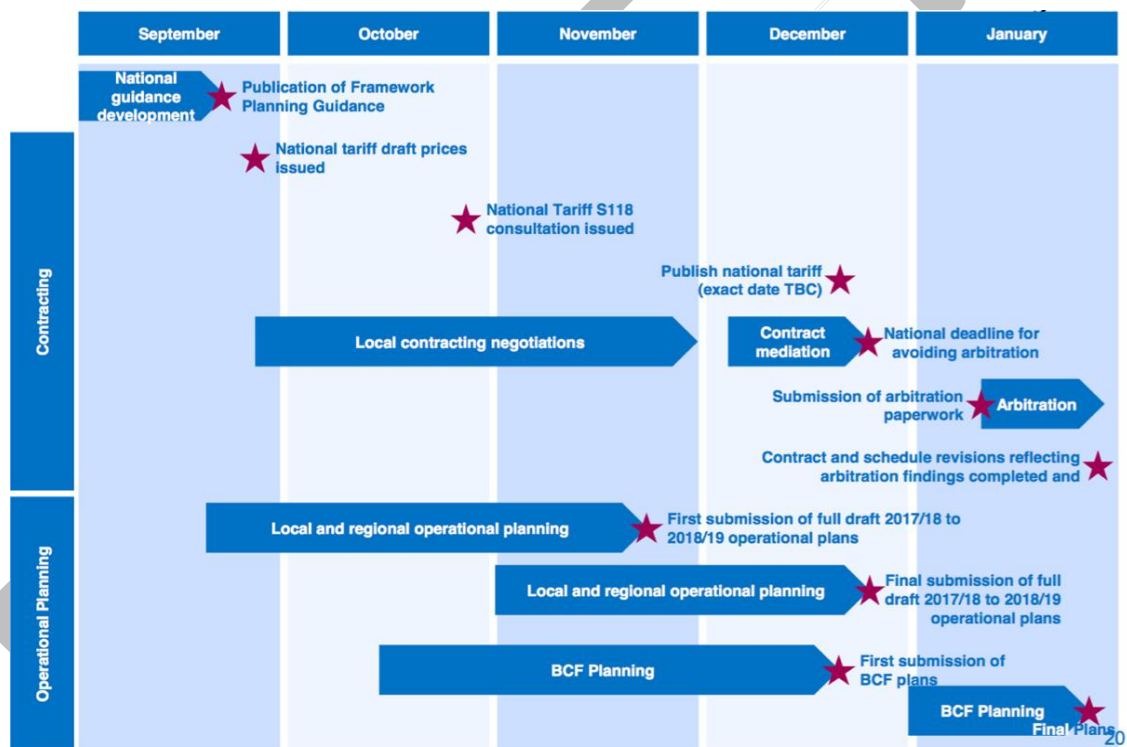
Note: The 16/17 in year FOT of £101m together with the £107m 16/17 normalizing adjustments represents the normalized 16/17 position excluding the specialist trusts (RNOH, T&P). Including the specialist trusts normalised 16/17 position (£8m) brings the combined 16/17 normalised deficit to £216m (shown in exhibit 13).

## 9 How we will deliver our plan

### 9.1 Delivery through 2 year contracts in NCL

Delivering the STP is a priority for health and care commissioners and providers in NCL - therefore it is essential that commissioning intentions and contracts reflect this. In line with national guidance, we are entering into a planning round for 2 year contracts covering 2017/18 and 2018/19. We will use this opportunity to ensure all contracts are strategically aligned to the STP, thus enabling its delivery. Whilst we recognise that implementation might look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Setting up 2 year contracts based around our STP delivery plans will both enable rapid implementation and support a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for the development of new commissioning and delivery arrangements.

Exhibit 15: High level plan for 2 year planning round to support delivery of the STP



We have developed a proposed process and a set of draft principles for managing the contract negotiations that will take place over the next couple of months. Our leadership group will meet regularly (every 2 to 3 weeks) to ensure leadership alignment, assess progress on operating plans, and to ensure that the behaviours of teams reflect the agreed NCL approach.

