AGENDA FOR THE HEALTH AND WELLBEING BOARD

Meeting in Common of Haringey and Islington's Health and Wellbeing Boards

MONDAY, 3RD OCTOBER, 2016 at 12.30 pm HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Please see membership list below.

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. WELCOME AND INTRODUCTIONS

The Co-Chairs will welcome those present to the meeting and introductions will be given.

3. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

4. NOTIFICATION OF URGENT BUSINESS

5. DECLARATIONS OF INTEREST

A Member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A Member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined in the Members' Code of Conduct.

6. QUESTIONS, DEPUTATIONS, PETITIONS

To consider any requests received.

7. POPULATION HEALTH - CHALLENGES, SIMILARITIES AND DIFFERENCES ACROSS HARINGEY AND ISLINGTON (PAGES 1 - 20)

An overview will be given of key health and care data across Haringey and Islington.

8. HARINGEY AND ISLINGTON WELLBEING PARTNERSHIP (PAGES 21 - 36)

a. Update on the Wellbeing Partnership (verbal)
b. Developing an Accountable Care Partnership Across Haringey and Islington
c. Discussion – Workstream on Cardiovascular Disease and Diabetes in Haringey and Islington

9. UPDATE ON NORTH CENTRAL LONDON SUSTAINABLE TRANSFORMATION PLAN (STP) (PAGES 37 - 118)

10. FUTURE JOINT HWB MEETINGS (PAGES 119 - 122)

To consider a paper setting out the process for establishing a joint Health and Wellbeing Board between Haringey and Islington.

11. DATES FOR FUTURE JOINT MEETINGS

Members of each Health and Wellbeing Board to agree a date for next joint meeting.

12. NEW ITEMS OF URGENT BUSINESS

To consider any new items of urgent business admitted at Item 4 above.

13. EXCLUSION OF THE PRESS AND PUBLIC

To consider whether, in view of the nature of the remaining items on the agenda, any of them are likely to involve the disclosure of exempt or confidential information within the terms of Schedule 12A of the Local Government Act 1972 and, if so, whether to exclude the press and public during discussion thereof.

14. NEW ITEMS OF EXEMPT URGENT BUSINESS

Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

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Membership	
Name	**Role/Organisation**
Councillor Claire Kober	Chair of Haringey Health and Wellbeing Board
Councillor Jason Arthur	Cabinet Member for Finance and Health
Councillor Elin Weston	Cabinet Member for Children and Families
Dr Jeanelle de Gruchy	Director of Public Health
Sharon Grant	Chair, Healthwatch Haringey
Sarah Price	Chief Operating Officer, Haringey CCG
Dr Peter Christian	Chair, Haringey CCG
Dr Dina Dhorajiwala	Vice Chair, Haringey CCG
Cathy Herman	Lay Member, Haringey CCG
Beverley Tarka	Director Adult Social Care LBOH
Jon Abbey	Director of Children's Services
Sir Paul Ennals	Chair Haringey LSCB
Geoffrey Ocen	Bridge Renewal Trust – Chief Executive

Agenda Item 7

Report for: Health and Wellbeing Board – 3 October 2016

Title: Population Health – Challenges, Similarities and Differences Across Haringey and Islington

Report authorised by : Julie Billett, Joint Director of Public Health (Camden and Islington)

Lead Officer: Mahnaz Shaukat, Head of Health Intelligence, Islington Council

1. Describe the issue under consideration

1.1 This report and the attached presentation provide the Joint Health and Wellbeing Boards of Islington and Haringey with an overview of the demographics and population needs of both boroughs, drawing out key similarities and differences.

2. Recommendations

2.1 To note and comment on the information in the presentation, particularly the opportunities and challenges facing the two boroughs.

3. Background Information

3.1 Overall the populations of Haringey and Islington have similar health and care needs and both boroughs face similar challenges to improving health and care outcomes for their residents. These shared needs, together with a focus on common health and wellbeing priorities and on reducing health inequalities and a shared provider landscape, provide significant opportunities for working across both boroughs to integrate health and care and to improve population health outcomes for residents.

3.2 Engagement with residents, service users and carers in both boroughs, as part of integrated care and service transformation developments locally, have also identified very similar issues and concerns amongst the residents of both boroughs, including: the desire for a more coordinated and seamless experience of health, care and support services; easy access to quality services, including those services that support people to stay well; services that promote choice, control and independence; and an holistic approach to addressing health, care and wider social needs.

3.3 The concept of population segmentation is introduced as a way of grouping the population according to similar health and care needs. The model presented segments the population into four segments; those who are healthy, those who are at risk of developing long term conditions, those who have 1-2 long term conditions and those who have 3 or more long term conditions. By segmenting the population in this way, we want to understand the needs and health and care experience of these groups in order to plan and provide better, more integrated health and care. The model is currently based on anonymous health data relating to individual residents and patients. An ambition going forward is to explore the potential for more sophisticated ways of segmenting and understanding our populations' health and care needs, including those wider determinants and risk factors for health and wellbeing at both the individual, family and household level.

3.4 A copy of the presentation is attached at Appendix A. The information provided to the Boards will help inform their decisions to enable the shared challenge of improving population health outcomes, care quality and system sustainability in both boroughs, in face of the significant financial constraints.

4. Contribution to strategic outcomes

The Haringey and Islington Wellbeing Partnership involves the organisations that provide and commission a significant proportion of the social and clinical care for residents of Haringey and Islington. The focus of the partnership is to work together on preventing poor health and on achieving demonstrable improvements in health care outcomes. The use of evidence and analysis to understand current and future health and care needs should be used to help determine what actions the partnership needs to take to improve the health and wellbeing of the local population and reduce health inequalities.

5. Statutory Officer Comments (Legal and Finance)

5.1 Legal

The Health and Social Care Act 2012 states that every local authority must establish a Health and Wellbeing Board for its area. Both Islington and Haringey's Health and Wellbeing Boards are responsible, on behalf of their Councils, for promoting the health and wellbeing of local residents. They must encourage integrated working and commissioning between health and social care services in order to secure the best possible health outcomes for all local people and reducing health inequalities, based upon the joint strategic needs assessment and the joint health and wellbeing strategies. Health and Wellbeing Boards have a number of statutory duties designated through the Health and Social Care Act (2012) that will inform what items should be taken to the Health and Well-Being Board meetings.

5.2 Finance

There are no financial implications arising directly from this report.

6. Environmental Implications

6.1 There are no significant environmental implications arising directly from this report.

7. Resident and Equalities Implications

7.1 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

7.2 A resident impact assessment has not been completed because an assessment is not necessary in this instance.

8. Use of Appendices

Appendix A – Presentation

9. Background papers

None.

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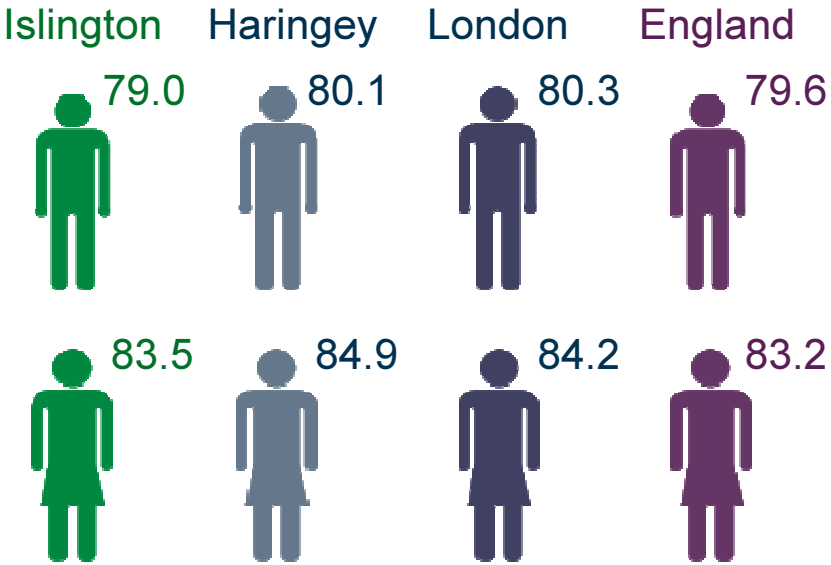
HARINGEY & ISLINGTON HEALTH & CARE – OUR POPULATION, OUR CHALLENGES AND OUR OPPORTUNITIES

Julie Billett, Director of Public Health

Camden and Islington

Life expectancy and healthy life expectancy

Life expectancy at birth 2012-14



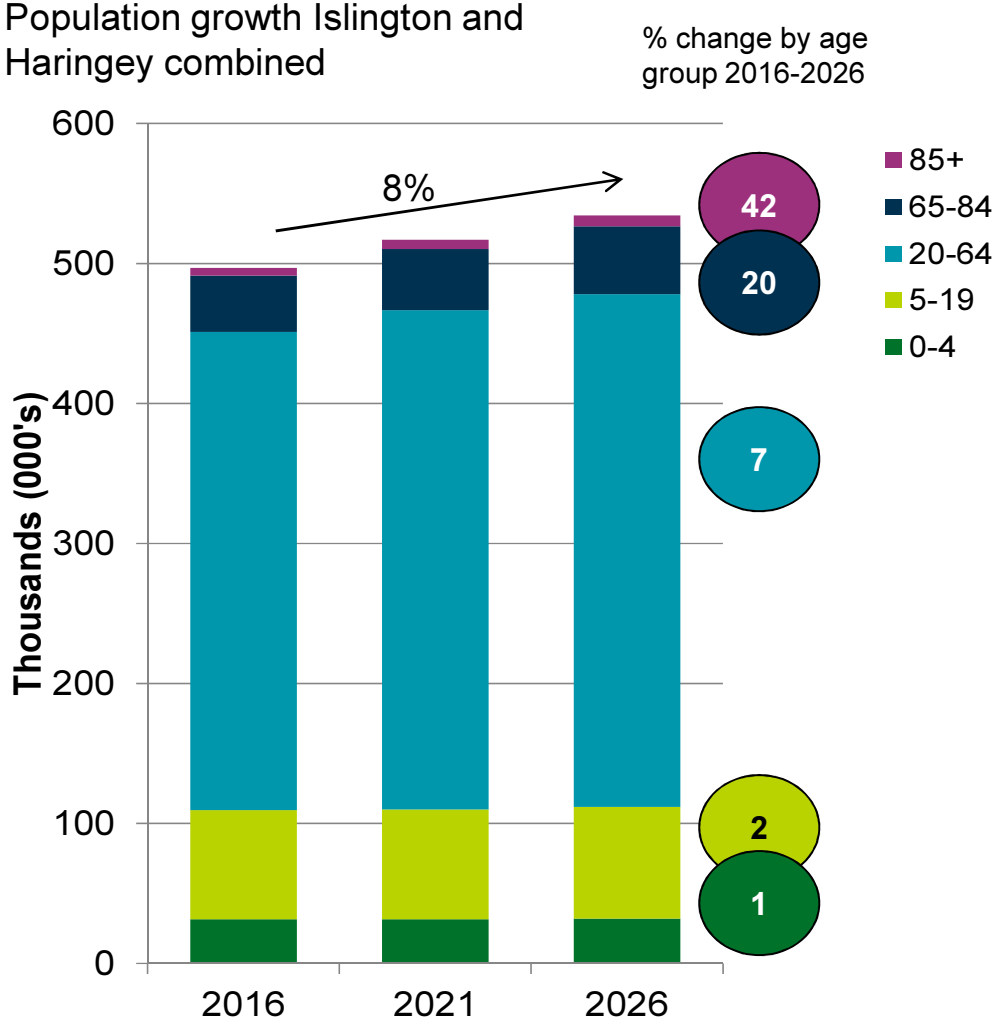
Source: PHOF, 2016

Healthy life expectancy at birth 2012-14

- Life expectancy at birth has increased in both Islington and Haringey over the past decade and for Haringey is now comparable to London and England for both males and females. Male life expectancy in Islington remains significantly lower than London and England.
- In both boroughs residents spend on average the last 20 years of life in poor health.

Population growth

Population growth Islington and Haringey combined



- The combined Haringey and Islington population is just under **500,000** with a projected **growth of 8% by 2026.**
- The highest expected growth is in the older age groups. The 85+ age group will rise from 5,500 to 7,800. The 65-84 group will rise from 40,300 to 48,500 people.
- The growth in the older age groups will be more pronounced for Haringey e.g 55% growth in the 85+ group in Haringey and 27% in Islington.
- The working age population will remain the largest population overall for both boroughs.
- Very little growth is expected in both boroughs amongst the under 20 age group.

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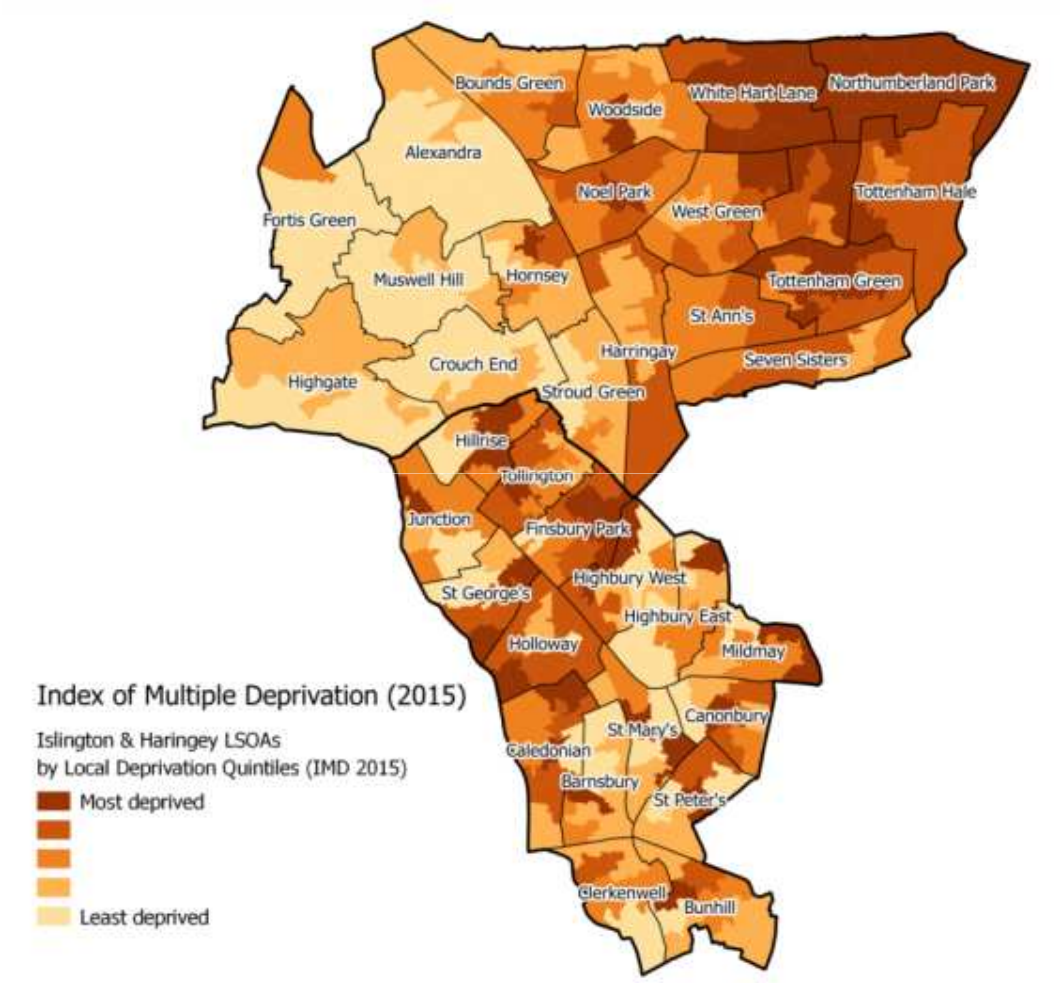
Source: GLA, 2016

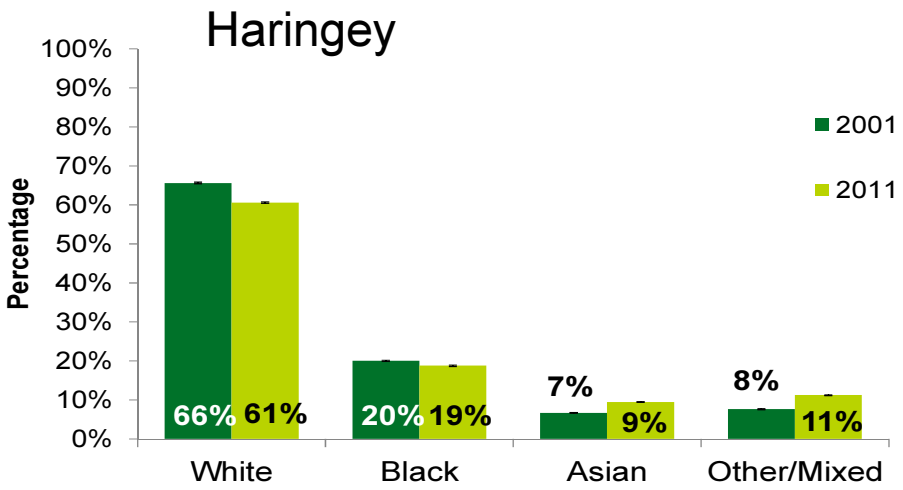
Deprivation

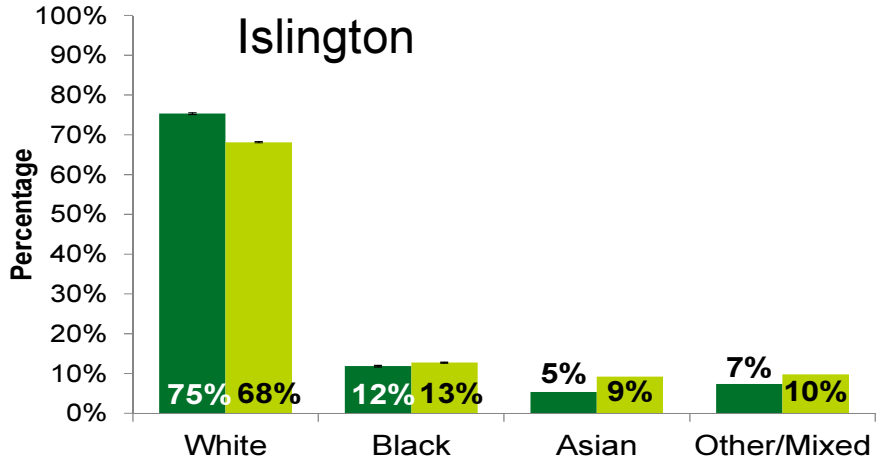


- Deprivation is a key influence on health and wellbeing and overall both boroughs experience similar levels of deprivation.
- In **Haringey deprivation** is more concentrated in the **north east** of the borough.
- In **Islington** areas of **deprivation** are more **evenly spread** throughout the borough, with residents with very different socio-economic circumstances living side-by-side.
- Overall Islington is ranked as the 5th most deprived borough in London and Haringey the 6th most deprived.
- The relative national deprivation ranking of both boroughs has improved since 2010.

Source: ONS, 2010-2015

Ethnicity



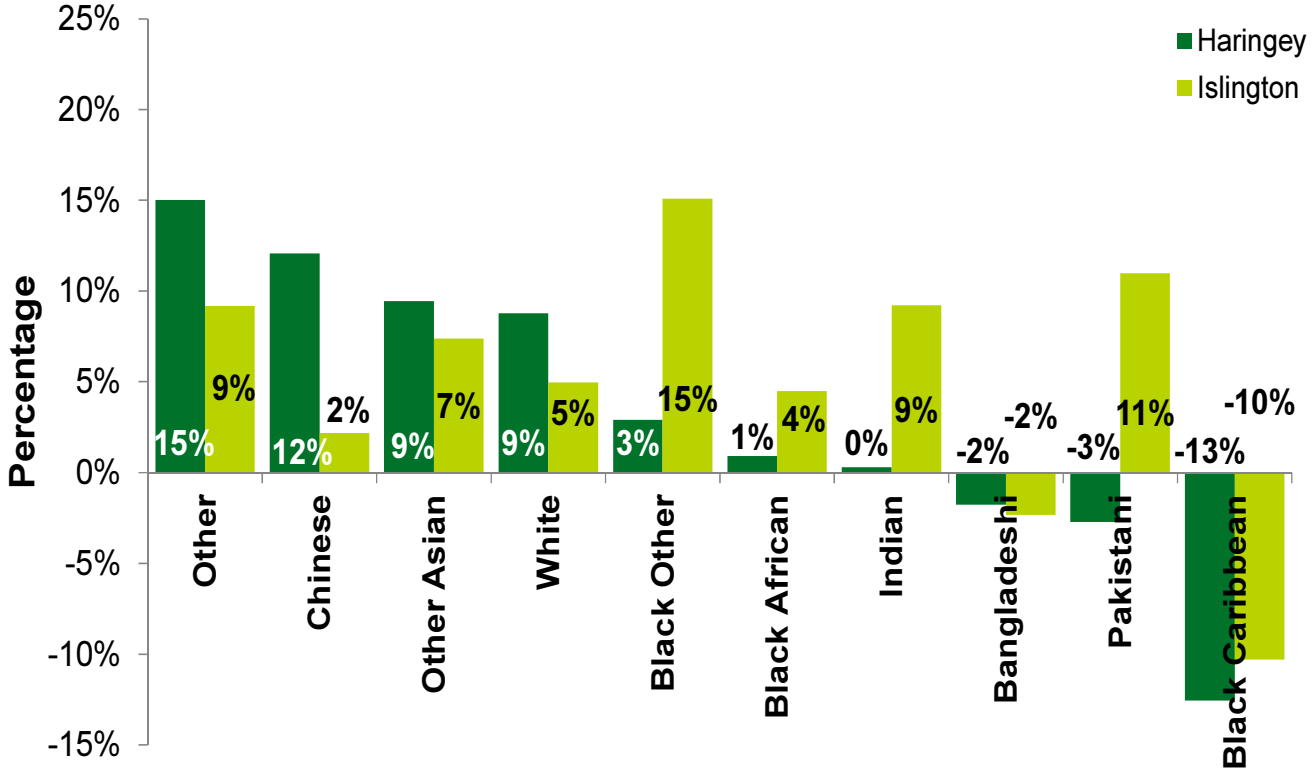


Source: NOMIS, 2016

- Both boroughs have ethnically diverse populations, with both boroughs seeing an increase in that diversity between 2001 and 2011.
- The most significant difference in the ethnic profile of the two boroughs is that Haringey has a larger Black population compared to Islington.
- The **Asian** ethnic group experienced the highest percentage growth in Islington (**101%**) from 2001 to 2011, although in absolute terms this increase was relatively small (n=9,550). The Asian ethnic group is made up of Indian, Pakistani, Bangladeshi and Other Asian.
- In Haringey, the largest percentage increase was in the **Other/Mixed** ethnic group (73%), a growth in absolute terms of 12,081.