We have agreed that operating plans and contracts will need to be strategically consistent with the STP. To achieve this, all finance and activity alignment will be overseen by the STP finance and activity modelling group, with overall plan alignment to be overseen by the NCL wide planning group led by the CCGs. All interim finance and activity submissions by CCGs and trusts between 21 October and 23 December should therefore be aligned across NCL

before submission. Whilst organisations will individually follow up queries with NHS England or NHS Improvement on 2017/18 control totals, no organisation will agree their individual target unless and until there is a pan-NCL plan agreed.

The risks of delivery of operating plans will be identified and jointly owned and managed, with the following principles:

- simplicity
- reducing transaction costs
- incentivising the changes in care delivery as set out in the STP
- incentivising the delivery in improved productivity as set out in the STP
- locating risk where it can best be managed
- an open book approach
- use of agreed sources of data.

In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money. We will focus our energies on achieving maximum benefit and we will seek to identify areas where we can further and faster to build confidence and momentum.

We will identify resources to take forward areas of further potential benefit. In addition, we will set up a process for independent peer review challenge of all areas of discretionary spend in providers and CCGs to identify further opportunities to reduce or avoid spend and to aid the collective delivery of plans.

## 9.2 Decision making in the programme

The STP is a collaboration between a range of sovereign organisations in NCL, each with its own governance and decision-making structures. We have not to date introduced any collective decision-making structures. However we have worked together to produce both the Case for Change and the STP.

The STP is a work in progress and therefore has not been signed off by any of the organisations within the STP. We will take this STP through the public sessions of each of the NHS provider boards, CCG governing bodies and Local Authorities for their support and input into the next steps.

### 9.2.1 Collective governance arrangements for CCGs

Going forward, in order to support a more collaborative commissioning approach across NCL, the 5 CCGs will need a mechanism for collective decision making. Governing Bodies have recognised this requirement and have agreed the principle of establishing a joint NCL-wide governance structure for some elements of commissioning.

Further work is being done on the details of the proposed joint governance structure. Engagement on the design has been ongoing during October 2016 and will continue with further details to be presented at Governing Body meetings in November 2016.

### 9.3 Programme architecture

In coming together as an STP footprint, we have developed a governance structure, which enables NHS and local government STP partners to work together in new ways. The NCL STP Transformation Board brings together executives from all programme partners monthly to oversee the development of the programme. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. Three subgroups feed into the Transformation Board: the Clinical Cabinet, the Finance and Activity Modelling Group and the Transformation Group.

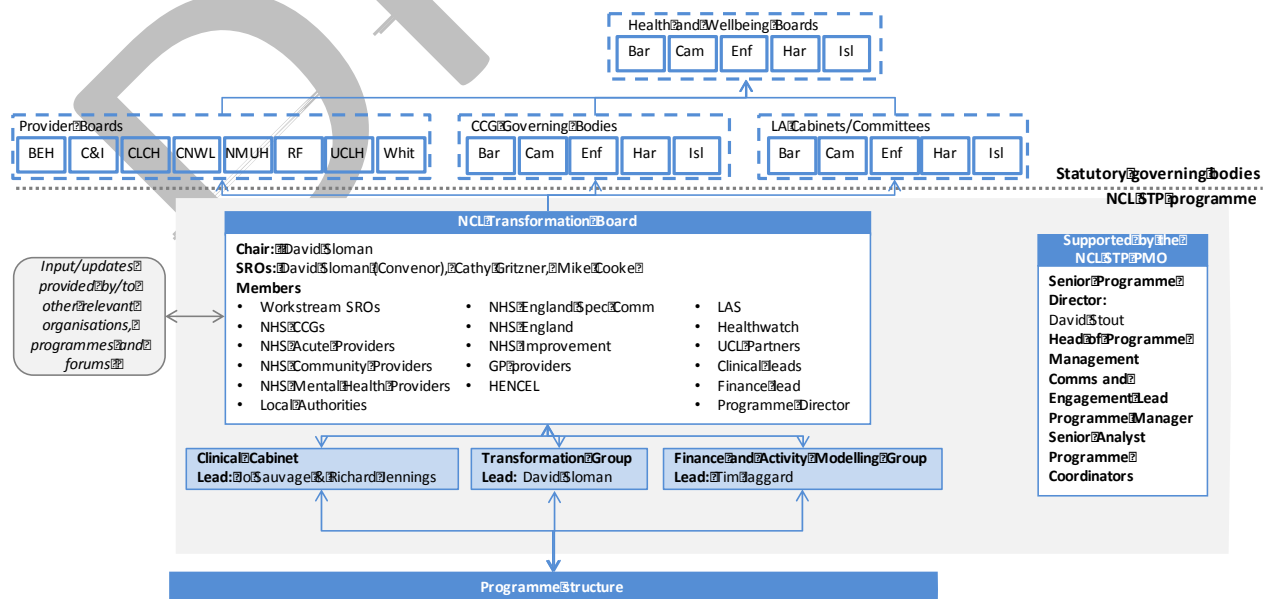
The Clinical Cabinet meets fortnightly to provide clinical and professional steer, input and challenge to all the workstreams as they develop. Membership consists of the 5 CCG Chairs, the 8 Medical Directors, clinical leads from across the workstreams, 3 nursing representatives from across the footprint, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children’s Services respectively.