Ethnicity growth

Population projections by detailed ethnic group, Haringey and Islington resident population, 2016 to 2026



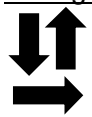
Source: NOMIS, 2016

- Population projections to 2026 indicate that the trend towards increasing diversity will continue in both boroughs.
- The projected ethnic makeup of the two boroughs shows some similarities and difference.
- Both boroughs will see a reduction in the Black Caribbean populations and Bangladeshi populations.
- The ethnic group with the highest projected population growth is **Black Other** (**15%**) in Islington and **Other** (**15%**) and the **Chinese (12%)** population in Haringey.

Health behaviours

	Haringey			Islington		
	Indicator	Compared to London	Progress	Indicator	Compared to London	Progress
Percentage of children aged 4-5 overweight or obese (2014/15)	23		5(%) 	22		3(%) 
Percentage of children aged 10-11 overweight or obese (2014/15)	37		4(%) 	38		3(%) 
Percentage of adults classified as overweight or obese (2012-14)	55		-	52		-
Prevalence of smoking among persons aged 18 years and over (2014)	21		0(%) 	22		5(%) 
Alcohol-related hospital admissions per 100,000 population (2014/15)	595		4 (per 100,000) 	753		31 (per 100,000) 

Change over time within the borough



Decrease/Increase/
No change

Significant increase

Change is not significant

Significant decrease

Compared with London average

Significantly higher

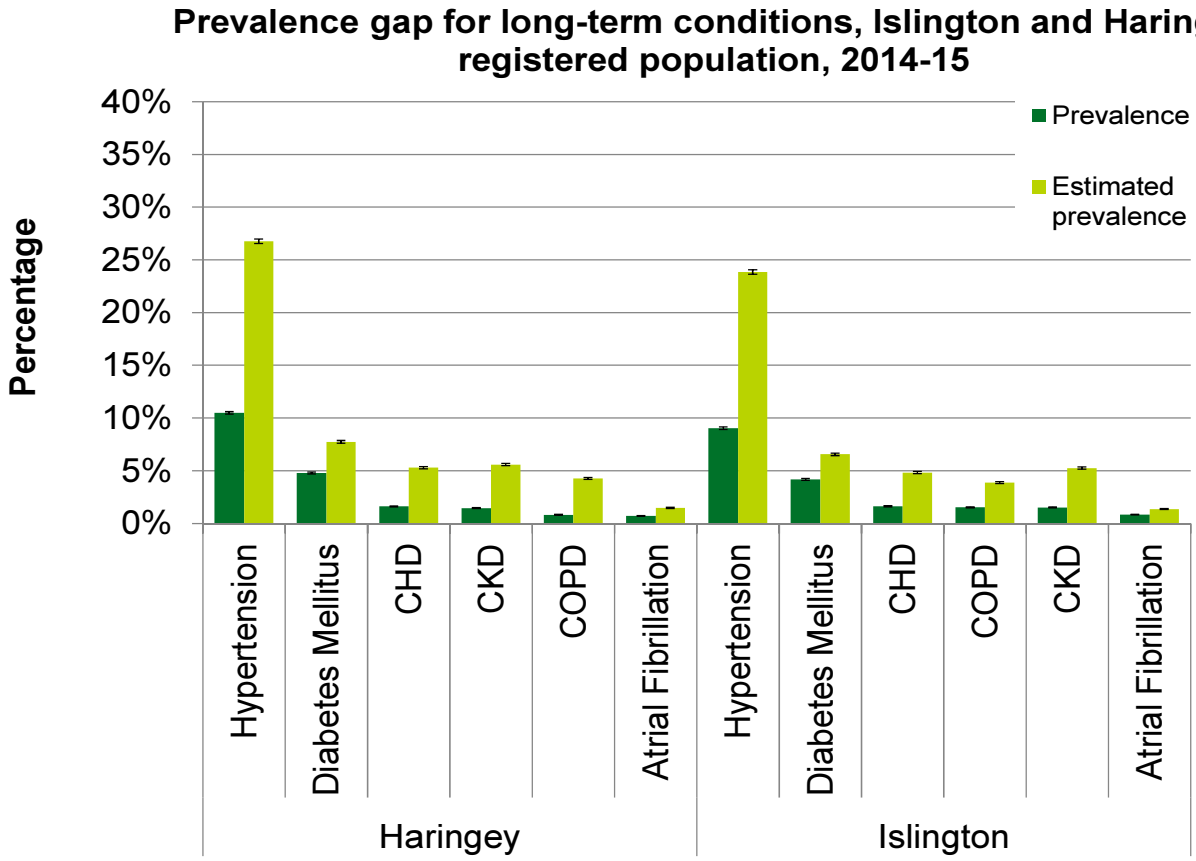
No significant difference

Significantly lower

Source: PHOF, 2016

- Both boroughs have a similar prevalence of health behavioural risk factors, although Islington has significantly more alcohol-related hospital admissions compared to Haringey.
- In reception aged children, the prevalence of obesity or overweight has **increased (5%) in Haringey** since 2007/08 and **decreased in Islington (3%).** Over that same time, Year 6 prevalence of overweight or obesity has decreased slightly in both boroughs.
- Prevalence of smoking in Haringey (21%) and Islington (22%) is **significantly higher** than the London average (17%).
- Islington ranks the highest in smoking prevalence amongst London boroughs and Haringey 5th highest.

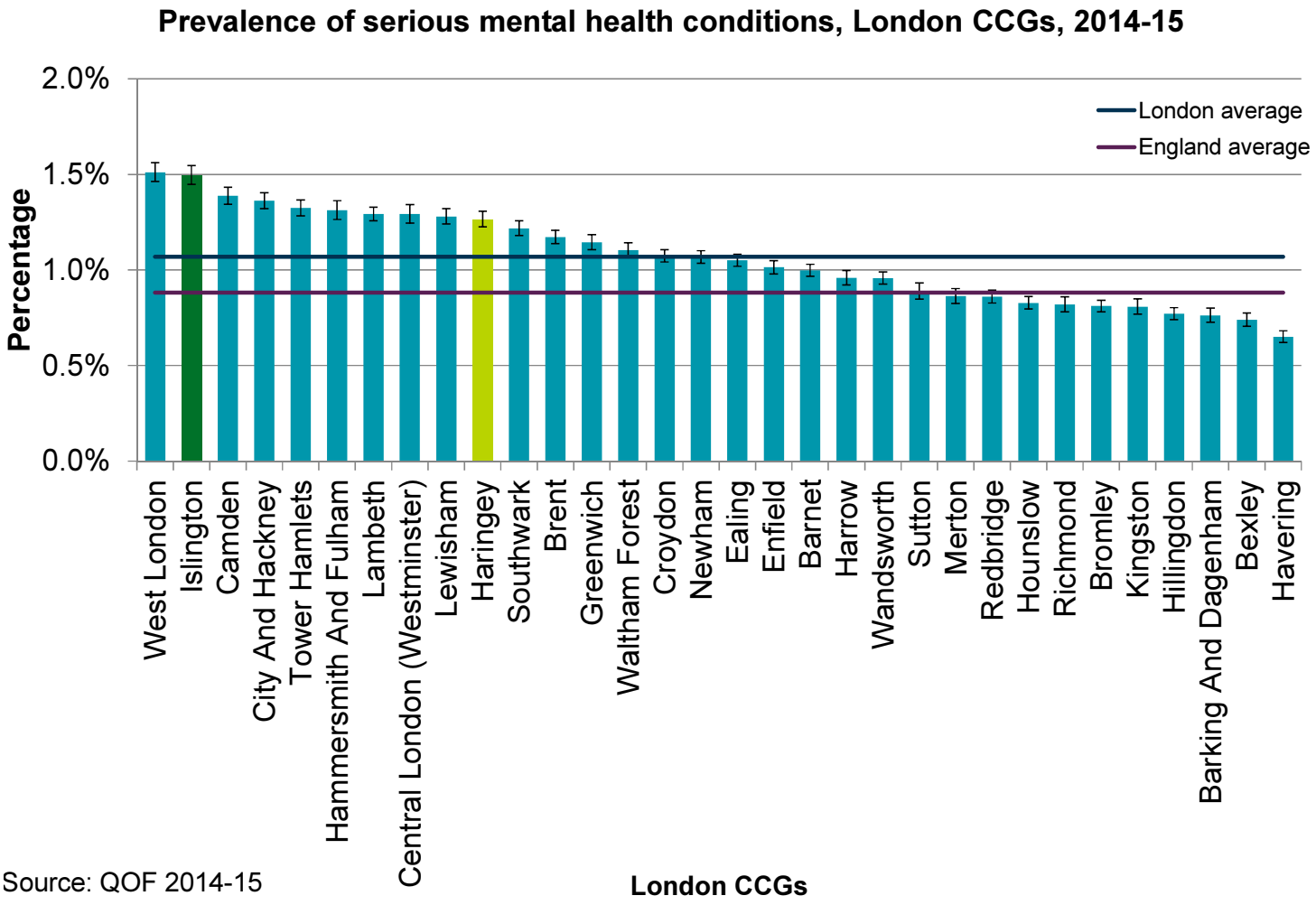
Prevalence of long term conditions



- Both boroughs have a similar prevalence of diagnosed and undiagnosed long term conditions (c20% of population living with one or more diagnosed LTC)
- The condition with the largest prevalence gap is **hypertension** for both Haringey (**16%**) and Islington (**15%**).
- The condition with the smallest gap is **atrial fibrillation** for both Haringey (**1%**) and Islington (**1%**)

Source: QOF 2014-15, PHE 2015
Note: Prevalence for LTCs based on all ages. Estimated prevalence for COPD, CHD, hypertension, diabetes based on ages 16+. Estimated prevalence for CKD based on ages 18+ and atrial fibrillation estimated prevalence based on all ages.

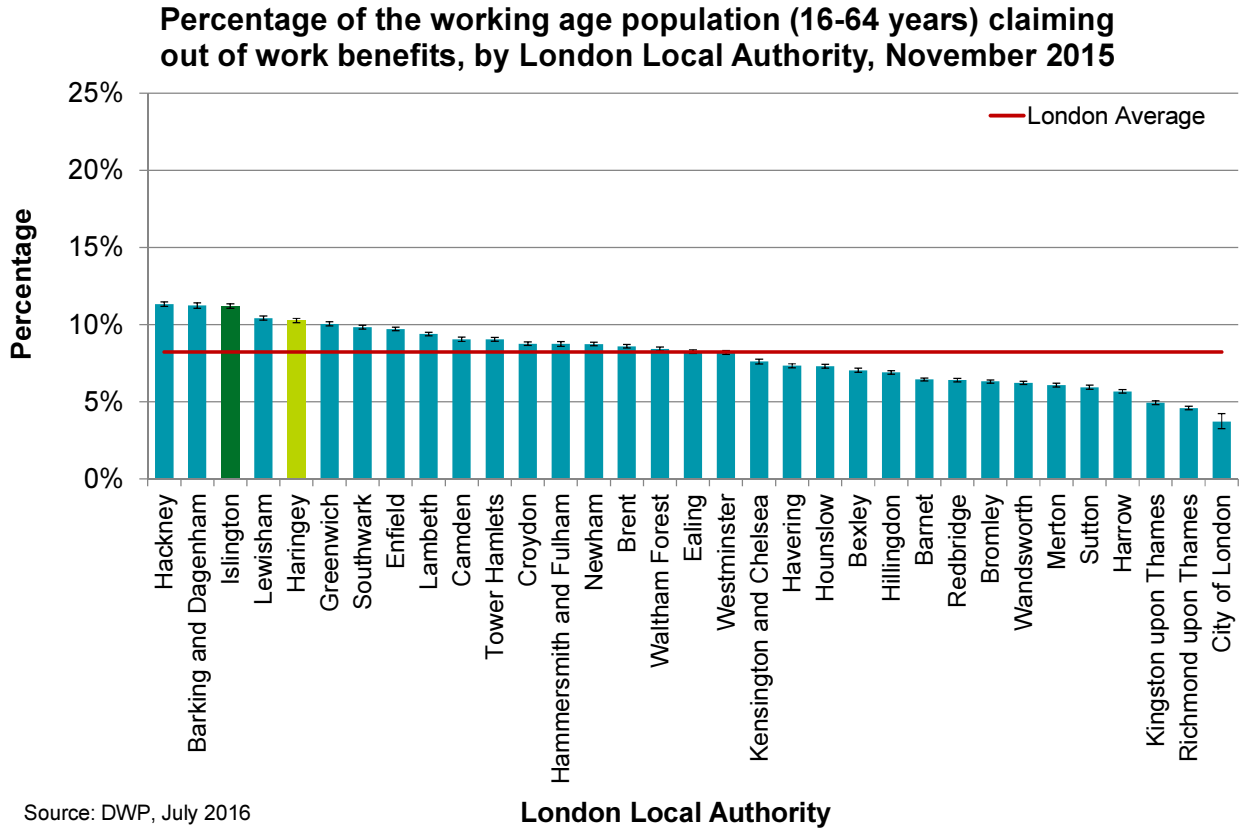
Serious mental ill health



Source: QOF 2014-15

- Islington has the second highest prevalence of serious mental health conditions in London (1.5%)
- Haringey has the 10th highest prevalence (1.3%).
- Both boroughs have a significantly higher prevalence compared to England and London.

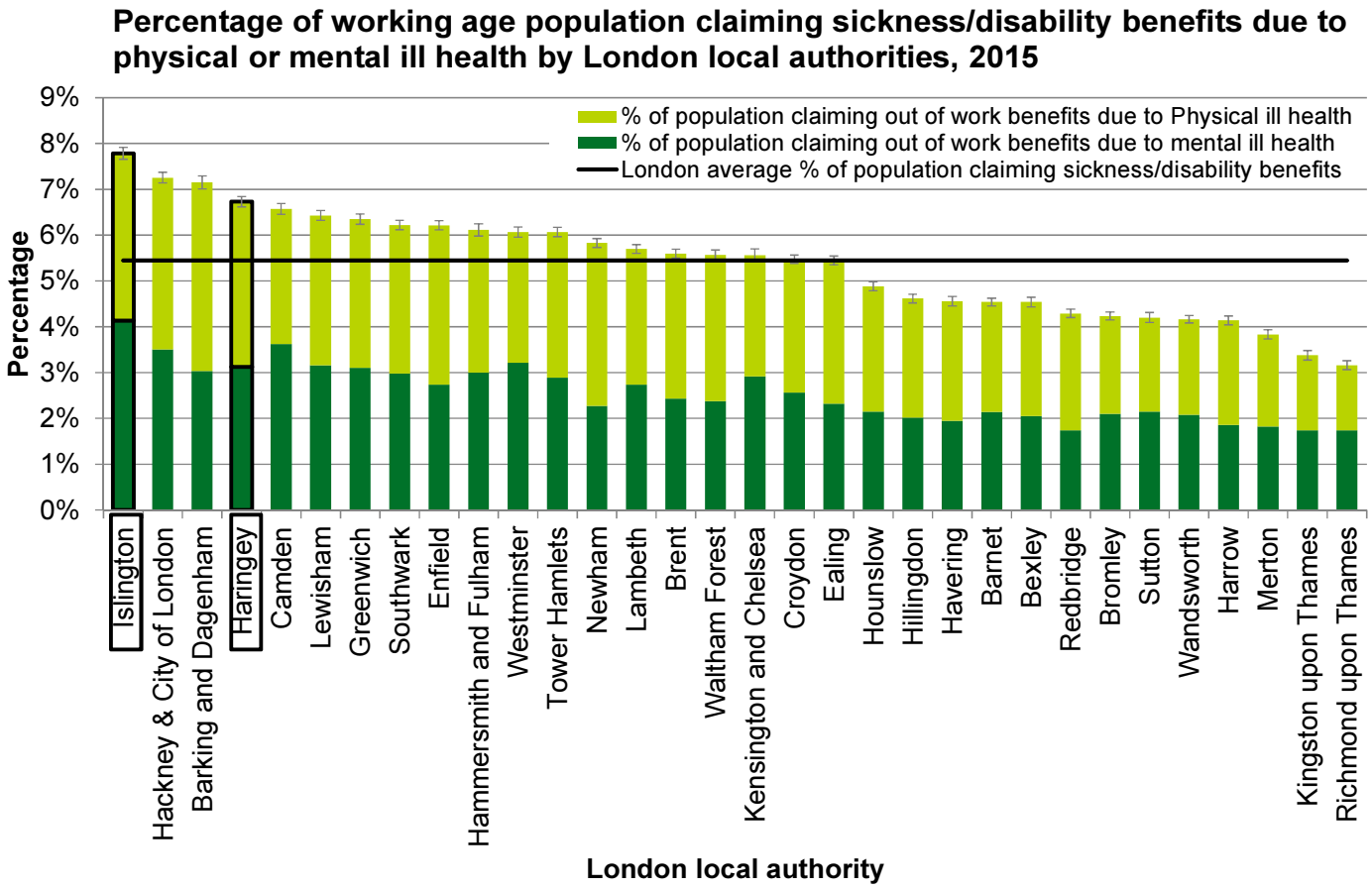
Out of work benefits



Source: DWP, July 2016

- **11%** of the working age population in Islington is claiming out of work benefits. This is the **3rd highest** proportion in London and higher than the London average (8%).
- **10%** of the working age population in Haringey is claiming out of work benefits. This is the **5th highest** proportion in London and higher than the London average (8%).

Sickness/disability benefits in London

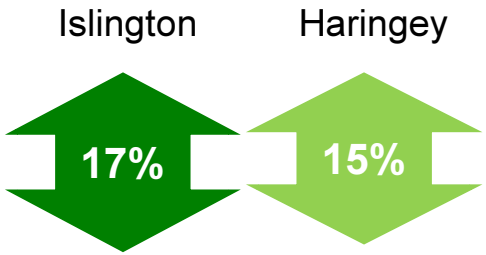


Source: DWP, May 2015

- Both Haringey and Islington have significantly higher proportion of their working age population claiming sickness/disability benefits due physical and/or mental ill health.

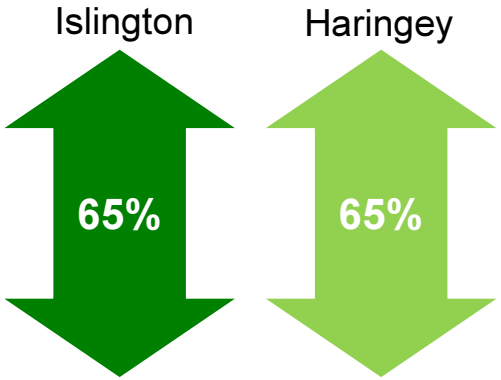
Health unemployment gap in Islington

compared to the whole working age population in 2014/15



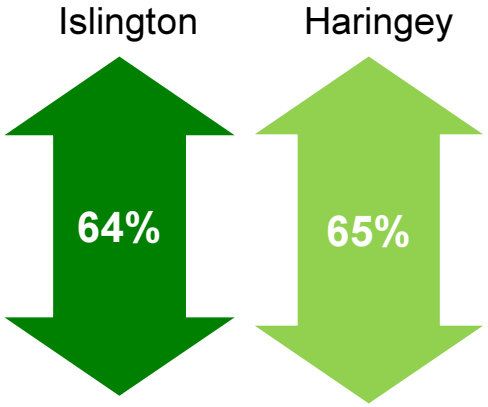
For those with a **long-term health condition** the employment rate gap was **17%** for Islington and **15%** for Haringey

London	10%
England	9%
Islington Rank*	1/32
Haringey Rank*	6/32



For those in contact with **secondary mental health services**, the employment rate gap was **65%** for Islington and Haringey

London	66%
England	66%
Islington Rank*	20/32
Haringey Rank*	19/32



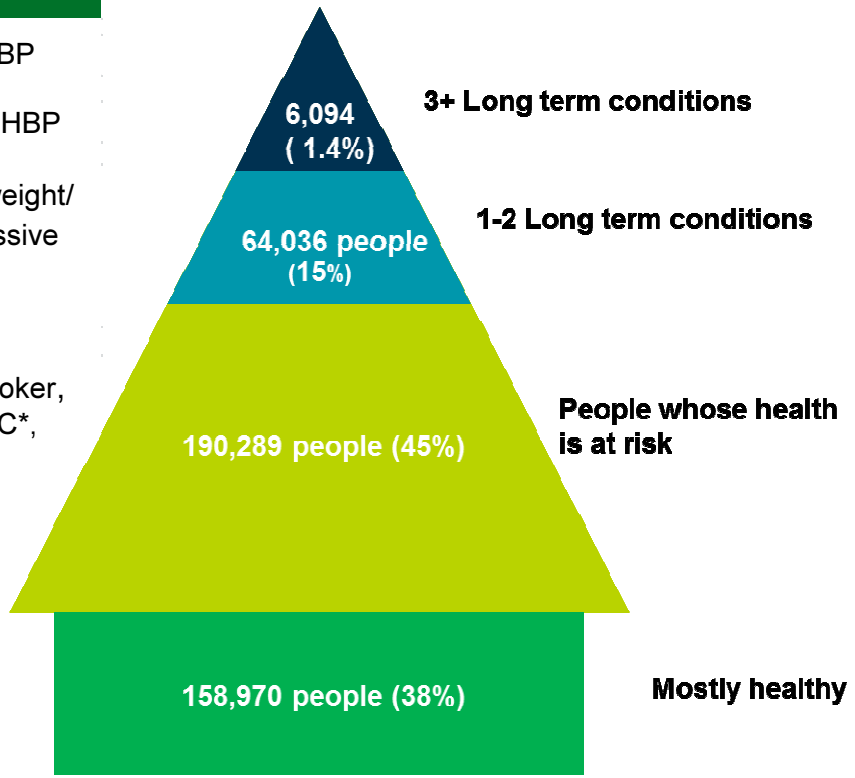
For those with **learning disabilities** the employment rate gap was **64%** for Islington and **65%** for Haringey

London	64%
England	67%
Islington Rank*	17/32
Haringey Rank*	16/32

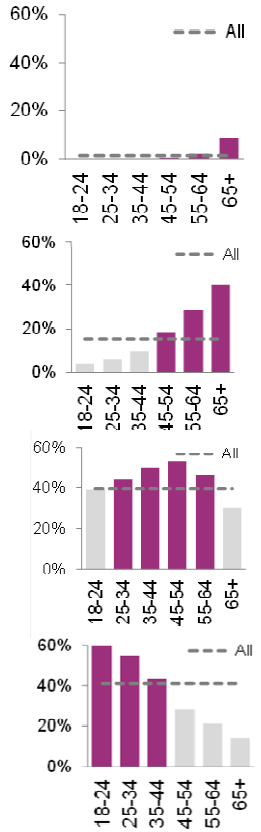
*London LA ranking with 1 representing largest gap. City of London has been excluded for all three measures;
Source: PHOF, 2016

Population segmentation: Haringey and Islington combined registered population 18+

Risk category	Criteria
3+ LTC	3 LTC* excluding HBP
'Early' LTC	1-2 LTC* excluding HBP
People whose Health is at risk	Underweight/Overweight/ Obese, Smoker/Passive smoker, No LTC* HBP
Healthy	Non Smoker/Ex Smoker, Healthy BMI, No LTC*, No HBP



Risk category by age group



- LTC = Long term condition and includes AF, Cancer, diabetes, chronic depression, depression, MI&CHD, CKD, COPD, Stroke & TIA, HF/LVD, Dementia, PAD, CLD, & MH/SMI
- HBP = high blood pressure

Source: Haringey's GP PH dataset (2013) & Islington's PH GP Dataset (2015)

Resident & patient perspective

What we have heard from focus groups and conversations with residents, service users and carers exploring the theme of integrated care.