The Finance and Activity Modelling Group is attended by the Finance Directors from all organisations (commissioners and providers). This group also meets fortnightly, to oversee the finance and activity modelling of the workstream plans as they develop.

The Transformation Group is an executive steering group made up of a cross section of representatives from all organisations and roles. This group is specifically responsible for driving progress between meetings of the Transformation Board, and meets fortnightly to do so. Membership includes the SROs of all workstreams.

Additionally, the NCL STP has a full time PMO which facilitates and coordinates the meetings of the main governance groups, as well as delivering communications and engagement support to the programme.

Exhibit 16: NCL STP current governance structure



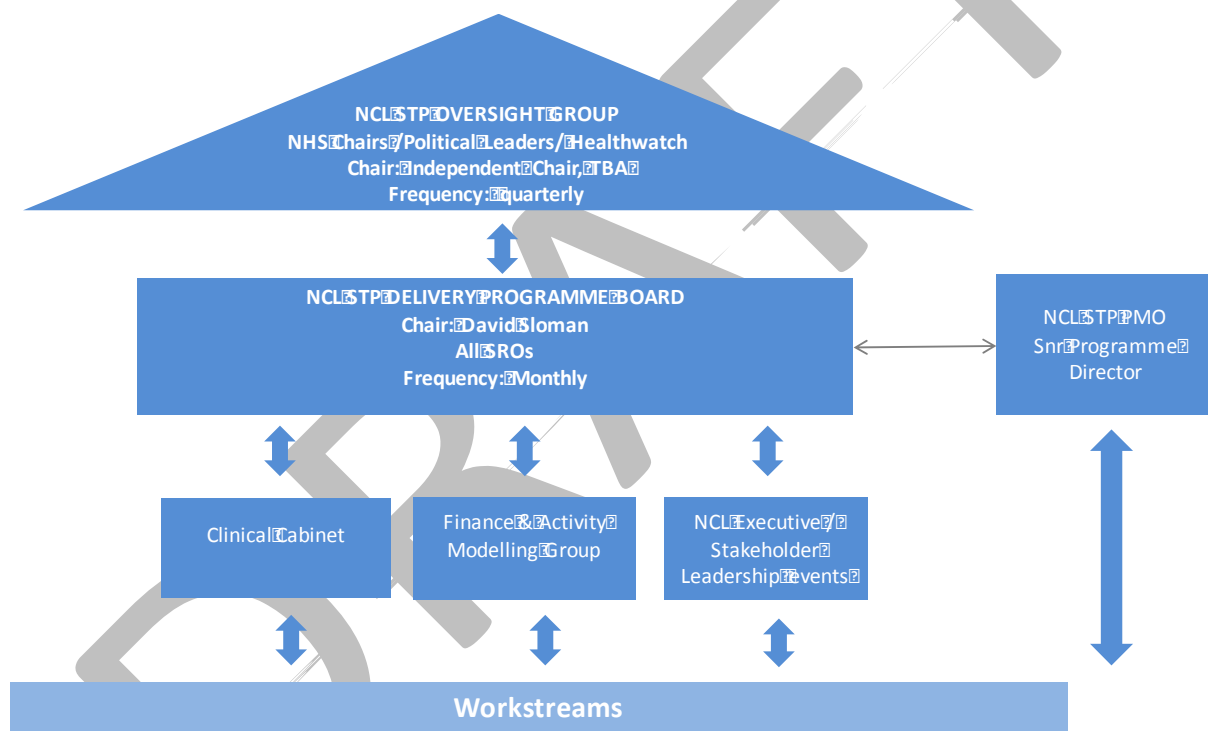
The component workstreams of the NCL STP feed into the overarching governance framework. The workstreams are responsible for developing proposals and delivery plans in the core priority areas. Every workstream has its own governance arrangements and meeting cycles which have been designed to meet their respective specific requirements, depending on the core stakeholders involved.