'I want to have longer appointments with someone who is well prepared so that I do not have to tell my story again

'I want to be treated as a whole person and for you to recognise how disempowering being ill is'

'I want to feel supported by my community and get the most out of services available locally'

'I want my care to be coordinated and to have the same appointment systems across services'

'Better access to health care through social services and vice versa"

'No clear systems and processes through all healthcare services'

'I want to be listened to and be heard'

'Helping people to help themselves'

Challenges and opportunities

Challenges

- Complexity in provider landscape and patient flows – no neat system boundaries
- Different organisational cultures and ways of working across the partners
- Balancing need for continued focus and work at local (ie borough or sub-borough level) with work across the H&I partnership and at sub-regional level

Opportunities

- Similar population health and care needs
- Shared challenge of improving population health outcomes, care quality and system sustainability in face of significant financial constraints
- Shared ambitions for our residents, shared values and a genuine commitment and willingness to working in partnership

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Report for: Health and Wellbeing Board – 3 October 2016

Title: Developing an Accountable Care Partnership across Haringey and Islington

Report Authorised by: Zina Etheridge, Deputy Chief Executive, Haringey Council

Lead Officer: Rachel Lissauer, Director of Commissioning, Haringey Clinical Commissioning Group
Charlotte Pomery, Assistant Director, Haringey Council

1. Describe the issue under consideration

1.1 This report provides an update to the Joint Health and Wellbeing Board on the work being undertaken around health and social care jointly across Haringey and Islington through the Wellbeing Partnership. Specifically, the report highlights work to develop an Accountable Care Partnership locally.

1.2 Members of the Joint Health and Wellbeing Board will be familiar with the overall programme of work underway across the two populations to drive a more integrated approach and to maximise use of resources for local health and care benefits. This Joint Health and Wellbeing Board meeting is an example of the different ways of working together which are already being put in place. As part of this work, the benefits of a more formal partnership structure to ensure that this work is taken forward at pace and scale, and with optimal accountability to local populations, are being explored.

1.3 The report proposes that now is an opportune time to build on the significant work already completed within each of Islington and Haringey across partner agencies to improve patient and user pathways, to build community and resident engagement, to streamline decision making and to develop shared governance over resources and seeks agreement in principle to the development of an Accountable Care Partnership for Haringey and Islington.

2. Recommendations

3.1 The Joint Health and Wellbeing Board is asked to:

a) adopt the principles and high level outcomes as developed by the Sponsor Board of the Haringey and Islington Wellbeing Partnership
b) agree in principle to the development of a form of accountable care partnership which best supports the outcomes sought by the Haringey and Islington Wellbeing Partnership
c) endorse further work to develop the detail of such a partnership, with the aim of gaining agreement on the final structure and form from constituent decision making bodies by April 2017

d) require the Sponsor Board to report back on progress in developing and implementing a project plan
e) request the Sponsor Board to consider as a matter of priority how community and stakeholder engagement will be undertaken and involve key stakeholders including Healthwatch

3. Background information and next steps

3.1 This paper proposes that the development of an Accountable Care Partnership across Haringey and Islington is agreed in principle and that work to develop the detail is now carried out.

3.2 Accountable care partnerships can take many forms but at their core are designed to be accountable to local populations for the care they deliver, collaboratively. They offer an innovative way of addressing some of the fundamental challenges facing health and social care in meeting the needs of local populations. Accountable care partnerships differ from Accountable Care Organisations as they do not seek to establish a single organisational structure but rather to harness the strengths and assets of existing organisations by working more effectively within a formal partnership with shared governance and shared accountabilities, risks and incentives. An accountable care partnership for Haringey and Islington would build on work already underway to reset our local commissioner-provider relationships – embedding a culture of acting within a single system with collective agreement as to how we allocate resources and deliver better for our local populations. There would need to be shared responsibility for the care of the whole population – and agreement as to how we continue to deliver at a very local level for our diverse local communities whilst working to shared principles and outcomes at a population level. This will mean working differently with our local populations and engaging effectively with them in planning and delivery.

3.3 A local accountable care partnership would itself need to operate effectively within the wider North Central London (NCL) sub-region and the complex landscape of health and care organisations which the Sustainability and Transformation Plan describes. We believe that our populations across Haringey and Islington are large enough to sustain an accountable care partnership – but we also know that they are not static and that they move across borough and organisational boundaries in different ways, accessing different services to meet their needs, as part of a global city. Many providers operate across populations and any partnership we develop would need to recognise the complexity of this landscape and the strength and myriad of relationships to be developed with partners, both locally and at a regional and national level. In developing further an accountable care partnership, we would need to demonstrate how it will help to achieve wider NCL goals for system transformation and sustainability and enable us to play a stronger role in meeting NCL's wider challenges.

3.4 The Haringey and Islington Wellbeing Partnership (the Wellbeing Partnership) has made significant progress in a short period of time and brought together a range of organisations, both commissioning and delivering health and social

care, to work differently and collaboratively to improve the health and wellbeing of their local populations. These organisations currently comprise the London Boroughs of Haringey and Islington, Haringey and Islington Clinical Commissioning Groups, the Whittington NHS Trust, the Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust.

3.5 The work carried out to date has led to:

3.5.1 A deep and rich understanding of our local populations, their needs and desired outcomes

3.5.2 A developing awareness of existing issues and complexities

3.5.3 Effective engagement with our communities, with close ties with local populations and strong support for more integrated provision

3.5.4 Strong, progressive relationships in place across local government and NHS; across providers, commissioners and front-line staff and with strong clinical and practitioner engagement

3.5.5 Significant progress in our integrated governance arrangements through the Wellbeing Partnership

3.5.6 A growing track-record of delivering successful integrated care initiatives across both boroughs, including working together to address the wider determinants of well-being and health (housing, employment etc).

3.6 The Wellbeing Partnership is also overseeing a broad programme with a number of work streams which will shape service redesign, resident and patient pathways, workforce development and have the potential to change fundamentally the way services are delivered locally. This paper does not cover further detail on this part of the programme.

3.7 Despite the work of the Wellbeing Partnership, the focus of and drivers for each organisation remain their own goals and finances given current accountability and governance arrangements. These individual organisational priorities can hinder further collaboration, contributing to inefficiencies and limiting our collective ability to achieve more, within our constrained resources. The work undertaken so far has confirmed that duplication of some services across providers still exist, that resources are not deployed optimally around some of our key drivers including prevention and early intervention, that staff work within fixed organisations boundaries and that we do not always work to a strong evidence base, often because of the poor quality of our information and data resources. Our current analysis and case for change often focus on system wide issues which can have a significant impact on both our service users and front-line staff – but without a system wide approach which can tackle them effectively.

3.8 One of the workstream groups, the Strategy and Commissioning Group, of the Wellbeing Partnership has been meeting to consider what if any changes to governance and structures would best support the existing work programme or whether the Wellbeing Partnership's ambitions can be delivered within existing structures. The group has now reached consensus in a number of areas and supports the thinking that changes to organisational structures through an Accountable Care Partnership, as described above, would help to drive integration across Haringey and Islington, improve outcomes and make most effective use of resources. In particular, the group suggested that the following issues will need to be addressed in developing such a partnership for Haringey and Islington:

3.8.1 The Wellbeing Partnership already has in place a firm set of principles and outcomes which are aligned to facilitate greater collaboration and strengthened joint governance and which will need to drive any next steps. It is suggested that agreement to this set of principles and outcomes could be further cemented by the development of a Memorandum of Understanding across all partners to underpin the detail required to determine the form of the appropriate accountable care partnership for Haringey and Islington.

3.8.2 The way funding flows within an accountable care partnership is often significantly different from current, organisationally based funding. The Wellbeing Partnership is already exploring what a single control total across organisations could mean – in effect, it could constitute the agreed, pooled financial resources for the local population in respect of health and care. It is noted that not all aspects of service provision or all budgets for organisations would necessarily be within the scope of the single control total – for local mental health trusts in particular, it is recognised that delivery within Haringey and Islington may constitute a relatively small element of their overall budget and operation. From experience, we know that there are challenges in working out pooling arrangements between two organisations and that moving to new ways of thinking about population level pooling will add further complexity to this picture which can be supported by operating to shared outcomes and criteria.

3.8.3 A further issue is the determination of which services and budgets would be brought within or would remain outside scope of the accountable care partnership. Primary and community care, as well as wider forms of community based provision, are critical to a model which operates at a population level, enables prevention and early intervention and delivers system wide transformation, both financially and in terms of outcomes for local residents. This is a key decision which will shape the future scope of the outcomes to be delivered. This oversight is required if we are to change service delivery on the ground to drive improved outcomes and reduce costs in the system.

3.8.4 An accountable care partnership would move away from individual Quality, Innovation, Productivity and Prevention targets, Cost Improvement Programmes and savings plans within organisations to plans that reduce system wide costs and optimise use of resources in the medium to long term.

A new contract form with acute /community providers will need to be explored and would need to apply across all acute providers delivering to local populations. The intelligence we hold with and about our local populations would need to be effectively used to make decisions and build the ongoing evidence base for greater collaboration. Whilst it is constructive to start with the money in order that we can work through to consider the appropriate governance model, we need to ensure that our interventions reflect a strong understanding of what works locally, within the context of Haringey and Islington. We would begin to map the growing consolidation of partnership arrangements as we move, in time, from sharing information through to exercising shared decision-making.

3.8.5 The areas of work suggested above would aim to facilitate the 'bottom up' work of scaling up areas of good practice so that there is a constant iteration between new ways of planning, resourcing and delivering services and an organisational form that facilitates these approaches. Our aim is for these approaches to engage fully with local communities and to build their voice into everything we do and engaging on principles with both residents and our workforce will be a core plank in the process. Work to develop a clear and meaningful communications plan will be required, fully engaging with key stakeholders and creating transparency through all stages of the process.

3.8.6 Learning from others, rather than starting afresh, is already being implemented as an approach and work with both the King's Fund and UCLP has informed the thinking to date. It is suggested that this approach should continue, with workshops led by such organisations who have been working with other health economies to understand how they progressed from the stage of the accountable care partnership concept to the next stage of working together in practice.

3.8.7 Finally, the governance arrangements required to support the vehicle for an accountable care partnership which is fit for our local populations and context will need to be worked up in light of the issues identified above.

3.9 To take forward the key areas identified above, which span principles and outcomes, finance, engagement, intelligence, legal and governance, it is proposed that the Joint Health and Wellbeing Board empower the Sponsor Board to draw up a project plan, setting out what is required to work through the steps identified above, and to bring key proposals back to the Joint Board for endorsement and decision. It is acknowledged that there are significant issues that will need resolving and it is considered that the Joint Board structure has the appropriate authority across the health and care landscape to consider these and respond with the best course of action.

3.10 It is acknowledged that the partnership will work closely with a wider range of partners, within the context of the Sustainability and Transformation Plan, affecting the outcomes that can be achieved across the population. This broader relationship working will include partners such as North Middlesex University Hospital NHS Trust and University College London Hospitals, which also serve the local population in a number of ways.

4. Contribution to strategic outcomes

4.1 These proposals support the strategic principles and outcomes of the H&I Wellbeing Partnership as well as priorities in the key strategic plans of all partners to the arrangements.

5. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

5.1 Legal

5.1.1 Accountable Care Partnerships are relatively new organisational forms intended to bring together commissioners and providers to take responsibility for the cost and quality of care for defined population, in this case Haringey and Islington, and within an agreed budget. Information available, suggest that accountable care partnerships may take many different forms including a fully integrated care systems with an opportunity to break down traditional barriers between organisations and to improve the quality of services. This form of system wide integration under a collectively defined and managed budget would require partners to sign an Accountable Care Partnership Agreement to affirm their collective accountability for outcomes, define their mutual responsibilities to deliver integrated care and to formally agree a joint governance structure to make decisions, allocate and manage funds, manage performance, share resources, risk and rewards and hold each other accountable for delivering outcomes. There may also be individual agreements between commissioners and providers that sits alongside or are aligned with the Accountable Care Partnership Agreement.

5.1.2 Section 195 of the Health and Social Care Act 2012 (duty to encourage integrated working) provides that, a Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner. The recommendation to the Haringey and Islington Health and Wellbeing Board to endorse the move towards an accountable care partnership falls within the function of the respective Boards to encourage integrated working across health and social care. The same also apply to the proposal that partners agree a memorandum of understanding on principles, outcomes, expectations and responsibilities and as a prelude to the accountable care partnership arrangements.

5.1.3 In scoping out the work required to move towards this new partnership model, partners should, amongst other matters, consider whether there is likely to be changes to services provided to residents of the respective boroughs. If so, the nature and extent of the changes and the need for public consultation, in particular, if there is likely to be an adverse effect on services delivered to residents. Partners should also consider the implications on existing contractual and other partnership arrangements for example Section 75

Health and Social Care Partnership Agreements and how this can be aligned with the proposed accountable partnership arrangements.

5.1.4 Partners must ensure that they seek the required authority of their respective decision making body to enter into the proposed partnership arrangement. For the local authorities, this would require a report to their respective Cabinet for a decision.

5.2 Chief Finance Officer

5.2.1 The creation of an Accountable Care Partnership that potentially could involve the budgets for Adults Social Care and Health in LB Haringey, Haringey CCG, LB Islington, Islington CCG and partner healthcare trusts is a major undertaking. While it may provide significant opportunities for synergies and efficiencies across the partnership, there are also risks about individual organisations having less direct financial control of parts of their finances at a time of financial constraint. Moreover, there are likely to be significant resources required to bring such a partnership into being.

5.2.2 At this stage, the report is seeking an agreement in principle to the concept and to carry out more work to establish the practical steps that would be necessary. The Haringey and Islington Health and Wellbeing Partnership should ensure that it has access to sufficient resources to undertake this activity.

6. Environmental Implications

6.1 There are no significant environmental implications arising directly from this report.

7. Resident and Equalities Implications

7.1 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

7.2 A resident impact assessment has not been completed because an assessment is not necessary in this instance.

8. Use of Appendices

None.

9. Background papers

None.

Report for: Heath and Wellbeing Board – 3 October 2016

Title: Cardiovascular Disease and Diabetes in Haringey and Islington – a population perspective and opportunities within the Haringey and Islington Wellbeing Partnership

Report authorised by : Dr Jeanelle de Gruchy, Director of Public Health, Haringey Council.

Lead Officer: Dr Will Maimaris, Consultant in Public Health, Haringey Council.

1. Describe the issue under consideration

1.1 This paper gives an overview of health and care needs relating to diabetes and cardiovascular disease (which includes heart disease and strokes) in Haringey and Islington.

1.2 This paper outlines opportunities to take a population based approach to improving outcomes for cardiovascular disease and diabetes, in a way that is financially sustainable, through the work of the Haringey and Islington Wellbeing Partnership.

1.3 There are particular opportunities relating to:

- Improvements in the health and social care model for people with diabetes and CVD, including early detection and prevention of cardiovascular disease and diabetes.
- Acting at population level to put preventative initiatives or policies in place that will keep people healthy.

2. Recommendations

2.1 That the Health and Wellbeing Boards note the issues raised in this paper and areas of good practice highlighted within the paper appendix attached.

2.2 That the Health and Wellbeing Boards note and comment on the opportunities for improving population health outcomes and value for money for cardiovascular disease and diabetes prevention and care through the Haringey and Islington Wellbeing Partnership.

3. Background information

3.1 Cardiovascular disease is a general term which describes a disease of the heart or blood vessels. Cardiovascular disease include strokes and heart disease. Because most cases of cardiovascular disease are a direct result of risk factors such as smoking and poor diet, the majority of cardiovascular disease is preventable.

3.2 Diabetes is a long-term health condition which is caused by the inability of the body to produce or respond correctly to the hormone insulin, which regulates blood sugar levels. Around 90% of people have type 2 diabetes which is closely linked to overweight and obesity (and is therefore generally preventable) and around 10% of people have type 1 diabetes, which is not linked to overweight and obesity and commonly starts in childhood or young adulthood.

3.3 Diabetes is not in itself a cardiovascular disease, but people with diabetes are at a greatly increased risk of developing cardiovascular disease, and the conditions are closely linked.

3.4 Population health needs and issues

3.5 Cardiovascular disease is a leading cause of death in both Haringey and Islington. As in the rest of the country, the numbers of people dying early (under the age of 75) from cardiovascular disease in Haringey and Islington has fallen in recent years. However, death rates in both boroughs still remain higher than the London average.[1]

3.6 Cardiovascular disease is also one of the major contributors to health inequalities – especially the gap in life expectancy – in Haringey and Islington.

3.7 Risk factors for cardiovascular disease and diabetes

3.8 Large numbers of people in Haringey and Islington have one or more risk factors for cardiovascular disease. For example, in Haringey and Islington.

- 1 in 5 people smoke
- 1 in 5 people have high blood pressure
- Nearly 2 in 3 people are overweight or obese (this is also the most significant risk factor for diabetes).

3.9 These risk factors are in turn linked to the wider social and environmental conditions that people live in.

3.10 Numbers of people with diabetes and cardiovascular disease.

[1] Source Public Health Outcomes Framework

3.11 Around 23,000[2] people (over 5% of the adult population) in Haringey and Islington are diagnosed with diabetes, with a further 6,000 estimated to have undiagnosed diabetes. National and local evidence suggests that people from South Asian, Black Caribbean, Black African and Turkish backgrounds are more likely to have type 2 diabetes.

3.12 A significant proportion of people with diabetes will also be living with other physical or mental health conditions. For example it is estimated that around 1 in 5 people with diabetes may also have some degree of depression.

3.13 The numbers of people diagnosed with cardiovascular disease is also significant, over 8,000 people are diagnosed with coronary heart disease and around 5,000 people have had a previous stroke in Haringey and Islington.[2]

3.14 Financial impact on health and care services

3.15 Benchmarking analysis (NHS Right Care) shows that Haringey CCG is spending £1.2 million more per year and Islington CCG £1million per year more on non-elective (emergency) care for cardiovascular disease compared to our best performing comparator CCGs. Much of this spend is due to heart attacks and strokes that could be prevented.

3.16 While we don't have firm figures on the proportion of adult social care spend that results from CVD and diabetes, we know that work in Greenwich identified that 66% of people in long-term residential care had at least one CVD diagnosis (including diabetes).

3.17 Taking a population approach to improving outcomes for diabetes and CVD in Haringey and Islington

3.18 In order to think about how we best improve population health outcomes for cardiovascular disease and diabetes it is helpful to look at different segments of the whole population, as described in the table below.

1. The whole population
2. People who are at high risk of developing cardiovascular disease or diabetes, (such as those who smoke or have pre-diabetes or high blood pressure)
3. People who are living with diabetes or cardiovascular disease

[2] Source: Quality Outcomes Framework 2014-15.

People who are living with diabetes and cardiovascular disease who have complex health and care needs. **Population segment**	**Example of size of population in Haringey and Islington**	**Local examples of existing approaches to improving outcomes.**
Whole population approaches	Over 500,000 people	Haringey obesity alliance Making every contact count Healthy High Streets
People who are at high risk of diabetes or cardiovascular disease	Over 100,000 people with high blood pressure. Over 80,000 people who smoke	Case finding for high blood pressure Diabetes prevention programme
People living with diabetes or cardiovascular disease	Over 23,000 people diagnosed with diabetes Over 8,000 people diagnosed with coronary heart disease	Care planning Self-management support Community diabetes nurses Value based commissioning for diabetes – The diabetes integrated practice unit.
People living with diabetes and/or cardiovascular disease who have complex health and care needs	Estimated as about 1% of the population (5,000 people)	Integrated locality teams

3.19 As captured in the table above there are many examples of good practice relating to the prevention and care of people with diabetes and cardiovascular disease in Haringey and Islington. There is further information on these examples in the accompanying slide pack:

3.20 However, in spite of the good practice highlighted above, there are still significant issues and gaps:

- There are large numbers of people who have cardiovascular conditions or diabetes but are not diagnosed.

- While there are many examples of excellent primary care for people with diabetes and cardiovascular disease, there is also evidence that many people are not receiving high quality primary care for diabetes and cardiovascular disease, much of which is about systematically applying interventions with a strong-evidence base such as tight blood pressure control and kidney checks in people with diabetes.

- There is a recognition that primary care is under-resourced, for example in terms of the numbers of practice nurses and GPs, particularly in Haringey. At present the majority of spend on diabetes and CVD care is on hospital care and high cost social care. As a system we do not have an effective mechanism for shifting investment towards primary care and prevention.

- People with long-term conditions often report feeling that they do not get the support that they need, and that their care is not joined up.

- Prevention services such as smoking cessation services are relatively small scale and are only reaching a small proportion of the at-risk population.

- Evidence-based self-management and patient education programmes are only being accessed by a minority of people with diabetes and cardiovascular disease.

- Our approaches for supporting local communities to improve their health and wellbeing could be improved.

- The environments that many Haringey and Islington residents live in do not make healthy choices easy for our residents.

3.21 <u>Opportunities to improve population health outcomes and financial sustainability for diabetes and CVD care through the Haringey and Islington Wellbeing Partnership</u>

3.22 The emergence of the Haringey and Islington Wellbeing Partnership provides an opportunity to improve our population-based approach to cardiovascular disease and diabetes. The partnership has a number of strengths.

- A strong understanding of our local population and their needs

- Strong, progressive relationships at senior levels already in place in local government and the NHS; across primary, community, hospital, mental health and social care
- A senior board overseeing the Haringey and Islington Wellbeing Partnership
- A proven track-record of delivering successful integrated care initiatives e.g. Integrated MH practice teams, Integrated Community Ageing Team, Learning Disability Partnership, ambulatory care

3.23 These strengths mean that the Haringey and Islington Wellbeing Partnership has the potential to be a vehicle that will drive improvements in cardiovascular and diabetes care and prevention.

3.24 There is a diabetes and cardiovascular disease work-stream of the Haringey and Islington Wellbeing Partnership and we have already begun to scope this area of work with our partners.

3.25 Some significant opportunities for collaborative working have been identified, as follows:

1. <u>Working as a whole system to develop a sustainable integrated model of clinical and social care for people with diabetes and cardiovascular disease</u>

3.26 This would build on previous collaborative working on value-based commissioning for diabetes, which is about working as a system to improve outcomes of care that have been jointly identified by service users and clinicians.

3.27 An integrated model of care has already been designed as part of the value based commissioning work for diabetes. The Haringey and Islington Partnership could help take this work forward by overcoming some of the barriers to current implementation, including stronger investment in and involvement of primary care, identifying appropriate estates for care delivery and developing integrated IT solutions.

2. <u>Whole population approaches to preventing cardiovascular disease and diabetes</u>

3.28 While improving the quality and value for money of the clinical and social care model for people with diabetes and cardiovascular disease is crucial, there are likely to be equally significant gains for population health and wellbeing by improving our whole population approach to prevention of cardiovascular disease.

3.29 Through the cardiovascular disease and diabetes work-stream of the Haringey and Islington Wellbeing Partnership we are looking to identify the population-wide approaches that will have the most impact on cardiovascular health and wellbeing and the best return on investment. This might, for example, build on and strengthen existing programmes in place in both Local Authorities, such as

the Making Every Contact Count approach to behaviour change and the Healthy Schools programme – and new approaches such as the Haringey devolution prevention pilot focus on tighter controls on tobacco and alcohol.

3.30 Links to the North Central London Sustainability and Transformation Plan

3.31 A number of the themes described in this paper are also acknowledged as part of the Case for Change for the North Central London Sustainability and Transformation Plan[3] including:

- Challenges in primary care provision
- A lack of focus on prevention across North Central London
- Gaps in early detection of disease
- Lack of integrated care and support for people with long-term conditions.

3.32 While the North Central London Sustainability and Transformation Plan will provide a framework to tackling some of these challenges, many of the solutions will need to be implemented at a local level, and the Haringey and Islington Wellbeing Partnership is a potential vehicle to do this.

3.33 Next steps

The opportunities outlined above will continue to be taken forward through the Haringey and Islington Wellbeing Partnership.

4. Contribution to strategic outcomes

4.1 This work relates to priorities identified in:

1. Haringey's Joint Health and Wellbeing Strategy 2015-2018
    - Increasing healthy life expectancy objective

2. Islington's Joint Health and Wellbeing Strategy 2013-16
    - In particular strategic outcome 2:
        - Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities

5. Statutory Office Comments (Legal and Finance)

5.1 Legal

There are no legal implications arising from the recommendations in this report.

5.2 Finance

There are no financial implications arising from the recommendations in this report.

6. Environmental Implications

6.1 There are no significant environmental implications arising directly from this report.

7. Resident and Equalities Implications

7.1 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

7.2 A resident impact assessment has not been completed because an assessment is not necessary in this instance.

8. Use of Appendices

8.1 None.

9. Background papers

9.1 None.

Report for: Health and Wellbeing Board – 3 October 2016

Title: Update on the North Central London Sustainable and Transformation Plan (STP)

Report Authorised by : Julie Billett, Director of Public Health, Islington Council

Lead Officer: Julie Billett, Director of Public Health, Islington Council

1. Describe the issue under consideration

1.1 This report and the accompanying presentation provide an update to the Health and Wellbeing Boards on the development of a five year, strategic plan for the health and care system across the five boroughs of North Central London (NCL) – Islington, Haringey, Camden, Barnet and Enfield.

1.2 North Central London is one of 44 "footprints" nationally that are developing Sustainability and Transformation Plans (STPs) in response to NHS Planning Guidance, issued in December 2015. This guidance asked NHS providers and Clinical Commissioning Groups to work with local authorities to develop whole system, place based plans to deliver three key ambitions for the health and care system:-

- to improve health and wellbeing outcomes
- to improve care quality; and
- to achieve finical sustainability.

1.3 An initial, high level STP plan was submitted in June 2016. Over the summer, further work has been undertaken to further develop the STP and a final plan will be submitted to NHS England on 21st October.

1.4 The presentation summarises key themes from the North Central London "case for change", describes the vision and ambitions for system transformation and improved outcomes, and provides an update on the emerging plans in each of the STP workstreams.

2. Recommendations

2.1 To note the progress to date on the development of a Sustainability and Transformation Plan for North Central London.

2.2 To note and discuss its overall objectives, vision and emerging plans for the transformation of the health and care system across NCL, and its implications

for and synergies with the Islington and Haringey Wellbeing Partnership.

3. Background Information

3.1 Through the NHS Shared Planning Guidance, every local health and care system in England has been asked to come together to create an ambitious, place-based, multi-year strategic plan built around the needs of local populations. These Sustainability and Transformation Plans (STPs), and this new partnership approach to strategic planning, are intended to be the vehicle for delivering the NHS Five Year Forward View.

3.2 Haringey and Islington are part of the NCL STP strategic planning footprint, alongside Barnet, Enfield and Camden.

3.3 Following submission of an initial, high level plan in June 2016, which set out a broad direction of travel for the NCL STP, partners across the health and care system have continued to work together over the summer to further articulate the 'case for change' and to develop plans across the following key workstreams:-

- population health and prevention
- transforming primary care
- mental health
- urgent and emergency care
- optimising planned care pathways
- consolidation of specialties
- organisational-level and system-level efficiencies

3.4 In addition, work has progressed across a number of "enabling" workstreams, including:- the health and care workforce; the health and care estate; digital and information; and new commissioning and delivery models.

3.5 The accompanying presentation provides an update on progress with the development of each of these workstreams, and the strategic plan overall, in readiness for its submission to NHS England on 21st October 2016.

4. Contribution to strategic outcomes

4.1 Given its focus on transforming the way that health and care services are commissioned and provided in NCL, and its ambition for improving health and wellbeing outcomes for NCL residents, the STP is the important strategic context for the work of the Haringey Islington Wellbeing Partnership. In turn, the Wellbeing Partnership is an important vehicle for delivering key aspects of transformation and change within the STP, across Haringey and Islington.

5. Statutory Officer Comments (Legal and Finance)

5.1 Legal

There are no legal implications arising from the recommendations in the report. However, Section 195 of the Health and Social Care Act 2012 (duty to encourage integrated working), provides that, a Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner. Health and Wellbeing Board may also encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together. Health-related services means services that may have an effect on the health of individuals but are not health services or social care services.

5.2 Finance

There are no financial implications directly arising from this report.

6. Environmental Implications

6.1 There are no significant environmental impacts related to the development of the STP for North central London. However, improved integration and joint working can help reduce duplication, which in turn can have a positive impact on the environment.

7. Resident and Equalities Implications

7.1 The Council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantage, take steps to meet needs, in particular steps to take account of disabled persons disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding. No specific resident impact assessment is required in regard to this report.

8. Use of Appendices

8.1 North Central London Sustainability and Transformation Plan Progress report – September 2016.

8.2 North Central London Case for Change.

9. Background Papers

None.

North Central London
Sustainability and
Transformation Plan

North Central London Sustainability and Transformation plan

Progress report – September 2016

NHS England
NHS Barnet Clinical Commissioning Group
NHS Camden Clinical Commissioning Group
NHS Enfield Clinical Commissioning Group
NHS Haringey Clinical Commissioning Group
NHS Islington Clinical Commissioning Group
BARNET LONDON BOROUGH
Camden
ENFIELD Council
Haringey LONDON
ISLINGTON
Barnet, Enfield and Haringey NHS Mental Health NHS Trust
A University Teaching Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Central London Community Healthcare NHS Trust
Your healthcare closer to home
Moorfields Eye Hospital NHS Foundation Trust
North Middlesex University Hospital NHS Trust
Royal Free London NHS Foundation Trust
The Tavistock and Portman NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Whittington Health NHS

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1 Executive summary

North Central London (NCL) has a complex health and social care landscape, with a diverse and growing population. 5 CCGs, 5 local authorities, 4 acute trusts (including 5 A&E sites), 2 mental health trusts and 2 community trusts make up the scope of our footprint. There are also 4 single specialist trusts in the area. Whilst there are good examples of organisations collaborating over the past few years, working collectively at a pan-NCL level is still relatively new, and we are building the trust required to deliver our Sustainability and Transformation plan (STP).

NCL is a vibrant part of the country's capital – there is rich cultural and economic diversity. Every borough has its own unique identity and local assets that we can build on. Many people in NCL lead healthy lives, but if people 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 can harness the intellectual capacity amongst our people to deliver outstanding outcomes. However, we are still not able to deliver universally for everyone to the standards we would like. Deprivation and inequalities exist across NCL, and poor health and wellbeing outcomes are often linked to this. There are particularly high levels of mental health problems in our population. Obesity levels are high for children, whilst immunisation levels are low. Our analysis tells us that too many people stay longer in hospital than is medically necessary. There are challenges with meeting acute standards, as well as issues workforce sustainability. Some of our estates aren't fit for purpose. Additionally, we face a financial challenge of £876m across health commissioners and providers by 20/21 if we do nothing.

We want people to be able to get the care they need when they need it, and this means supporting people to live full and independent lives in their communities to maximise health and wellbeing. When people do need specialist care, they should get it quickly and in the most appropriate setting, and be supported in their recovery. To deliver on our vision, we have created a programme of work that will meet the triple aim of health and wellbeing; care and quality; finance and efficiency. The programme includes a focus on: population health; transforming primary care; mental health; urgent and emergency care; optimising the elective pathway; consolidation of specialties; organisational-level productivity and system productivity. Delivery in these workstreams will be underpinned by a number of system enablers including: health and care workforce; health and care estates; digital and information; commissioning models; new care models and new delivery models. We recognise that there are a many significant and complex interdependencies across these workstreams and are currently in the process of identifying these and establishing the best possible process for effective management. We have developed a governance structure that has enabled us to mobilise the programme and engage all organisations across the system in developing our plan.

Our aim is to transform the way that healthcare is commissioned and provided in NCL through this STP, ensuring the system is both high performing, and clinically and financially sustainable in the future. Key decisions going forward will include how we design care for the specific needs of population groups, the delivery vehicles for care (and thus the shape of the provider landscape in NCL as a whole), and the way we can optimally commission services. We are committed to being radical in our approach and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

2 North Central London has a complex health and social care landscape

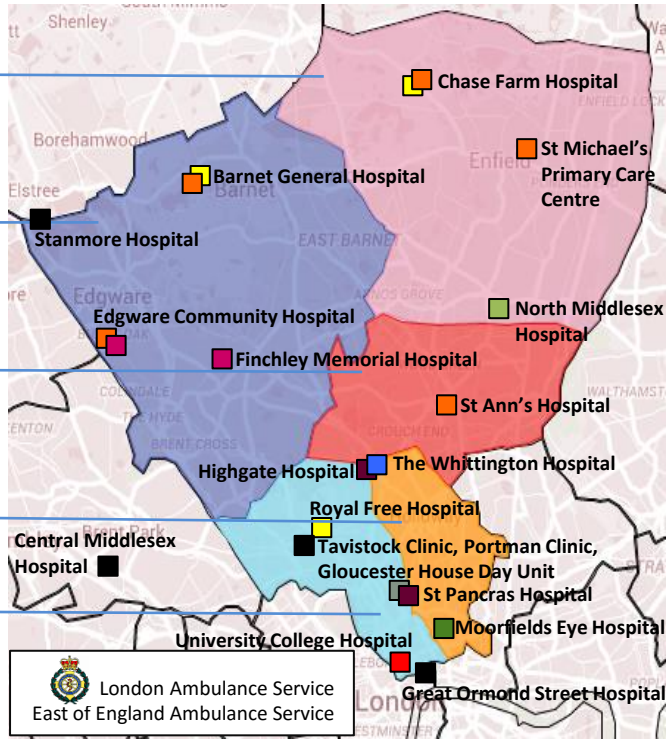
Enfield CCG / Enfield Council
~320k GP registered pop, ~324k resident pop
48 GP practices
CCG Allocation: £362m (-£14.9m 15/16 OT)
LA ASC, CSC, PH spend: £184m

Barnet CCG / Barnet Council
~396k GP registered pop, ~375k resident pop
62 GP practices
CCG Allocation: £444m (£2.0m 15/16 OT)
LA ASC, CSC, PH spend: £158m

Haringey CCG / Haringey Council
~296k GP registered pop, , ~267k resident pop
45 GP practices
CCG Allocation: £341m (-£2.8m 15/16 OT)
LA ASC, CSC, PH spend: £163m

Islington CCG / Islington Council
~233k GP registered pop, , ~221k resident pop
34 GP practices
CCG Allocation: £339m (£2.7m 15/16 OT)
LA ASC, CSC, PH spend: £138m

Camden CCG / Camden Council
~260k GP registered pop, , ~235k resident pop
35 GP practices
CCG Allocation: £372m (£7.2m 15/16 OT)
LA ASC, CSC, PH spend: £191m



Total health spend **£2.5b**

Total care spend **c.£0.8b**

NHS England
- Primary care spend **~£180m**
- Spec. comm. spend **~£730m**

15/16 OT		
£185m	-£12.4m	BEH Mental Health NHS Trust (main sites, incl Enfield community)
£136m	£0.7m	Camden and Islington NHS FT (and main sites)
£249m	-£8.3m	North Middlesex University Hospital NHS Trust
£951m	-£51m	The Royal Free London NHS FT
£940m	-£31m	University College London Hospitals NHS FT
£293m	-£14.8m	Whittington Health NHS Trust (incl Islington and Haringey Community)
£202m	£2m	Moorfields Eye Hospital NHS FT
N/A – not in scope for NCL STP finance base case		Central and North West London NHS FT (Camden Community)
		Central London Community Healthcare NHS Trust (Barnet Community)

The specialist providers are out of scope: GOSH and RNOH
Tavistock and Portman NHS FT is out of scope financially but within scope for mental health

Note: all OT figures are normalised positions

Vanguards in scope
- Royal Free multi-provider hospital model
- Accountable clinical network for cancer (UCLH)

NCL CCGs activity stats

A&E	522,838
Elective	134,513
Non-elective	163,487
Critical Care	25,718
Maternity	45,528
Outpatients	1,803,202

Total GP registered population 1.5m

Our population
- Our population is **diverse and growing**.
- Like many areas in London, we experience **significant churn** in terms of people using our health and care services as people come in and out of the city.
- There is a **wide spread of deprivation** across NCL – we have a younger, more deprived population in the east and south and an older, more affluent population in the west and north.
- There are high numbers of households in **temporary accommodation** across the patch and around a quarter of the population in NCL **do not have English as their main language**.
- Lots of people come to settle in NCL from abroad. The largest **migrant communities** arriving during 2014/15 settling in Barnet, Enfield and Haringey were from Romania, Bulgaria and Poland. In Camden and Islington in 2014/15 the largest migrant communities were from Italy, France and Spain.

2 We are building on our local strengths

Who we are

North Central London (NCL) comprises 5 CCGs: Barnet, Camden, Enfield, Haringey and Islington, each coterminous with the local London Borough. The population of NCL is c.1.44m and has a £2.5bn health and c.£800m social care budget. There are four acute trusts: The Royal Free London NHS Foundation Trust (sites in scope including Barnet Hospital, Chase Farm Hospital and The Royal Free hospital in Hampstead), University College London Hospitals NHS Foundation Trust (University College Hospital site*), North Middlesex University Hospital NHS Trust, the Whittington Health NHS Trust and three single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. 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 Trust. There are over 200 GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative.

Our history

Historically, neither local residents nor health and care professionals have identified NCL as a "place". Whilst there are good examples of strong partnership working where areas have come together, we have not generally operated on a 5 borough footprint in recent years. The disparities (in terms of population, geography, provider landscape and finances) between the different boroughs in NCL mean that it can be difficult to align around a common vision. The STP process has helped us to realise that we need to do something radically different in order to deliver the quality of care that we want for our population – and that we can only do so by working together collaboratively and at scale, across the whole footprint. However, we have individual and collective achievements that can be built on.

Building on our strengths

We know we have the capability to deliver significant change, for example:

- All of our boroughs are already working in GP federations. In Islington, practices are working together to make sure that people can see a doctor when their surgery is closed: with individuals' consent, the entire GP record is available.
- Our delivery of the national Transforming Care programme in Enfield has significantly improved the lives of people with learning disabilities and autism: through diverting funding away from clinical assessment and treatment services, we have set up a community intervention service which uses combination of proven holistic therapies and Positive Behaviour Support techniques. As a result, hospital bed days per month for this cohort in Enfield have reduced from 188 to 30 between 2012 and 2015.
- We can build on the UCLP work on atrial fibrillation which many CCGs have collaborated on leading to an increase in anticoagulation rates in primary care and reduction in strokes.
- We have developed an Ambulatory Care Network at Whittington Health to address the issues of inappropriate admissions and long length of stay, through providing a safe alternative and an improved experience for patients.
- We can further develop the new model of care for CAMHS which is now referenced in 50% of CAMHS transformation plans nationally and being piloted in Camden.
- Barnet, Enfield and Haringey Mental Health Trust's Enablement Programme launched in April 2015 is helping people who use our services to "Live, Love and Do".
- The first Multidisciplinary Diagnostic Centre for cancer in England opened in NCL at UCLH.

What next

The next step is to build on this to complete the pan-NCL strategic plan for health and care services to improve outcomes and ensure whole system viability for the population, drawing on the Better Health for London Next Steps. We have started to build the trust between organisations that will be required to deliver this kind of plan. Providers have a good relationship and local authority engagement has been notably strong. The CCGs in NCL have extensive experience of commissioning: clinical leadership is embedded in what we do and we are knowledgeable about what patients and local residents need and want. However, we recognise that no single organisation or sector can do this alone. We have committed to working together to develop a plan that considers services at scale, but that takes into account the unique characteristics of local areas.

*UCLH also have a number of specialist hospitals including the Royal London Hospital for Integrated Medicine, the National Hospital for Neurology and Neurosurgery, the Royal National Throat, Nose and Ear Hospital, and the Eastman Dental Hospital

3 Case for change: health and wellbeing

People in NCL are living longer but in poor health
The number of older people is growing quickly, and older people have higher levels of health and care service use compared to other age groups. Older people in NCL are living the last 20 years of their life in poor health, which is worse than the England average.

There are different ethnic groups with differing health needs
There are large Black and Minority Ethnic (BME) groups in NCL. These groups have differing health needs and health risks. In addition, a quarter of local people do not have English as their main language, which creates additional challenges for effective delivery of health and care services.

There is widespread deprivation and inequalities
Poverty and deprivation are key drivers of poor health and wellbeing outcomes. Many local children grow up in poverty and many adults are claiming sickness or disability benefit. There are stark inequalities in life expectancy in NCL; for example, men living in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas.

There is significant movement into and out of NCL
Almost 8% of local people move into or out of NCL each year, which has a significant impact on access to health services and health service delivery, such as registering with a GP and delivering immunisation and screening programmes. Large numbers of people also come into NCL daily to work.

There are high levels of homelessness and households in temporary housing
There are increasing levels of homeless households in NCL. Four of the five boroughs are in the top 10% of areas in England for number of homeless households with a priority need, and all five are in the top 10% for number of households in temporary accommodation. Poor housing is one of the main causes of poor health and wellbeing (especially for children), and housing locally very is expensive.

Lifestyle choices put local people at risk of poor health and early death
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, but have not yet developed a long term health condition. The biggest killers in NCL are circulatory diseases and cancer; these diseases are also the biggest contributors to the differences in life expectancy across NCL.

There are poor indicators of health for children
The number of children living in poverty is high, particularly in Camden and Islington. Childhood obesity is high, whilst immunisation levels are low.

There are high rates of mental illness among both adults and children
The rates of mental illness are high in Enfield, Haringey and Islington, and many mental health conditions go undiagnosed. Just c.72k of the estimated c.194k people who have common mental health problems or severe mental health illness in NCL are known to GPs, and only 4% of adults on Care Programme Approach are in employment, compared to the London average of 5% and England average of 7%. In addition, up to a third of people with dementia in Camden and Enfield are thought be undiagnosed. People with mental health conditions are also more likely to have poor physical health.