### 9.3.1 Future programme architecture

We recognise that as we move from planning to implementation that we will need to amend our programme architecture to ensure that it is fit for purpose. We will work with the Transformation Board to agree any required changes to the programme architecture so that we are ready to move forward with implementation from the new year.

Our initial proposal for discussion is set out in exhibit 17.

*Exhibit 17: Proposed future programme architecture*



This structure would comprise the following new groups:

- STP Oversight Group:** This oversight group would be made up of Chairs and political leaders and would go some way to address the current ‘democratic deficit’ and representation of views of the local population. It is proposed that this group meet quarterly and might benefit from an appointed Independent Chair. Membership of this group would ensure scrutiny of the delivery of STP delivery and ensure a better connection with the NHS boards, governing bodies and local authority leadership.
- STP Delivery Programme Board:** To drive and oversee the progression and delivery of the STP. It is proposed that the delivery board meet monthly. This would replace the Transformation Group.

- **Executive leadership events:** CEOs and other relevant executive directors and stakeholder representatives would meet periodically as requested by the Delivery Board in order to resolve delivery issues.

### 9.3.2 Health and wellbeing boards

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, it will be important that we engage with HWBs as we develop the STP. Engagement of HWBs will also be an important means of ensuring engagement of local political leadership in the STP process.

### 9.3.3 Overview and scrutiny committees

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area. Commissioners and providers of NHS services (including NHS England, CCGs, NHS trusts, NHS foundation trusts and private providers) must consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Ordinarily, where the services in question are commissioned by NHS England or CCGs (as the case may be), the commissioners carry out this exercise on behalf of providers. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

The local authority may scrutinise such proposals and make reports and recommendations to NHS England and the Secretary of State for Health. Legislation provides for exemptions from the duty to consult in certain circumstances, for example where the decision must be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from Healthwatch.

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place across NCL which has already put the STP on its agenda as a standing item. We will ensure that we liaise closely with the JHOSC as the STP plans develop so that we can plan ahead for any likely need for public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

### 9.4 Programme resourcing

We have dedicated resources in place to support the delivery of the STP, with an agreed overall programme budget of £5m in 2016/17. Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality. Each SRO is supported by a dedicated programme manager, and in some cases a broader team of support. A programme budget for 2016/17 has been allocated to each of the workstreams based on

their proposed requirements. STP partner organisations are also giving in kind to each of the workstreams to ensure high quality plans can be delivered at pace.

We will review the requirements for 2017/18 and beyond as we finalise the delivery plans and phasing of implementation. A £10m resource requirement to deliver the plan has been factored into our financial modelling.

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## 10 Engagement

We have come a long way since being asked to come together as 22 health and social care organisations with disparate views last December. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

The most important people we need to engage with are those who use our services – the residents of NCL. We have specifically created a shared core narrative for this purpose – ensuring it is in patient-focused and accessible in language to begin to involve people in the process. Now that we are in a position to communicate our collective thoughts effectively, our intention is to engage residents, local Councillors, our workforce and other key stakeholders to get feedback on our plans. We have held initial public meetings in each of the 5 boroughs to begin the process of co-design with patients, people who use services, carers, families and Healthwatch.

Our approach going forward will be to collaborate more extensively with people who use services and carers, local political stakeholders as well as members of the public, to ensure that our residents help inform our decisions. This approach is guided by the following core principles (often called the “Ladder of Citizen Participation”). We will undertake different types of engagement as set out on the ladder as appropriate:

1. ‘inform’ stakeholders
2. ‘engage’ with stakeholders in open discussions
3. ‘co-design/ co-produce’ services with stakeholders

Feedback from our local residents will be fundamental to our decision making and will help us shape the way the final plan is implemented.

### 10.1 Our future plans

We will now build on the success of our initial public engagement events by:

- holding a quarterly forum in each borough
- holding pan-NCL events on specific issues that may arise in support of the borough level events
- hosting meetings with the public on focussed topics such as urgent and emergency care, primary care, and mental health to get in-depth input from the community
- organising ‘Tweet chats’ on specific areas of interest
- developing a designated YouTube channel and populating it with relevant resources.
- using partner digital media channels – Twitter, Facebook, Instagram – to promote our public engagement programmes and information. We will also use these channels to test ideas and progress on local priorities which will help us develop our plans further.

To do this, we will:

- use Healthwatch, other patient representative groups and resident's associations, local authority engagement networks and the range of other networks available to reach out to the public and share our draft plans
- work in partnership with communications teams across NCL organisations and use their wide range of community channels to socialise the STP, for example Camden CCG's citizens' panel and Enfield's Patient Participation Groups Network.
- use existing online engagement tools that CCGs, local authorities and providers have to engage specific audiences and reach those who may be unable to attend our events.

We recognise it is crucial to ensure our local political stakeholders are actively involved in the oversight of the plans as they develop. We are planning on doing this by:

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to share progress updates of the STP at all meetings at the Joint Health Overview and Scrutiny Committee (JHOSC) ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all media stories and regularly updating the Transformation Board and those meeting with elected members on the STP as it develops, media development and any public concerns.

There is also a need to engage more of our own workforce in the planning process. We will do this via:

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This will include working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- running events within our membership organisations to showcase the range of work which is happening across NCL and to ensure staff understand the current plans, and how they may affect them as we progress into implementation.

We will continue to build our communications and engagement capabilities across the system. We are planning to host a workshop with communications leads from across sectors to co-design the future engagement strategy, having now identified the key audiences that we need to engage with across the 5 boroughs. The strategy will include the design of a programme of deliberative-style events which will bring together different groups to more

directly shape our plans. We will establish a designated communications and engagement workstream to oversee delivery of the strategy, with a Senior Responsible Officer for engagement.

## 10.2 Public consultation

A formal public consultation is not needed for every service change. However, it is likely to be needed should substantial changes to the configuration of health services in a local area be proposed as our plans develop and we are committed to ensuring we consult widely and effectively.

We are already beginning to develop a comprehensive picture of local views and concerns through our early engagement, building an extensive stakeholder and community database and contacts which will enable us to develop a detailed plan of those affected by any proposed changes.

We also have an existing relationship with both general and specialist media outlets (including digital). We are already working on STP stories with these stakeholders and will continue to do so whether formal consultation is required or not.

## 10.3 Equalities analysis and impact assessment

Under the Equality Act 2010, we are required to analyse the effect and impact of the NCL STP in relation to equality. We are committed to carrying out an equality impact assessment to ensure our plan does not discriminate against disadvantaged or vulnerable people, or other protected groups.

Our equality analysis will consider the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate against any unintended consequences for some groups. We are committed to undertaking an Equalities Impact Assessment as our plans become more fully developed.

We already have a good overview and analysis of equality information from across the NCL footprint through our existing and ongoing partnership work with the 5 local authorities, CCGs, providers and other representative organisations. We are building on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions through the STP. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Throughout our engagement to date, and building on the insight above, we have taken advice on best practice to ensure that all our public facing work is as fully accessible as possible, including sharing information in a variety of formats to ensure our we are able to engage all our residents, using interpreters or Easy Read material where required. We will continue to hold events and meetings in accessible locations (accessible for people with disabilities and easily reached on public transport, with adaptations made for attendees'

communication needs). Our aim is to enable different groups to be fully involved as the STP progresses.

## 11 Conclusion and next steps

The STP is work in progress and we recognise that we have much more work to do to deliver the vision we have set out.

The immediate next steps between now and Christmas are to:

- to take steps to stabilise our financial position, developing more detailed ideas in the areas we have not yet fully explored
- agree the priorities for implementation in the first 2 years of the STP to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly.