There are differing levels of health and social care needs
The majority of people are largely healthy, but there is high use of health and social care by those with long term conditions, severe mental illness, learning disabilities and severe physical disabilities, dementia and cancer.

This suggests that the priority groups for focus are **people with mental illness and people at risk of poor mental or physical health**. It is also important to make sure **high quality services are available when required** for the majority of local people who are **not high users of services**. Consideration needs to be given to **reducing health inequalities**, the **requirements of different ethnic groups** and **the significant movement of people** into and out of NCL.

3 Case for change: care and quality

There is not enough focus on prevention across the whole NCL system (including health, social care and the wider public sector). Many people in NCL are healthy and well, but still at risk of developing long term health conditions. There is therefore an important opportunity for prevention of disease among these people. Between 2012 and 2014, around 20% (4,628) of deaths in NCL could have been prevented. In addition, the wider determinants of health such as poverty, housing and employment have a significant impact on individuals' health and wellbeing.

Disease could be detected and managed much earlier. There are people in NCL who are unwell but do not know it. For example, there are thought to be around 20k people who do not know they have diabetes, while 13% of local people are thought to be living with hypertension. There are opportunities for better, more systematic management and control of long term health conditions in primary care.

There are challenges in provision of primary care. There are low numbers of GPs per person in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person in all CCGs, but particularly in Camden and Haringey. Satisfaction levels and confidence in primary care is mixed across NCL. There are high levels of A&E attendances across NCL compared to national and peer averages, and very high levels of first outpatient attendances, suggesting that there may be gaps in primary care provision.

Lack of integrated care and support for those with a LTC. Levels of non-elective admissions are similar in NCL to other areas of London. However, there are high levels of hospitalisation for the elderly and those with chronic conditions. Many people with long term health conditions – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition.

Many people are in hospital beds who could be cared for at home. The majority of people with long hospital stays are elderly. This can be harmful to health, and not what people want. Delayed discharges are high in some hospitals in NCL and hundreds of people could potentially be cared for closer to home or in their home. There is also a large number of people whose admission to hospital might have been avoided.

There are differences in the way planned care is delivered. This may be because of levels of patient need, or differences in clinical practice. The number of people seen as outpatients 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.

Challenges in mental health provision. There is still stigma associated with mental illness, and many people either do not know how, or do not want, to access mental health services. At the same time demand for mental health services has increased due to reduced funding for other public services, increasing population, higher public expectations and changes to legislation. There are high levels of mental illness in NCL, and high rates of early death, particularly in Haringey and Islington. High numbers of people are admitted to hospital: the rate of inpatient admissions in NCL is 828 per 100k, compared to 587 England-wide. Many people receive their first diagnosis of mental illness in Emergency Departments. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services within urgent care.

Challenges in the provision of cancer care. There are many opportunities to save lives and deliver cancer services more efficiently. Late diagnosis is a particular issue, as is low levels of screening and low awareness of the symptoms of cancer in some groups. Waiting times to see a specialist and for diagnostics are long, with referrals to specialists having almost doubled in five years. There is a shortfall in diagnostic equipment and workforce, and a lack of services in the community. Some hospitals are seeing few patients with some types of cancer, in some cases less than 2 per week.

Workforce challenges. There is a significant shortfall predicted in GPs, nurses, allied healthcare professionals, with an aging workforce and increasingly attractive career opportunities elsewhere. Many people are leaving the NHS entirely. There is a high vacancy and turnover rate locally in health and social care. The number of GPs and practice nurses per person in parts of NCL is low.

Some buildings are not fit for purpose. Many of the local buildings are old and not fit for purpose, although there have recently been a number of major developments locally. It is estimated that 15% of NHS building space is not being used, incurring £20-25m a year in running costs. A large number of primary care buildings are also not fit for purpose – around 33% of GP premises in London need replacing.

Information technology needs to better support integrated care. The level of digital maturity of providers across NCL is variable, with most below the national average for digital capabilities, particularly their capability to share information with others. There is no NCL-wide governance structure or leadership team to implement digital transformation, resulting in fragmentation of information flows and duplication of effort.

3 Case for change: finance

- In 2015/16 the health system across NCL had an underlying deficit of around £120m deficit.
- If we do nothing that deficit will continue to rise over the next 5 years as a result of population growth and demand for healthcare, together with the forecast costs of delivering care exceeding the funding increases over the period to 2020/21.
- There is an increased demand for specialised services driven by advances in science and an ageing population. This has caused spending to rise more quickly than in other areas of the NHS, resulting in a financial challenge
- The scale of the financial pressures are still being validated but early analysis suggests that without action the NCL system will have a significant financial problem

4 In response to the case for change, we have collectively developed an overarching vision for NCL which will be delivered through the STP

Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind. It will be supported by a world class, integrated health and social care system designed around our residents.

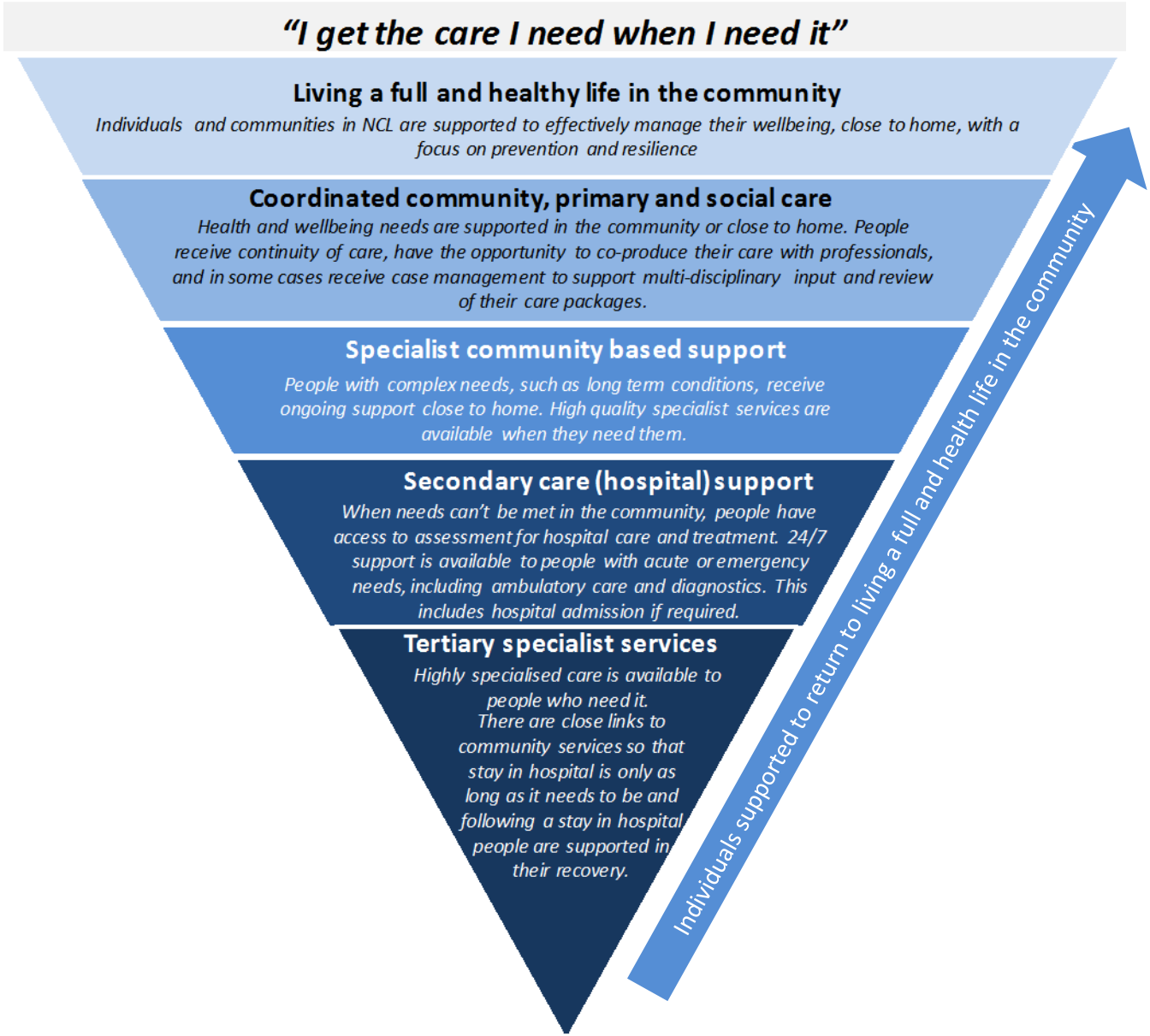
This means we will:

- help people who are well, to stay healthy
- work with people to make healthier choices
- use all our combined influence and powers to prevent poor health and wellbeing
- help people to live as independently as possible in resilient communities
- deliver better health and social care outcomes, maximising the effectiveness of the health and social care system
- improve people's experiences of health and social care, ensuring it is delivered close to home wherever possible
- reduce the costs of the health and social care system, eliminating waste and duplication so that it is affordable for the years to come
- at the same time we will ensure services remain safe and of good quality
- enable North Londoners to do more to look after themselves
- have a strong digital focus, maximising the benefits of digital health developments.

Our core principles are:

- residents and patients will be at the heart of what we do and how we transform NCL. They will participate in the design of the future arrangements.
- we will work together across organisational boundaries and take a whole system view
- we will be radical in our approach and not be constrained by the current system
- we will harness the world class assets available to us across the North Central London communities and organisations
- we will be guided by the expertise of clinicians and front line staff who are close to residents and patients
- we will build on the good practice that already exists in North Central London and work to implement it at scale, where appropriate
- we will respect the fact that the five boroughs in NCL have many similarities, there are significant differences which will require different responses in different localities.

4 The vision will be delivered through a consistent model of care



5 We have made a start on the journey towards realising our vision…

Establishing effective partnership working
Recognising that NCL-wide collaborative working across NCL is a relatively new endeavour, we are continuing to build relationships across the programme partners to ensure that health and care commissioners and providers are aligned in the process of transforming care. The STP Senior Responsible Officers (SROs) are working to bring CCGs, providers and local authorities together across the 5 boroughs recognising the history and context that underlies working together in a new way. We have established a governance framework that supports effective partnership working and will provide the foundation for the planning and implementation of our strategic programme going forward.

Understanding the size and nature of the challenge
We have undertaken analysis to identify the gaps in health and wellbeing, and care and quality in NCL in order to prioritise the areas we need to address. The clinical cabinet has finalised our case for change, which sets out a narrative in support of working in a new way and provides the platform for strategic change through identifying key areas of focus.

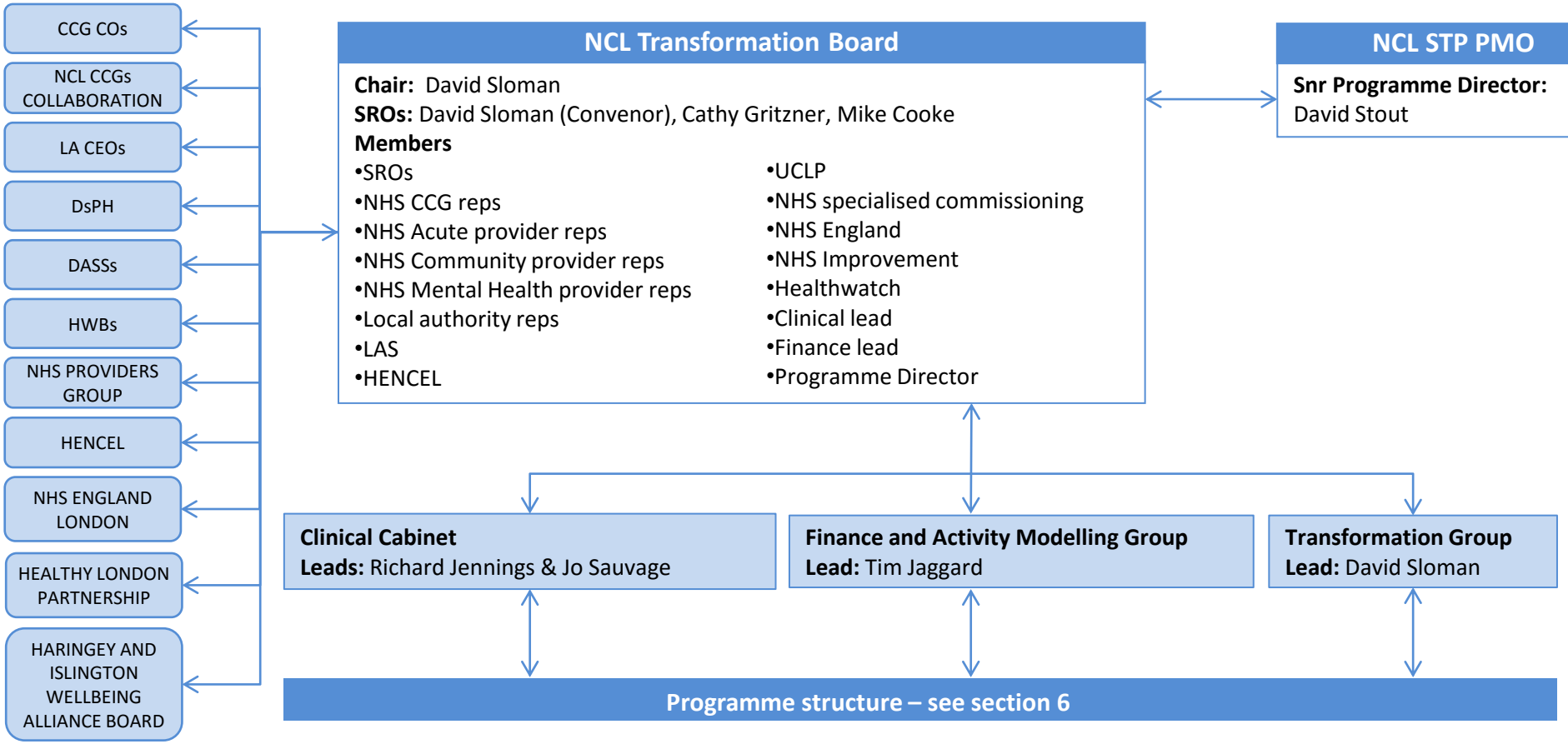
Finance directors from all organisations have been working well together to identify the projected NCL health and care position in 20/21 should we do nothing. We are working closely with NHS England to address the challenge around specialised commissioning, which is particularly relevant in our footprint given the specialist trusts that fall within the NCL geography.

Building the foundations of a major transformation programme
We have confirmed a budget which we feel reflects the scale of the challenge ahead of us. This funding will sustain the key roles we have already appointed to drive delivery – a senior programme director, two clinical leads and a communications and engagement director – as well as support the provision of additional resource across the various programme workstreams.

Delivering impact from year one
There is already work in train that will ensure delivery of impact before next April. CCG plans are being implemented which will build capacity and capability in primary care and delivering on the 17 specifications in the London Strategic Commissioning Framework (SCF). However we recognise that we will need to broaden our out of hospital strategy to ensure that it is co-produced and integrated with social care. Our case for change highlights some urgent issues that need addressing to ensure the short-term sustainability and viability of general practice, and our plans will ensure this as well as reducing variation and improving the offer to people across the patch. Specifically we are on track to deliver 8am – 8pm access across 100% of practices by 17/18 to deliver 135,000 additional GP and practice nurse appointments across NCL. Leveraging the opportunities afforded to us through our status as a London estates devolution pilot will potentially free up capital to provide much needed investment for primary care to deliver the larger-scale transformation required in line with our aspirational model of care. The implementation of our Local Digital Roadmap will support the delivery of the mental health, primary care and estates work, and our two Vanguards are continuing to progress with their plans.

5 We have developed a robust governance structure that enables collaborative input and steer from across the STP partners

The NCL STP **Transformation Board** meets monthly to oversee the development of the programme and includes representation from all programme partners. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. There are three subgroups supporting the Transformation Board. The **Clinical Cabinet** provides clinical and professional steer and input with CCG Chair, Medical Director, nursing, public health and adult social services and children's services membership. The **Finance and Activity Modelling Group** is attended by Finance Directors from all partner organisations. The **Transformation Group** is a smaller steering group made up of a cross section of representatives from organisations and roles specifically facilitating discussion on programme direction for presentation at the Transformation Board. Every workstream has a senior level named SRO to steer the work and ensure system leadership filters down across the programme.



6 We are in the process of designing a cohesive programme that is large scale and transformational in order to meet the challenge

Development of programme structure

- *Programme designed to meet the triple aim and the enablers needed to achieve this*
- *Senior NCL leaders performing SRO role for each workstream*
- *Scope of workstreams agreed*
- *Development of detailed delivery plans for each workstream based on logic model approach: reviewing inputs, activities, outputs and outcomes*

	A Health and wellbeing	B Care and quality	C Productivity	D Enablers
High level impact	• Improves population health outcomes • Reduces demand	• Increases independence and improves quality • Reduces length of stay	• Reduces non value-adding cost	• Facilitates the delivery of key workstreams
Initiatives	1. Population health including prevention *(David Stout, STP PD)* 2. Primary care transformation *(Alison Blair, ICCG CO)* 3. Mental health *(Paul Jenkins, TPFT CEO)*	4. Urgent and emergency care *(Alison Blair, ICCG CO)* 5. Optimising the elective pathway *(Richard Jennings, Whittington MD)* 6. Consolidation of specialties *(Richard Jennings, Whittington MD)*	7. Organisational-level productivity including: a) Commissioner b) Provider *(FDs)* 8. System productivity including: a) Consolidation of corporate services b) Reducing transactional costs and costs of duplicate interventions *(Tim Jaggard, UCLH FD)*	9. Health and care workforce *(Maria Kane, BEHMHT CE)* 10. Health and care estates *(Cathy Gritzner, BCCG CO and Dawn Wakeling, Barnet Council DASS)* 11. Digital / information *(Neil Griffiths, UCLH DCEO)* 12. New care models & new delivery models *(David Stout, STP PD)* 13. Commissioning models *(Cathy Gritzner, BCCG CO)*

Identifying and managing interdependencies across all workstreams, e.g. estates and digital enablers on population health, primary care transformation and mental health

6 Health and Wellbeing – Population health including prevention workstream

Development of a NCL approach to population health to achieve better health and better care at lower cost, with a reduction in health inequalities. Co-designing new models of care with residents and making best use of community assets including the voluntary and community sector. This includes a focus on preventing disease in the first place (primary prevention), preventing the deterioration/progress of disease (secondary prevention), earlier diagnosis and proactive management (including self-management) of certain conditions (e.g. diabetes), addressing the wider determinants of health such as homelessness and employment, and developing new models of care for particular population groups. The alignment of population health approaches to wider determinants of health through place-based and system leadership will drive improvement in outcomes.

Key features within scope include using population level data to understand needs across population groups (including children) and track health outcomes; aligning financial incentives with improving population health; development of different strategies for different population groups, including a whole system approach to prevention; delivering cost-effective interventions at a much larger scale to have a demonstrable impact on outcomes (e.g. smoking cessation and others from Better Health for London); developing integrated health and care records to co-ordinate services; scaled-up primary care systems; and close working with individuals to support and empower them to manage their own health and wellbeing.

6 Health and Wellbeing – Primary care transformation workstream

Focused on reducing demand by providing radically upgraded out of hospital care and support for individuals with different levels and types of needs. Close links with the urgent and emergency care workstream to achieve this. Investment in NCL GP capacity through additional staff and making time for patients initiatives to address immediate and long-term sustainability and transformation of GP practice capabilities. Particular focus on services for people with long term conditions and complex needs requiring continuity and planned care.

Development of primary care hubs to enable extended access and range of services to the community, integrating a range of health and wellbeing services around the individuals to support early intervention and prevent demand.

Development of federations of GP practices to deliver an enhanced, equitable offer to all patients, extending a range of primary care specialities across locality patient lists so residents can access the right service at the right time.

6 Health and Wellbeing – Mental health workstream

Transformation of mental health services to ensure needs are being met holistically across mental and physical health, addressing the social determinants of mental health problems and supporting our population to live well.

Areas of work include: building community resilience, strengthening of integrated out-of-hospital mental health teams, investing in the acute care pathway, developing a female Psychiatric Intensive Care Unit (PICU) and rehab housing, taking a population segmentation approach to Child and Adolescent Mental Health Services (CAMHS) supporting the delivery of Children and Young Person (CYP) plans, and scaling up of 24/7 all age liaison services

Through these workstreams the variations in mental and physical health outcomes across NCL will be addressed, including those for people with medically unexplained symptoms, depression, dementia and co-morbid physical issues such as diabetes.

Strong links with enabling workstreams including workforce, digital and estates.

6 Care and Quality - Urgent and Emergency Care (UEC) workstream

Focused on improving quality of urgent and emergency care and meeting standards, rather than improving out of hospital care which is covered in the primary care transformation workstream. Taking an integrated approach across health and social care will be key to transforming urgent care.

Improvement in NCL UEC services to reduce variability and improve quality and sustainability within the services currently named Emergency Departments, London Ambulance Service, East of England Ambulance Service, Urgent Care Centres and Walk-In Centres. Stabilisation of immediate issues in UEC services across NCL. Complete London-wide designation of UEC services work, and any necessary consolidation/ reconfiguration for all services within NCL, including Walk-In Centres. Implementation of Integrated Urgent Care.

Redesign of Urgent and Emergency Care pathways (including paediatric pathways) across NCL to include areas such as 7 day hospital development, transformation of UEC front door, and increasing the service offer for treatment at home by ambulance services. Implementation of digital urgent and emergency care, including direct booking to primary care. Review of workforce demand, capacity, roles and training.

6 Care and Quality – scope of workstreams and deliverables

Optimising the elective pathway

Understanding the variation in delivery of planned care between all acute providers in NCL and ensuring, where appropriate, pathways are consistent to ensure patient safety, quality and outcomes, and efficient care delivery. Focused on specialties with high volume or high variability, where there is opportunity to achieve high impact and realistic implementation.