At the same time, we are clear that we will not lose focus on the longer term transformation that will support sustainability.

There remain many issues to resolve and we know we do not have all the answers. But we are determined to succeed and will continue to work with people who use services, the public and our staff to find solutions in the months and years ahead.

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<b>NORTH CENTRAL LONDON JHOSC</b>	<b>WARDS:</b> All
<b>REPORT TITLE</b> Whittington Health Update on LUTS Clinic	
<b>REPORT OF</b> Whittington Health Director of Strategy and Deputy Chief Executive	
<b>FOR SUBMISSION TO</b> NCL Joint Health Overview and Scrutiny Committee	<b>DATE</b> 25 <sup>th</sup> November 2016
<p><b>REPORT</b></p> <p>This paper provides an update to the JHOSC on developments regarding the LUTS service at Whittington Health. Since the last JHOSC meeting of 30 September we have:-</p> <ul style="list-style-type: none"> <li>- Received the full and final RCP report from the Royal College of Physicians</li> <li>- Continued the operational running of the LUTS service.</li> <li>- Met with service users to discuss progress and the RCP report which was shared with everyone prior to meeting.</li> <li>- Discussed the RCP report and recommendations at Trust Board</li> <li>- Written to patients and MP's providing updates of progress and shared the RCP report with stakeholders.</li> <li>- Continued to engage with UCLH regarding the succession plan and supported the wider MDT being in place.</li> <li>- Provided an update and the full RCP report on the Trusts public website.</li> <li>- There has been a parliamentary adjournment debate on 28 October regarding on Testing Regimes for Urinary Tract Infections prompted by the MPs interested in the work of Professor Malone Lee. The work also featured in a piece on Radio 4 Women's Hour on 31 October.</li> <li>- The Trust has continued to progress actions as part of implementing the recommendations of the RCP report.</li> </ul> <p><b>1. RCP Report</b></p> <p>The final RCP report was received on 19<sup>th</sup> October 2016. The report outlines twenty-seven recommendations which are grouped into six themes.</p> <p>The recommendations were discussed at Trust Board on 2<sup>nd</sup> November 2016 and the Trust accepts these recommendations. Local commissioners also welcome the report and are fully engaged to work with the Trust to resolve any issues.</p> <p>Several recommendations are aimed at patient safety and identifying any possible instances of harm from the prescribing of nitrofurantoin, that may not yet have been identified. An initial review of patients who have been prescribed nitrofurantoin has already taken place and the Trust is looking to commission an external review to see if there is any evidence of other patients who may have been inadvertently harmed. The resource within the Medical Directors team has been strengthened with the Associate Director for Patient Safety now being in post.</p>	

## **2. The succession plan**

The RCP report provided six recommendations with regard to management and clinical leadership of the LUTS clinic and the Trust continues to make progress in all areas.

Discussions continue to take place with UCLH, UCL, commissioners and service users to ensure a sustainable and viable safe tertiary service in an appropriate setting and provide a robust succession plan.

The multidisciplinary team is now established at UCLH and arrangements continue to be strengthened. The aim is to have an integrated service in place by the end of March 2017.

## **3. Clinical governance arrangements**

There are eight clinical governance recommendations, all of which have been actioned. The Trust has worked to ensure treatment is provided in a safe manner and that the clinic and its entire staff are operating within the policies and procedures of the Trust.

## **4. New patients**

The Trust is committed to reopening to new patients once we have secured the detail of the succession plan with UCLH colleagues and commissioners and when the commissioners and our Trust Board are assured that the safety concerns raised within the RCP report have been addressed.

Three of the six recommendations have been completed.

In consultation with the service user group it has been agreed that the service will continue to be run from the Hornsey site for the time being, with strengthened governance arrangements whilst focusing our work on securing a more sustainable solution with colleagues at UCLH.

## **5. Paediatric patients**

The Trust is working with Great Ormond Street NHS Foundation Trust to secure a local tertiary pathway for paediatric patients.

## **6. Service user engagement**

The Trust has met with service users four times within the last six months, who have been very helpful in influencing how the Trust develops the service and improving levels of communication. The Trust has provided updates on the public website, corresponded with MP's and is currently writing to all patients to update them on progress to date. There is a further meeting being finalised with service users in December.

## **7. Pulmonary fibrosis investigation**

The review process is being finalised by the Trust, in collaboration with our Commissioners.

The Trust continues to work with Professor Malone Lee, his clinical team and a core group of service users to continue to improve the governance and sustainability of the service so that it can open to new patients.

**Contact Officer:**

Siobhan Harrington, Director of Strategy and Deputy Chief Executive  
Whittington Health

**RECOMMENDATIONS**

The Joint Health Overview and Scrutiny Committee are asked to note this update.

Signed:

Simon Pleydell, Chief Executive, Whittington Health

Date: 16 November 2016

**REPORT ENDS**

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North Central London Joint Health Overview and Scrutiny Committee

Work Planning 2016-17

Future Items

Date of meeting	Potential Items	Lead Organisation
30 September 2016	<ul style="list-style-type: none"> <li>Lower Urinary Tract Clinic; Lead – Councillor Martin Klute <i>To report on the outcome of the review into the clinic.</i></li> </ul>	Whittington Hospital
	<ul style="list-style-type: none"> <li>NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly <i>To provide an update including details of the submission, outline risks and strategic approach to NHS estates</i></li> </ul>	CCGs/Local authorities
	<ul style="list-style-type: none"> <li>GP provision in Care Homes; Lead – Councillor Abdul Abdullahi <i>To report on progress by each CCG since the last presentation on the issue including what has been done to address areas where provision was found to be lacking and how has best practice been incorporated.</i></li> </ul>	CCGs
	<ul style="list-style-type: none"> <li>Whittington Hospital – Development of Estates: Update; Lead – Councillor Martin Klute <i>Councillor Klute to provide an outline of issues to be addressed.</i></li> </ul>	Whittington Hospital

25 November 2016	<ul style="list-style-type: none"> <li>NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly</li> </ul>	CCGs/Local authorities
9 December 2016 <i>(Special meeting)</i>	<ul style="list-style-type: none"> <li>NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly</li> </ul>	CCGs/Local authorities
14 December 2016 <i>(Special meeting)</i>	<ul style="list-style-type: none"> <li>NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly</li> </ul>	CCGs/Local authorities
3 February 2017	<ul style="list-style-type: none"> <li>Royal Free – Relationship with North Middlesex</li> </ul>	Royal Free/NMUH
	<ul style="list-style-type: none"> <li>Dementia Pathway; Lead – Councillor Graham Old <i>To report on provision within each borough including relevant statistics and work with acute providers.</i></li> </ul>	CCGs
	<ul style="list-style-type: none"> <li>NHS England Adult Screening Annual Report</li> </ul>	NHS England
	<ul style="list-style-type: none"> <li>Reducing A&amp;E Attendance During the Winter Period (including the role of local authorities)</li> </ul>	Acute providers/CCGs
	<ul style="list-style-type: none"> <li>Whittington Hospital – Development of Estates: Update; Lead – Councillor Martin Klute</li> </ul>	Whittington Hospital

	<ul style="list-style-type: none"> <li>NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly</li> </ul>	CCGs/Local authorities
24 March 2017	<ul style="list-style-type: none"> <li>Health Tourism at the Royal Free; Lead – Councillor Alison Cornelius</li> </ul>	Royal Free
	<ul style="list-style-type: none"> <li>UCLH; Lead – Councillor Alison Kelly</li> </ul>	UCLH
	<ul style="list-style-type: none"> <li>CAMHS; Lead - Councillor Pippa Connor</li> </ul>	CCGs
	<ul style="list-style-type: none"> <li>LAS Update</li> </ul>	LAS
	<ul style="list-style-type: none"> <li>Whittington Hospital – Development of Estates: Update; Lead – Councillor Martin Klute</li> </ul>	Whittington
	<ul style="list-style-type: none"> <li>NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly</li> </ul>	CCGs/Local authorities

To be arranged:

- Quality Accounts:
  - Royal Free
  - UCLH
  - Whittington
- Patient safety

- NMUH – Achievement of Foundation Status
- 7 day NHS;
- Stop Gap Services (Maternity)
- Sexual Health Services