Specialties in scope for the initial phase of work include: trauma and orthopaedics (T&O), general surgery, ophthalmology, cancer, gastroenterology and ear nose and throat (ENT). Analysis to support understanding of current variability to include: activity volumes by setting of treatments; volumes of activity with and without procedures; ratios of first to follow-up outpatient appointments; daycase rates; and source of outpatient referrals. Identification of potential areas for improvement and appropriate changes to pathways based on this analysis, as well as on national and international best practice such as the Shared Accountability approach (Intermountain Health) and similar value-based care models. Additionally, identification of variability in key NCL-wide cross-cutting themes, such as referral thresholds, pre-assessment, discharge and diagnostics will help inform plans to deliver improvement or standardisation, which might be applied to benefit all pathways of care in general.

Consolidation of specialties

Identification of clinical areas which might benefit from consolidation (bringing multiple services into one), networking across acute providers, or acute providers collaborating and/or configuring in a new way. Identification of areas where planned care services are heavily reliant on locums and where these services can either be consolidated, changed or transferred. Development and implementation of plans for delivering high quality and sustainable services in these areas. Central to this will be understanding activity volumes and workforce requirements at each site under different configurations. Underpinning analysis of volumes of activity, workforce composition, and projected workforce capacity against demand to be undertaken to support and ratify opportunity assessment. Work with the Finance and Activity Modelling Group and NHS England Specialised Commissioning to support identification of the opportunities for specialised commissioning (particularly around consolidation) within NCL. Support the development of delivery plans against the identified opportunities for specialised commissioning.

Close working with the new care models and new delivery models workstream to ensure alignment with overarching strategy for service configuration.

6 Productivity - Organisational-level productivity

Radically improving provider productivity is an essential part of the work to close the financial gap in NCL. Provider plans assume very significant delivery of CIP, improving provider productivity by c.2% per year up to 2020/21). This has been modelled on organisation-level improvements assuming little or no working across organisations: we know that 2% delivery each year will be tough and will required strong local leadership in all providers.

Providers in NCL have committed to delivering around 3% CIP delivery across the organisations, which is clearly an ambitious target but will set the tone for the approach to productivity as part of our STP. Our CIP delivery plans are based around the following schemes which align strongly to the recommendations coming out of the Carter review:

- **Corporate and administrative rationalisation:** minimising back office and administrative processes and streamlining teams and effort
- **Reducing spend on agency staff:** reviewing current spend on agency staff and putting in initiatives that reduce the need to depend on this
- **Prescribing with generics:** ensure this is the standardised approach across the organisation
- **Reviewing inventory and spend:** identifying any areas of high or varying spend and ensuring best value approach is consistent across the organisation
- **Reducing running costs on estates:** looking for ways to save on heating, lighting etc. based on best practice and eliminating any anomalies of high spend
- **Reviewing approach to procurement:** controlling stock levels and approach to procurement to ensure best possible value
- **Improving rostering efficiency:** Ensuring staff skill mix and level is appropriate to need

6 Productivity - System productivity workstream

Business as usual CIPs (defined as those deliverable within organisations, without collaboration or transformation) are already assumed within the organisational-level provider productivity workstream. Building on the learning from the Royal Free vanguard and other work that already exists in NCL, this workstream will specifically explore delivery opportunities beyond BAU CIPs and Carter opportunities through pan-organisational collaboration. As part of this, we will pay close attention to social and environmental impact and will use our powers as employers and purchasers effectively, including maximising social value and eliminating unnecessary resource use. This could include improving supply chains and freight consolidation, and stripping out waste from clinical pathways. In NCL, much work has already been undertaken in this area, for example the development of a shared procurement function across most trusts, outsourcing of payroll functions in several places, and advanced pathology and imaging rationalisation. Additionally many incremental savings are already included in business as usual CIP plans (for example, UCLH's Shelford procurement work, strategies for reducing agency spend. Other opportunities include:

- Workforce management and talent acquisition to reduce total cost of agency and locum staff
- Pharmacy, medical, surgical and food – procurement and distribution
- Digital information – pooled data across organisations irrespective of organisational boundaries
- Corporate finance functions – to create a collective and joined up resource management system

The workstream will also look collectively at structural issues which impact on capacity, capability and cost across the whole system, including the market management of residential and home care.

6 Enablers - Health and care workforce workstream

Development of new workforce models which are person-centred and focused on prevention and self-care, which will enable the delivery of the STP. Implementation of the right numbers of the right workforce, including review of existing roles and requirements for modified and new roles across all settings. Promoting active travel among staff to reduce air pollution and improve physical activity. Close working with the productivity workstream to develop pan-NCL strategies to reduce bank and agency spend, improve retention, and attract registered professionals and support staff into our footprint.

Enabled by the creation of an Improvement Academy building on UCLP's improvement and safety work where we will harmonise the way we recruit, retain and develop our staff across the footprint. The Local Workforce Action Board (LWAB) will oversee implementation of this work. The workstream will enable local authorities and health to work collaboratively to design a future workforce capable of delivering integrated, person-centred care.

6 Enablers - Health and care estates workstream

The management of One Public Estate across NCL to maximise use of the asset and improve facilities for delivering care.

Development of an overarching estates strategy to deliver this (underpinned by the development of a comprehensive estates database and a pan-NCL estates programme architecture with single governance), with a focus on a number of specific opportunities, including potential site redevelopment at St Ann's, St Pancras and Moorfields.

Development of a detailed plan for capital investment to ensure maximum benefit realisation and enable delivery of benefits in other workstreams. Significant development of out of hospital estates to respond to the planned transformation across the STP programme, including utilisation and efficiency improvement, development of primary care hubs, creating mental health community support, providing accessible urgent care.

6 Enablers– scope of workstreams and deliverables

Digital and information

STP requirements have driven the development of the digital vision: digitally activated population; new and enhanced care delivery models; integrated digital record access and management; insights driven learning health system; workforce integration and enablement; whole system digital delivery model; standards and compliance. These elements have been mapped against each of the STP workstreams. The capabilities required to deliver each theme are included in the local digital roadmap, phased by strategic priority, and based on NCL's current digital landscape and the state of readiness to move towards whole system digital transformation. Digital technologies could play a major role in encouraging behaviour change and self-care. Building on digital excellence and ambition of NCL local authorities, there is the potential to harness big data and analytics across the system to support primary and secondary prevention.

New care models and new delivery models

We are developing our model for population health for NCL. As part of that work we will review the most appropriate organisational delivery models for the effective delivery of our agreed approach to population health. Options which will be explored include the development of accountable care systems/organisations, multispecialty community providers (MCPs), primary and acute care systems (PACS). Through this work we will identify the preferred model(s) and agree an implementation plan for the agreed approach.

6 Enablers - Commissioning models

Developing strong commissioning in order to deliver on the NHS Five Year Forward View and meet the challenges addressed through the STP. Supporting partnership working to develop whole population models of care, improve outcomes for patients and address care, financial and quality gaps. Building on the extensive experience of commissioning, clinical leadership and knowledge about what local residents need and want that is already embedded within NCL CCGs to improve commissioning. Collectively developing plans for a new commissioning system that will implement the STP with the following characteristics:

- Covering a sufficiently large population to commission at scale, driving more ambitious change and productivity improvement
- Clarity and simplicity, speaking with one voice when needed
- Achieving consistency of standards and the reduction of variation in pathways
- Sharing scarce commissioning leadership, capacity and capability
- Managing jointly areas of change requiring consultation, capital/revenue investment etc.
- Take tough decisions when the resources invested do not make the biggest difference to our patients/residents

Our initial new commissioning model balances the importance of local relationships and existing programmes of work with the need to commission at scale.
At the NCL level, the 5 CCGs are developing a single commissioning and financial strategy executed through a single operating model so there is a consistent commissioning approach. We will also enhance commissioning arrangements where we do this across NCL, for example through a proposal for delegated commissioning for primary care. Appropriate governance arrangements will be put in place during 2016/17. At sub NCL level, CCGs will remain as statutory entities in their current configuration.

With our focus on population health systems and outcomes and the transition to new models to deliver these, we will need to consider how we further strengthen strategic commissioning over the next 2 years. In particular we will work with partners to consider how we commission with local authorities for integrated health and social care, as well as commissioning across pathways with NHS England functions. The responsibility for developing strategic place-based commissioning in NCL rests with health organisations and local authorities. We expect national support to ensure rules on procurement and competition do not create barriers to place based systems, as well as support for innovations in commissioning, contracting and payment mechanisms.

7 Over the next few months, we will continue to develop the STP

Next steps
Having established the priority areas to focus on through the case for change and identified immediate actions, we now need to make sure these come together as an overriding strategic plan that will govern the future development of services in NCL, and ensure this is reflected in operating plans and commissioning intentions. We in the process of considering the system as a whole in developing a full STP, rather than piecing together bottom up local plans that may not deliver transformation at scale when put together. However, we understand the urgency and need to move at pace. Between now and September we will have fully scoped and developed a formalised our approach to managing the multiple and complex interdependencies that exist between our transformation workstreams.

	Jul 16 – Oct 16 – *develop STP*	Oct 16 – Jan 17 – *implementation planning*	Feb 17 onwards - *comprehensive implement'n*
Trans-formation Board	• Set the scale of ambition for the STP, including outcomes for population health • Sign off and take ownership of pan-NCL STP • Establish what is best delivered at organisational / borough level as opposed to NCL wide	• Assure ambition is reflected in detailed plans • Sign off implementation plans and obtain endorsement from constituent bodies, ensuring ownership of detailed plan for each workstream	• Ensure plans on track and agree necessary mitigations • Lead engagement with staff, public and politicians
Trans-formation Group	• Develop and take ownership of pan-NCL plan, ensuring no gaps in scope • Ensure plan is aligned and interdependencies mapped	• Oversee management of interdependencies and continue to align existing work / operating plans / commissioning intentions around this	• Oversee STP implementation and ensure alignment with operating plans across NCL • Review plans and add to workstreams / scope if required as any gaps emerge
Clinical cabinet	• Assess workstream plans, ensuring they meet challenges set out in the case for change • Lead broader engagement with clinicians and practitioners across NCL to ensure ownership of case for change and active participation in STP development	• Undertake detailed work with each of the workstreams to achieve clarity on scope and clarify implications from a clinical perspective • Identify and support management of interdependencies	• Review case for change to identify any gaps and progress against the key areas • Support implementation of all workstreams with clinical input
Finance and activity model-ling group (FAMG)	• Develop a whole system finance and activity model, linking into workforce modelling requirements • Articulate quantifiable scale of ambition • Develop investment requirements to implement plans • Ongoing review of in-year delivery across the system to track against projected Status Quo	• Develop whole system productivity plans in detail, ensure 17/18 CIP plans aligned • Set out detailed proposal for transformation funding • Develop granular understanding of where and how benefits accrue, including phasing • Review potential to bring every organisation to financial balance and explore what a NCL system control total might mean	• Support inputs required for business case development where required, and track early impacts of workstreams / initiatives • Support implementation as required • Ensure transformation fund is allocated as required across workstreams
Work-streams	• Further develop plans for each workstream • Map out interdependencies • Provide input to FAMG for impact modelling and investment requirements	• Develop detailed delivery plans for each workstream with benefit phasing • Ensure interdependencies aligned	• Implementation and roll out of plans • Monitoring and evaluation to track impact and iterate plans to ensure continuous improvement

8 We will ensure all our stakeholders and wider programme partners are appropriately involved in the development of the programme

Engagement to date

- Workstreams have been engaging with relevant stakeholders to develop their plans.
- The general practice transformation workstream has worked collaboratively with the London CCGs (and local groups of GPs) to develop pan-London five year plan
- Mental health workstream was initiated at stakeholder workshop in January 2016 and a further workshop in May. Further service user and carer engagement is done via programme updates and specification for a citizens panel is being developed
- Significant engagement was undertaken through reprocurement of 111 process in urgent and emergency care workstream
- The estates workstream has been developed through a working group, with representatives from all organisations in scope
- NCL Digital Roadmap Group meets to define, shape and contribute to the interoperability programme with representation from all key organisations
- Early engagement with Health & Wellbeing Boards and the Joint Overview & Scrutiny Committee

Communications & engagement objectives

- To develop and support the engagement and involvement of STP partners across all organisations at all levels
- To ensure a strong organisational consensus on STP content and the future development of the strategic plan and its implementation. In particular, political involvement and support
- To co-ordinate and support STP partners in their own stakeholder engagement to raise awareness and understanding of:
  - the challenges and opportunities for health and care in NCL
  - how the STP – specifically the emerging priorities and initiatives - seeks to address the challenges and opportunities in order to develop the best possible health and care for our population
  - what the NCL strategic plan will mean in practice and how they can influence its further development and implementation
- To encourage and gather feedback from stakeholders – NHS, local government, local and national politicians, patients and the wider community – that can:
  - influence our emerging plans and next steps
  - help build support for the STP approach
- To ensure equalities duties are fulfilled, including undertaking equalities impact assessments

Delivering the objectives

- Forward planning in place to join up all partners and stakeholders in NCL footprint
- Dedicated communications lead now in place and taking with forward
- Stakeholder mapping underway for external and internal bodies through partnership work with CCG communications and engagement leads to include partners such as local authorities, NHS providers, GP practices and others to be determined as work progresses
- In addition to partners and stakeholders already consulted, we will identify opportunities for more STP partners clinicians/staff to have input into specific work streams, particularly local political engagement which will be key for community leadership of change
- Formal engagement with boards and partners already established and on-going
- Effective communications channels will be established for all stakeholders and partners for transparent contributions to ongoing plans and discussions, including staff, clinicians, patients, politicians etc.
- A core narrative has been created to cover our health and care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – in person-centred, accessible language
- Review requirements for consultation before March 2017

9 Conclusion and next steps

We know there is more work to do to crystallise our current workstreams plans and complete the wider strategic plan for NCL to ensure that we meet our challenge. Between now and our STP submission in October, we will build on the trust and excellent working relationships we have developed between partner organisations in order to fully define the scope of our plans and set out the tangible impact we expect to have, over specified periods of time. In parallel, we will be further exploring the opportunities that we have not yet quantified in order to show how we plan to close our financial gap. Specific additional opportunities potentially include reducing bed days through reduced length of stay, reducing variation in elective pathways and opportunities around estates. Assessing these will enable us to set out our ask for a fair share of the Strategic Transformation Fund to be used non-recurrently to support sustainability and transformation in our services.

Our case for change describes where we are now and where differences in the services available to local people can be seen, and is the first step in understanding what is not working so well. This will be used to guide the transformation of local services over the next 5 years. We have built a significant programme to respond to this that covers health and wellbeing; care and quality; productivity (at organisational and system level); and the enablers required to deliver transformation. There is strong leadership in place through senior workstream SROs and the overarching governance framework for the programme that includes clinical leadership, input and ownership from all partner organisations' finance directors, and a triumvirate of SROs representing health commissioners, providers and local authorities to ensure our work is truly led from a whole system perspective. We can build on the high quality work that is going on locally and intend to share best practice in general practice and primary care across all 5 boroughs, promoting learning and continuous improvement (for example, from Camden's prescribing behavioural change methodology).

Our immediate next step will be to work up the strategic plan through a process of co-creation, and to develop a credible proposition for population health and new care models in NCL with tangible options that all partners can buy into, building on the plans already underway for a new commissioning model in NCL. In parallel we will ensure we are addressing urgent issues faced – for example, the sustainability of some of our general practice provision across the patch, and improvement in the provision of mental health services for those with mental health problems – through a whole system, rather than a siloed, response. We will articulate this in terms of concrete, 18-month delivery plans for all of workstreams, particularly in terms of provider sustainability, primary care and mental health services. When we have a better idea of what population health will mean in terms of model(s) of care and delivery vehicles, we will be able to undertake detailed analysis of the impact on activity and patient flows and will articulate this in our next submission.

Difficult decisions lie ahead. These include working through arrangements that will mean that organisationally, the NCL health and care system will look very different following transformation. We are serious about doing something radically different and considering the transformation required across the whole system in NCL, not just individual boroughs or organisations. We are doing this because it is the right thing to do, and the only way forwards to empower people to live healthy and happy lives in NCL in a way that is financially and clinically sustainable. We recognise that we will need to work with all local partners, patients, people who use services, carers and professionals to best understand how to make all of this real over the coming months, and will begin the roll-out and implementation of our programme communications and engagement strategy to enable this.

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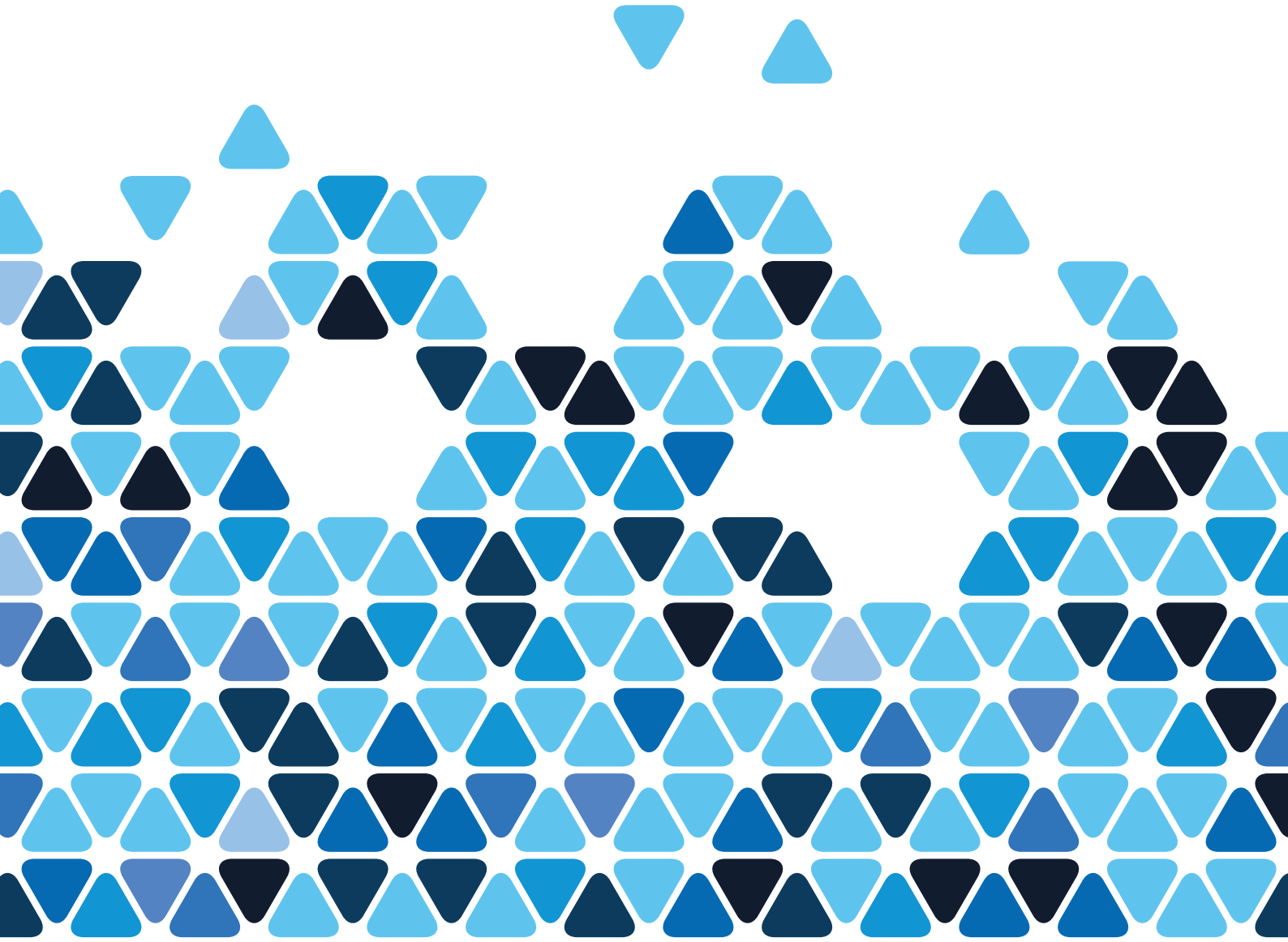
North Central London Sustainability and Transformation Plan

North Central London

Sustainability and Transformation Plan – Case for Change

September 2016



North Central London Sustainability and Transformation Plan

Contents

Foreword

On behalf of all our health and social care partners in North Central London, we present our Case for Change, which tells the story of where we are now. It is important that we recognise our current situation, because we take pride in the services we provide, and it will help us understand where services need to be improved.

We know that there are differences across North Central London; waiting times for services and health outcomes vary, and the quality of care and patient experience of health and social services is sometimes not as good as it could be. This Case for Change is the first step in understanding what is not working so well, and where improvements can be made.

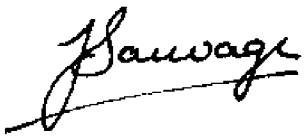
Local doctors, nurses and care workers are committed to working together to ensure we continue to improve. Never before has there been this opportunity to work so closely together to address the most important issues; to plan and deliver health and care for local people, with a strong focus on keeping people well.

In this document we describe the changing health and care needs of local people, and the key issues facing health and care services in North Central London. This document does not contain solutions but will be used to guide our understanding of where we need to transform local services over the next five years. We will work together to address the issues raised and to make sure we are able to provide high value and quality services to all.

We have come together as the North Central London STP Clinical Cabinet – a group of senior doctors, nurses and care professionals to work together to improve care and quality and make local services better. We believe that every person in North Central London should receive the same high quality standard of care. We recognise that we will need to work with all local partners, patients, carers and professionals to achieve this.

Signed by

Dr Richard Jennings, Co-Chair North Central London STP Clinical Cabinet (and Medical Director, Whittington Hospital NHS Trust)



Dr Jo Sauvage, Co-Chair North Central London STP Clinical Cabinet (and Chair, Islington CCG)

North Central London Sustainability and Transformation Plan

On behalf of the North Central London Clinical Board:

Dr Debbie Frost, Chair, Barnet CCG
Dr Caz Sayer, Chair, Camden CCG
Dr Mo Abedi, Chair, Enfield CCG
Dr Peter Christian, Chair, Haringey CCG
Dr Jonathan Bindman, Medical Director, BEH Mental Health NHS Trust
Dr Vincent Kirchner, Medical Director, Camden and Islington NHS Foundation Trust
Dr Joanne Medhurst, Medical Director, CLCH NHS Trust
Dr Alex Lewis, Medical Director, CNWL NHS Foundation Trust
Dr Cathy Cale, Medical Director, NMUH NHS Trust
Dr Stephen Powis, Medical Director, Royal Free NHS Foundation Trust
Dr Geoff Bellinghan, Medical Director, UCLH NHS Foundation Trust
Dr Matthew Shaw, Medical Director, Royal National Orthopaedic Hospital NHS Trust
Flo Panel Coates, Chief Nurse, UCLH NHS Foundation Trust
Helen Donovan, Executive Nurse Lead, Barnet CCG
Clare Johnston, Director of Nursing and People, Camden and Islington NHS Foundation Trust
Dr Julie Billett, Director of Public Health, Camden and Islington Council
Ray James, Director of Adult Social Services, Enfield Council
Jon Abbey, Director of Adult and Children's Services, Haringey Council

1 Executive summary

This Case for Change document describes the changing health and care needs of local people and the key issues facing health and care services in North Central London (NCL). It will be used to guide the transformation of local services to improve care and quality over the next five years.

NCL comprises five CCGs – Barnet, Camden, Enfield, Haringey and Islington – each covering the same area as the local London Borough. There are around 1.44m residents in NCL and the area spends £2.5bn on health care and £800m on social care. There are five acute hospitals, three specialist hospitals, three providers of community services and three providers of mental health services, as well as 237 GP practices.

The needs of local people drive local requirements for health and social care:

1. **People are living longer but in poor health:** the number of older people is growing quickly and older people have higher levels of health and care service use compared to other age groups. Older people in NCL are living the last 20 years of their life in poor health, which is worse than the England average. There are also large numbers of care homes in the north of NCL.

2. **There are different ethnic groups with differing health needs:** there are large Black and Minority Ethnic (BME) groups in NCL. These groups have differing health needs and health risks. In addition, a quarter of local people do not have English as their main language.

3. **There is widespread deprivation and inequalities:** poverty and deprivation are key drivers of poor health and wellbeing outcomes. Many local children grow up in poverty and many adults are claiming sickness or disability benefit. There are stark inequalities in life expectancy in NCL; for example, men living in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas.

4. **There is significant movement into and out of NCL:** almost 8% of local people move into or out of NCL each year, which has a significant impact on access to health services and health service delivery, such a registering with a GP and delivering immunisation and screening programmes. Large numbers of people also come into NCL daily to work.

5. **There are high levels of homelessness and households in temporary housing:** Four of the five boroughs are in the top 10% of areas in England for number of homeless households with a priority need, and all five are in the top 10% for number of households in temporary accommodation. Poor housing is one of the main causes of poor health and wellbeing (especially for children), and buying or renting housing locally is very expensive.

6. **Lifestyle choices put local people at risk of poor health and early death:** 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, but have not yet developed a long term health condition. The biggest killers in NCL are circulatory diseases and cancer; these diseases are also the biggest contributors to the differences in life expectancy across NCL.

7. **There are poor indicators of health for children:** the number of children living in

poverty is high, particularly in Camden and Islington. Childhood obesity is high, whilst immunisation levels are low.

8. **There are high rates of mental illness amongst both adults and children:** rates of mental illness are high in Enfield, Haringey and Islington, and many mental health conditions go undiagnosed. For example, up to a third of people with dementia in Camden and Enfield are thought to be undiagnosed. People with mental health conditions are also more likely to have poor physical health.

9. **There are differing levels of health and social care needs:** the majority of people are largely healthy, but there is high use of health and social care by those with long term conditions, severe mental illness, learning disabilities and severe physical disabilities, dementia and cancer.

This suggests that the priority groups for focus are people with mental illness and people at risk of poor mental or physical health. It is also important to make sure high quality services are available when required for the majority of local people who are not high users of services. Consideration needs to be given to reducing health inequalities, the requirements of different ethnic groups and the significant movement of people into and out of NCL.

There are challenges in the delivery of care and quality:

1. **There is not enough focus on prevention across the whole NCL system (including health, social care and the wider public sector):** many people in NCL are healthy and well, but still at risk of developing long term health conditions. There is therefore an important opportunity for prevention of disease among these people. However, only 3% of health and social care funding is spent on public health in NCL. Between 2012 and 2014, around 20% (4,628) of deaths in NCL could have been prevented. In addition, the wider determinants of health such as poverty, housing and employment have a significant impact on individuals' health and well-being. There are opportunities for greater integration across the NCL health and care system to enable a focus on prevention and early intervention.

2. **Disease and illness could be detected and managed much earlier:** there are people in NCL who are unwell but do not know it. For example, there are thought to be around 20,000 people who do not know they have diabetes, while 13% of local people are thought to be living with hypertension. There are opportunities for better, more systematic management and control of long term health conditions in primary care, in line with evidence-based care standards.

3. **There are challenges in primary care provision in some areas:** there are low numbers of GPs per person in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person in all CCGs, but particularly in Camden and Haringey. Satisfaction levels and confidence in primary care is mixed across NCL. As referenced above, there are high levels of undiagnosed long term conditions in NCL. There are also high levels of A&E attendances across NCL compared to national and peer averages, and very high levels of first outpatient attendances, suggesting that there may be gaps in primary care provision.

4. **Lack of integrated care and support for those with long term conditions:** levels of non-elective admissions are similar in NCL to other areas of London. However, there are high levels of hospitalisation for the elderly and those with chronic conditions. Many people with long term health conditions – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition. The lack of available social care services in some parts of NCL may contribute to high levels of hospitalisation for some groups.

5. **There are many people in hospital beds who could be cared for at home:** the majority of people who stay for a long time in hospital beds are elderly. Staying longer than necessary in hospital is often harmful to health, and not what people want. Delayed discharges are high in some hospitals in NCL and hundreds of people

could potentially be cared for closer to home or in their home. There is also a large number of people whose admission to hospital might have been avoided.

6. **Hospitals are finding it difficult to meet increasingly demanding emergency standards:** three of the five acute hospitals in NCL do not meet the 16-hour consultant presence standard at the weekend. Within A&E, there are shortages of middle grade doctors. Local hospitals are not meeting key quality standards for people admitted as emergencies.

7. **There are differences in the way planned care is delivered:** variation in the delivery of planned care may be because of the levels of patient need, or because of differences in clinical practice. The number of people seen as outpatients 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.

8. **Challenges in mental health provision:** there is still a lot of stigma associated with having a mental illness, and many people either do not know how, or do not want, to access mental health services. Information on help and support within local communities is not available everywhere. Demand for mental health services has increased due to social pressures related to reduced funding for public services, increasing numbers of people, higher public expectations and changes to legislation. There are very high levels of mental illness in NCL, and high rates of early death, particularly in Haringey and Islington. Community based teams cannot manage people with the most serious issues and therefore high numbers of people are admitted to hospital – many under the Mental Health Act. Many people receive their first diagnosis of mental illness in Emergency Departments. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care. There is also no high quality health-based place of safety in NCL.

9. **Challenges in the provision of cancer care:** there are many opportunities to save lives and deliver cancer services more efficiently. Late diagnosis of cancers is a particular issue, as is low levels of screening for cancer and low awareness of the symptoms of cancer in some groups of people. Waiting times to see a specialist and for diagnostics are long, with referrals to specialists having 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 the weekend. 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.

10. **Workforce challenges:** there are a number of workforce challenges in NCL. There is a significant shortfall predicted in GPs, nurses, allied healthcare professionals with an aging workforce and increasingly attractive career opportunities outside London. Many people are leaving the NHS entirely. There is a high vacancy and turnover rate locally in health and social care. The number of GPs and practice nurses per person in parts of NCL is low, especially Haringey.

11. **Some buildings are not fit for purpose:** many of the local buildings are old and not fit for purpose, although there have recently been a number of major developments locally. Good quality buildings that are fit for purpose reduce infection and the length of time people stay in hospital, make it easier for staff to do their jobs and are a more pleasant environment for people in hospital and reduce costs. It is estimated that 15% of NHS building space is not being used, incurring £20-25m a year in running costs. A large number of primary care buildings are also not fit for purpose – around 33% of GP premises in London need replacing.

12. **Information technology needs to better support integrated care:** the level of digital maturity of providers across NCL is variable, with most below the national average for digital capabilities, particularly their capability to share information with others. There is no NCL-wide governance structure or leadership team to implement

digital transformation, and individual organisations continue to operate independently within their own areas with resultant fragmentation, lack of joined up information flows and duplication of effort.

13. **Financial challenge:** there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers in NCL are already £121m in deficit in 2015/16 and, if nothing changes, will be £876m in deficit by 2020/21. This does not include the health budget impact of the local authority financial challenge, which has not been calculated.

In summary, this suggests the following areas for focus:

1. Health promotion, particularly focusing on those who are healthy and well but are at risk of developing long term health conditions.
2. Early detection and management of disease and illness, especially through more systematic management and control of long term health conditions in primary care.
3. The quality of primary care provision and the primary care workforce. It also suggests a focus on reducing variation between practices. This may reduce Emergency Department attendances, short stay admissions and first outpatient attendances.
4. Better integration of care for those with long-term conditions, and ensuring that suitable and sufficient social care is available. There also needs to be a focus on people in residential and nursing homes.
5. Reducing the length of stay and avoidable admissions in acute hospitals, in partnership with social care.
6. The delivery of emergency services in hospitals in NCL.
7. Understanding the differences between hospitals in the delivery of planned care in greater detail.
8. The provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis and access to integrated services.
9. Recruiting and retaining the workforce, particularly where there are high vacancy and turnover rates or shortages in staff, and a focus on new roles and developing the existing workforce through new skills and ways of working, as well as adapting roles to changing requirements.
10. The cancer pathway across primary and acute providers.
11. Buildings that are old, expensive to run and not fit for purpose, and developing buildings that support patient and clinical needs.
12. Developing system-wide governance and leadership to support the implementation of integrated information sharing and technology.
13. Addressing the projected financial deficit.

2 Context

North Central London (NCL) comprises five CCGs – Barnet, Camden, Enfield, Haringey and Islington – each coterminous with the local London Borough.

The number of people living in NCL is approximately 1.44 million, and the area has a £2.5 billion health budget and £800 million social care budget. There are four acute trusts: The Royal Free London NHS Foundation Trust (sites in scope including Barnet Hospital, Chase Farm hospital and the Royal Free Hospital in Hampstead), University College London Hospitals NHS Foundation Trust (sites in scope including University College Hospital[1]), North Middlesex University Hospital NHS Trust, and the Whittington Health NHS Trust. In addition, there are three single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust.

Community services are provided by Central and North West London NHS Foundation Trust (St Pancras hospital site), the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust (sites in scope including Edgeware community hospital and Finchley memorial hospital). Mental health services are provided by the Tavistock and Portman NHS Foundation Trust (sites in scope include the Tavistock clinic, the Portman clinic and Gloucester House day unit), Camden and Islington NHS Foundation Trust (sites in scope including Highgate Mental Health Centre and St Pancras Hospital), and Barnet, Enfield and Haringey Mental Health Trust (sites in scope including St Ann's Hospital, Edgeware Community Hospital, Chase Farm Hospital, Barnet Hospital and St Michael's Hospital).

In addition, there are 237 GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative.

Some information about the local health and social care landscape is shown in Exhibit 1 overleaf.

[1] *UCLH also have a number of specialist hospitals including the Royal London Hospital for Integrated Medicine, the National Hospital for Neurology and Neurosurgery, the Royal National Throat, Nose and Ear Hospital, and the Eastman Dental Hospital*

Exhibit 1 – NCL overview

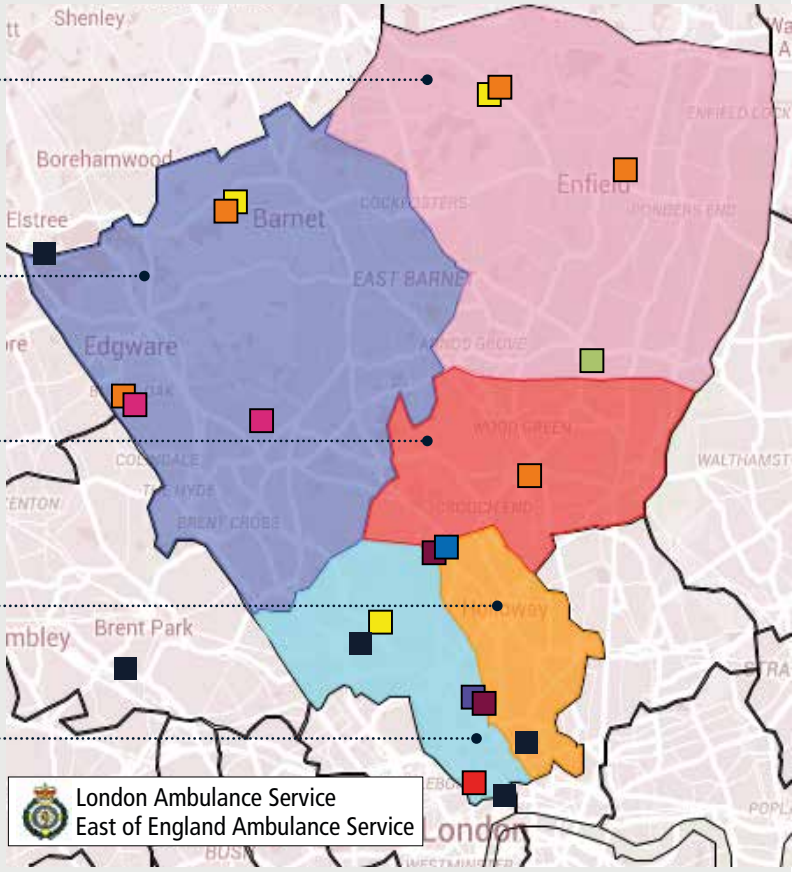
Enfield CCG / Enfield Council
~320k GP registered pop
~324k resident pop
49 GP practices

Barnet CCG / Barnet Council
~396k GP registered pop
~375k resident pop
62 GP practices

Haringey CCG / Haringey Council
~296k GP registered pop
~267k resident pop
45 GP practices

Islington CCG / Islington Council
~233k GP registered pop
~221k resident pop
34 GP practices

Camden CCG / Camden Council
~260k GP registered pop
~235k resident pop
35 GP practices



Total health spend £2.5bn

Total care spend £800m

NHS England

Primary care spend £~180m

Spec. comm. spend £~730m

- BEH Mental Health NHS Trust (main sites, incl Enfield community)
- Camden and Islington NHS FT (and main sites)
- North Middlesex University Hospital NHS Trust
- The Royal Free London NHS FT
- University College London Hospitals NHS FT
- Whittington Health NHS Trust (incl Islington and Haringey Community)
- Central and North West London NHS FT (Camden Community)
- Central London Community Healthcare NHS Trust (Barnet Community)
- Specialist providers

Other specialist providers out of scope:
GOSH; MEH; TPFT; RNOH

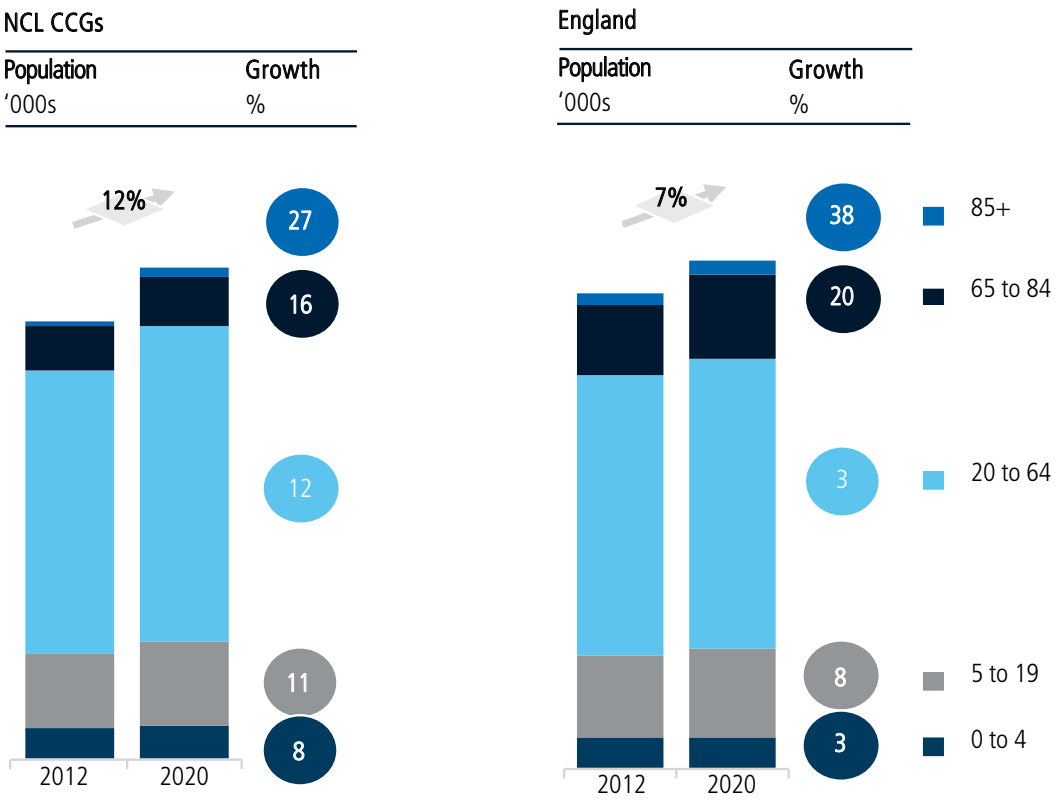
Note: registered pop data shows 2014 figures. Source: ONS

3 Health and wellbeing

3.1. People in NCL are living longer but in poor health

As shown in Exhibit 2, older people (aged 65+) are the fastest growing group of people in NCL, although in total numbers[1] this age group will remain the second smallest in 2020, after children aged 0-4 years old. Older people have much higher levels of health and care service use compared to other age groups, particularly hospital admissions and use of community services; the rates of most long-term health conditions also significantly rise with age[2].

Exhibit 2 – Growth in numbers of people in NCL and England



Source: Population Projections Unit, Office for National Statistics, 2012. The data shows similar growth rates for 2016-2021

Whilst overall life expectancy is increasing for all NCL residents, people in NCL on average live the last 20 years of their lives in poor health; for Islington this is much worse than the rest of England[3].

There are also large numbers of care home beds in the north of NCL; for example, Barnet and Enfield have 13% of London's care home beds but have only 8% of its people[4]. This presents a substantial challenge to the health and care system, and an opportunity for improvements in quality and sustainability, which could lead to reductions in the cost of admissions to hospitals from care homes and improvements in the quality of life of residents.

3.2. There are different ethnic groups with differing health needs[5]

Levels of ethnic diversity vary across NCL, ranging from 32% of people in Islington from a Black and Minority Ethnic (BME) group to 42% in Enfield. The largest BME communities in NCL are Turkish, Irish, Polish and Asian (Indian and Bangladeshi) people. There are also high numbers of people from Black Caribbean and African communities, in particular in Haringey and Enfield. The number of people from BME communities is much greater in younger age groups.

Health needs vary across BME communities. For example, there is a greater risk of diabetes, stroke or renal disease for some BME people compared to White English people; and people from some BME communities, including Black Caribbean, African and Irish, use more hospital services[6]. The number of BME people across NCL is expected to increase slightly from 37% in 2012 to 38% in 2020[7]. The biggest increases in BME communities are forecast in Barnet and Enfield. The fastest growing ethnic communities across NCL are the Chinese and Other group followed by Black Other and Asian ethnic groups.

The different health needs for different ethnic groups

"They know how to eat well but their husband complain if they don't serve traditional food all the time" (Bangladeshi young women) [sic]

Source: Healthwatch Camden

Overall, around a quarter of people in NCL do not have English as their main language. This diversity presents challenges, both in addressing potentially new and complex health needs, and delivering accessible healthcare services.

What good looks like: Care planning for type 2 diabetes patients in Tower Hamlets

Tower Hamlets has a high prevalence of type 2 diabetes. This is partially due to the large Bangladeshi resident population, who are more susceptible to developing this condition. Since 2010, GPs have been providing patient centred care plans to patients which allow individuals to manage their own conditions and prevent the onset of other conditions. By 2014, diabetes patients on a care plan in Tower Hamlets had achieved the highest levels of blood pressure and cholesterol control in the country and had better control of their own condition.

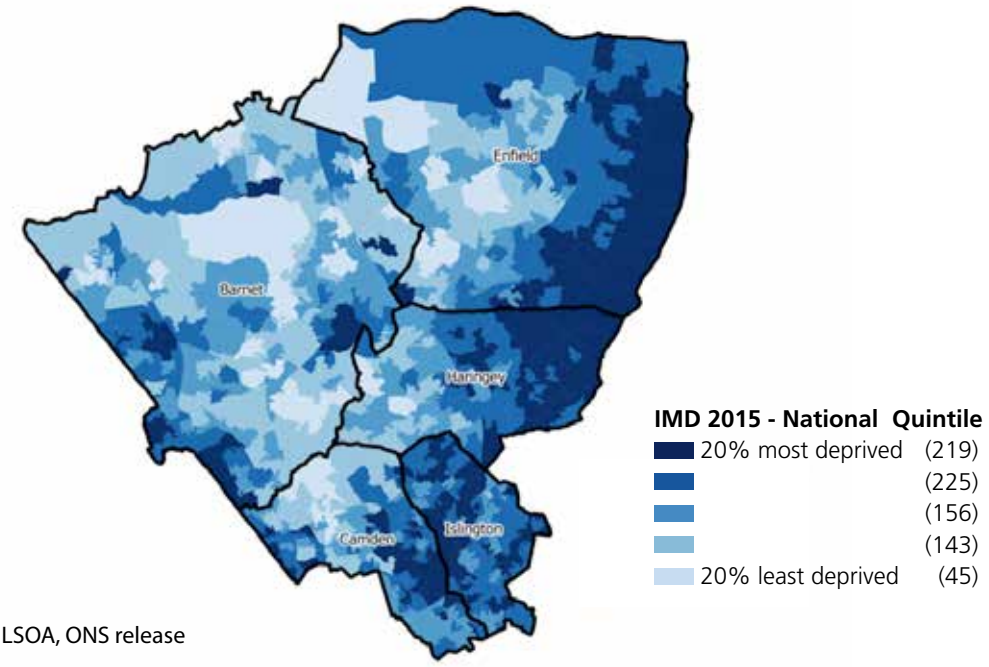
Learning from local best practice examples is part of the NCL STP process. We have the opportunity to roll out successful care programmes such as care planning for diabetes patients across all the boroughs, to ensure every individual can access the high quality care they need.

Source: Tower Hamlets JSNA, 2015

3.3. There is widespread deprivation and inequalities

There is a wide spread of deprivation across NCL, but people tend to be younger and more deprived in the east and south, and older and more affluent in the west and north. Deprivation across NCL is shown in Exhibit 3.

Exhibit 3 – Deprivation levels across NCL



Source: IMD 2015 by LSOA, ONS release

Poverty and deprivation are key causes of poor health outcomes. Higher levels of deprivation are linked to many health problems, such as prevalence of long term health conditions. 30% of NCL children grow up in child poverty[8], with 6% living in households where no-one works[9]. More than 40,000 working age adults in NCL are claiming sickness or disability related out-of-work benefits[10], and the gap in the employment rate for those in contact with more specialised mental health services and the overall employment rate is 63%[11]. There are stark inequalities in life expectancy; for example, men in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas[12].

What good looks like: addressing the social determinants of health

The Mental Health Working service supports people with a long term mental health problem to make the journey back into work through training, education, employment or volunteering. It also supports those who are already in work, to help them remain in employment. Experienced advisors work with each individual to develop a personalised support plan identifying barriers to work, career goals and steps needed to find, remain in or return to work. The advisors then provide ongoing advice and guidance. The programme is jointly commissioned by the London Boroughs of Camden and Islington.

If replicated throughout NCL this could improve and maintain public mental health whilst increasing the levels of employment.

Source: mind.org.uk

3.4. There is significant movement into and out of NCL[13]

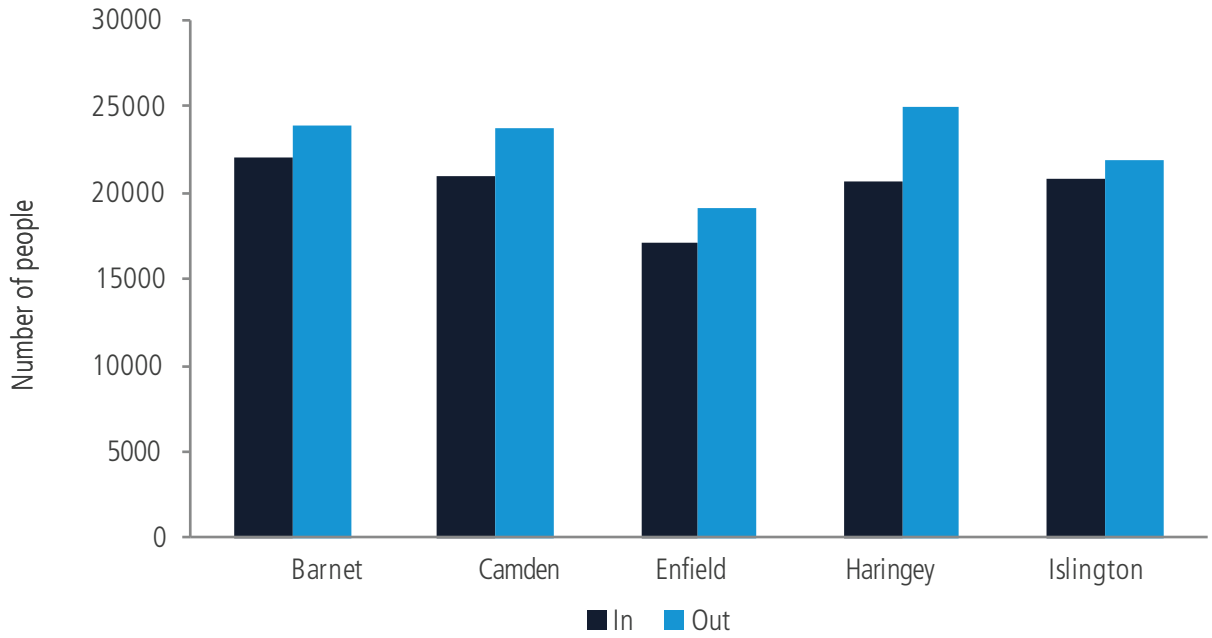
All boroughs in NCL experience significant population inflows and outflows. In 2014, on average 20,000 people moved into each of the NCL boroughs from other areas of England and Wales, whilst just under 23,000 moved out to other parts of the country. This is illustrated in Exhibit 4. Camden, Islington and Haringey experienced the highest population churn, with around 10% of people in these boroughs moving out in 2014. The pattern of people moving in and out is different across age groups. In Islington and Camden, more people aged 15 to 29 from other areas move in. For other all other age

groups, more people move out to other areas. However, in contrast, for all NCL boroughs there are more people from outside the UK moving in than leaving. This contributes to a demographic profile that has a high level of non-native inhabitants.

Large numbers of people also come into NCL every day to work. These people sometimes use health and social care services, particularly urgent care, whilst being registered with a GP outside NCL.

This high level of movement of people into and out of NCL has a significant impact on access to health services and health service delivery, such a registering with a GP and delivering immunisation and screening programmes.[14]

Exhibit 4 – Internal migration into and out of NCL



Source: ONS mid-year population estimates, 2014

3.5. There are high levels of homelessness and households in temporary housing

There is a growing demand for housing in NCL, and increasing levels of homeless households[15]. People and families who are homeless or in temporary housing require support from numerous local public services. Housing is often one of the main causes of poor health and wellbeing, especially for children, and buying or renting housing locally is very expensive.

Homelessness and temporary housing

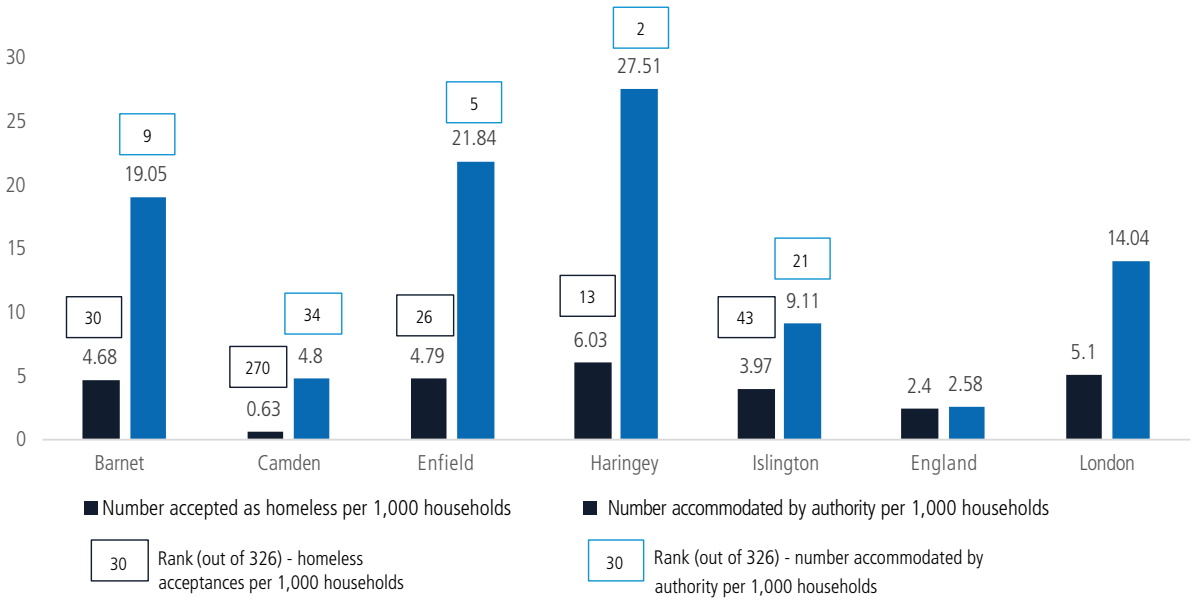
'I became homeless and had a nervous breakdown. My family is a single parent family. I got a place at University, but I became home sick and wanted to come home to London. When I came back I went to my GP who diagnosed me. Finding accommodation was really hard on a low income. I couldn't afford a deposit and I was street homeless for a while. I was diagnosed in the London Borough of Barnet and went through IAPT [Improving Access to Psychological Therapies]. I had no family or friends and no help from anyone. I felt lost. As I am under 35 I was not eligible for single accommodation and had to take shared accommodation. I then went to a homeless charity, but they did not have the expertise to understand what I needed.

Source: Healthwatch Islington

All of the NCL boroughs except Camden are in the top 10% of areas in England for homeless

households with a priority need, and all are in the top 10% for households in temporary accommodation (Barnet, Enfield and Haringey are in the top 3%)[16]. This is shown in Exhibit 5.

Exhibit 5 – Homeless acceptances and households accommodated by authority per 1,000 households [5]



Source: www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

What good looks like: integrated care for the homeless

Central London Community Healthcare (CLCH) provides services to homeless people from Great Chapel Street Medical Centre. A fully integrated model, delivered using a multidisciplinary team which includes primary care, social care and mental health practitioners delivers services including dentistry, vaccinations and mental health support. The services have been designed around the needs of the homeless population. A case management approach is taken for patients with multiple, complex needs. Outreach clinics for people who are harder to engage, phased in two parts, also operate from the medical centre: a nurse led targeted outreach clinic and a winter enhanced outreach service offers which provides health assessments and advice at Cold Weather Shelters. The outreach teams also work with acute providers to train staff in the areas of health and social care entitlements for the homeless.

This service could be scaled up as part of the NCL STP process, to ensure the homeless population are better supported by our health and care services.

Source: Great Chapel Street Medical Centre website, accessed August 2016

3.6. Lifestyle choices put local people at risk of poor health and early death

Lifestyle behaviours such as smoking, alcohol consumption, physical inactivity, poor diet and being overweight cause poor health, worsening of disease, multiple illnesses and early death . 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, but have not yet developed a long term health condition[18].

Risk factors among different age groups

"Older women smoke but won't admit to it!"

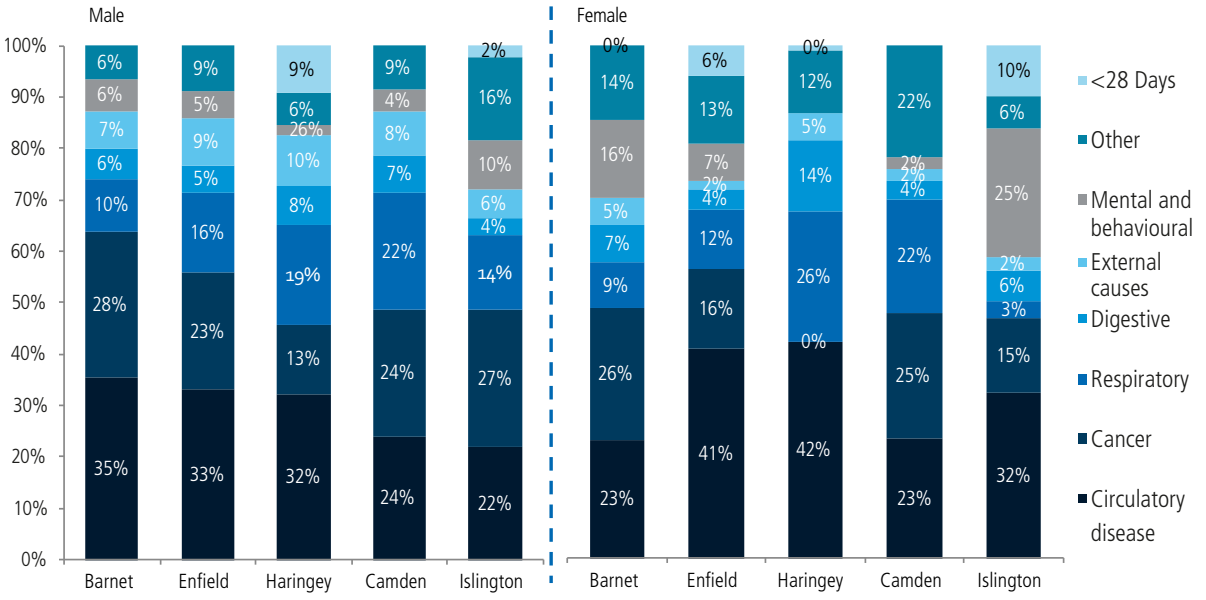
Source: Healthwatch Camden

Within NCL, the number of overweight children aged 10 to 11 years is much higher than the England average in three of the five boroughs – Enfield, Haringey and Islington[19]. It is likely that being overweight is partly responsible for more than a third of all long term health conditions in NCL[20]. Smoking cuts lives short and is partly responsible for around one in six early deaths of local people[21]. Alcohol-related hospital stays are much higher than average in Islington[22]. Among older people, Camden, Haringey and Islington have much higher numbers of people who fall resulting in serious injury[23]. Importantly, lifestyle and clinical risk factors tend to cluster in the same individuals and groups of people.

As shown in Exhibit 6, the biggest killers in NCL are circulatory diseases and cancer; these diseases are also the biggest contributors to the differences in life expectancy across NCL.

Exhibit 6 – Breakdown of male and female life expectancy gap by cause of death

Breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile within each borough, by percentage cause of death, 2012-2014



Source: LHO segment tool, May 2016

3.7. There are poor indicators of health for children

Supporting children to have the best start in life is very important to their future health and life opportunities. However, a third of children in NCL do not reach a good level of development by age 5[24], and there are numerous opportunities to improve the health and wellbeing of children during these important early years.

Exhibit 7 – Childhood prevention indicators

	Barnet CCG	Camden CCG	Enfield CCG	Haringey CCG	Islington CCG	England Average	London Average
Excess weight in 4-5 year olds (2014-15)	19.9	20.3	23.4	22.9	22.1	21.9	22.2
Excess weight in 10-11 year olds (2014-15)	32.6	34.3	41.4	37.1	38.1	33.2	37.2
Vaccination coverage MMR (2 yrs) (2014-15)	80	86	89	87	94	92	87
Vaccination coverage MMR (5 yrs) (2014-15)	74	80	86	84	90	92	81
Children in poverty (2013)[1]	15.8	27.6	25.5	24.4	32.4	18.6	21.8
Low birth weight at full term, % (2014)[1]	2.5	2.9	2.7	3.1	3.5	2.9	3.2
Breastfeeding initiation at 48hrs, % (2014-15)[1]	85.1	90.5	86.7	90.9	88.2	74.3	86.1
Infant mortality rate, per 1000 live births (2011-13)[1]	2.6	4.1	4.6	3.4	2.3	4.0	3.8

Better than England average | Not significantly different than England average | Worse than England average

Source: PHE 2015, HSCIC 2015. 1: Public Health Outcomes Framework Data Tool, Public Health England

The number of 0-4 year olds is growing twice as fast as in the rest of England overall[25], and the number of school age children (5-19 years) is also increasing[26]. There are higher than average numbers of children living in poverty, particularly in Camden and Islington[27]. As shown in Exhibit 8, CCGs in NCL have high levels of childhood obesity, and immunisation levels are particularly low compared to other similar areas[28].

3.8. There are high rates of mental illness amongst adults and children

The number of children with a mental health disorder is above the England average in Enfield, Haringey and Islington, which have large areas of deprivation[29]. As shown in Exhibit 8, the number of people with serious mental illness (psychotic disorders) is higher than the England average in all five boroughs. Islington has the highest rate of psychotic disorders in England, and Camden the third highest. People with psychotic disorders are by far the largest group in mental health inpatient services, including 24-hour long term rehabilitation units. Islington has the highest number of people with diagnosed depression in London[30].

Exhibit 8 – Mental wellbeing indicators

	Indicator	Time period	Barnet	Camden	Enfield	Haringey	Islington	England average	London average
Children and young people	Prevalence of any mental health disorders in children (5-16 yrs)	2014	8.4%	9.1%	9.9%	9.9%	10.1%	9.3%	9.3%
	Prevalence of emotional disorders in children (5-16 yrs)	2014	3.3%	3.6%	3.9%	3.9%	4.0%	3.6%	3.6%
	Children rate per 10,000 identified as 'in need' due to abuse, neglect or family dysfunction	2015	60%	57%	59%	50%	62%	67%	60%
Adults	Serious mental illness prevalence, all ages[1]	2014/15	1.0%	1.4%	1.0%	1.3%	1.5%	0.9%	1.1%
	Depression prevalence, 18 and over[1]	2014/15	5.5%	6.3%	4.8%	5.1%	7.5%	7.3%	5.3%
	Gap (% point) in the employment rate for people with mental health	2014/15	63%	62%	65%	65%	65%	66%	66%
	Excess premature (18-74 yrs) mortality rate from serious mental illness (DSRs per 100,000)	2013/14	286	263	265	360	342	352	322

Better than the England average | Not significantly different to the England average | Worse than the England average

Source: Public Health of England (2016); [1] QOF data (2014/15); [2] Primary Care Web tool (accessed 11th April 2016).

People with mental health conditions are more likely to have a lifestyle that may lead to poor physical health. For example, almost half of adults with severe mental illness are smokers, compared to less than a quarter of people without a severe mental illness[31]. It is well established that people with a mental illness often also have poor physical health. There is also a high rate of psychoactive substance use in people with mental illnesses.

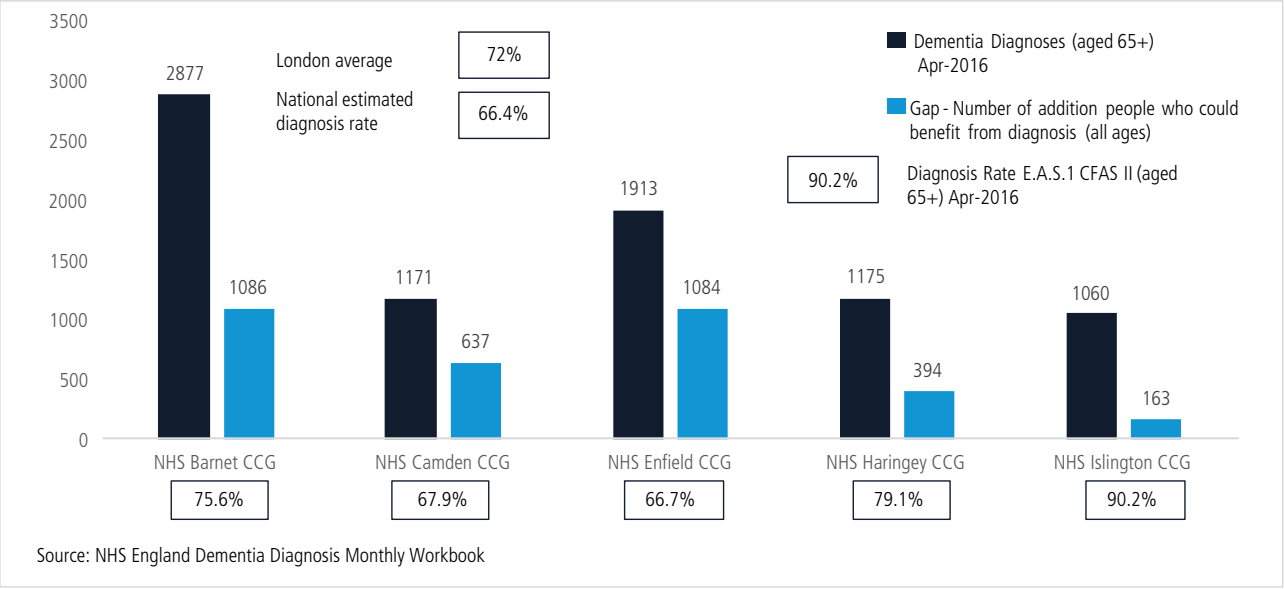
The number of people with undiagnosed dementia is higher than the London average in two of the five boroughs. As shown in Exhibit 9, nearly a third of people with dementia across NCL are thought to be undiagnosed, with a particularly high proportion in Camden and Enfield[32]. Even where diagnosis rates are higher, as in Barnet, Haringey and Islington CCGs, there are thought to be many more people remaining undiagnosed[33]. This indicates that there is a need to increase detection of dementia in primary care, focusing on practices with relatively low diagnosis rates and those with a significant challenge due to a large list size. Diagnosed mental health conditions, particularly dementia, are likely to increase, due to an ageing population and increased identification of dementia sufferers.

Dementia care

Jenny, 93, has dementia and a mental health condition. Her daughter telephoned to say she is finding it very difficult as her carers service was stopped three weeks ago. Haringey Council have asked her mother to go in to see them, but her mother doesn't comprehend what is going on and the daughter doesn't have a wheelchair. There is also a need for respite.

Source: Healthwatch Haringey

Exhibit 9 – Dementia indicators, April 2016



Source: NHS England Dementia Diagnosis Monthly Workbook

3.9. There are differing levels of health and social care needs

One way of understanding the needs of local people is to break down the population into different groups. This can be done by grouping people of a similar age and with similar health needs. The analysis can then be used to identify how work across health and social care can achieve a greater impact, and estimate the potential benefits that can be achieved through interventions targeting particular groups.

Exhibit 10 shows that there are around 1.1m people (78% of the population) in NCL who are mostly healthy and use an estimated 37% of health and social care. However, there are around 247,000

(17%) people with one or more long-term conditions, who use an estimated £764m (35%) of health and social care; the estimated 71,000 older people with long term conditions are particularly high users of health and social care (c. £4,300 per person per annum).

There are an estimated 21,000 people in NCL with severe mental illness who are individually very high cost (for example, c. £16k per person per year for those over 70) as are those with learning disabilities and severe physical difficulties; an estimated £246m is spent on fewer than 14,000 adults with a physical and learning disabilities (c. £17,000 per person per year).

Reported dementia affects an estimated 5,400 people, with an estimated spend of around £105m per year spent on this group (an average of nearly £20,000 per person per year). There are also around 17,000 people with cancer, costing an estimated £120m per year in total.

The calculation used to generate these figures is shown in more detail in Appendix 1.

Exhibit 10 – NCL health and care segmentation, 2014-15

Population (k) | Total spend, £m | Spend per head

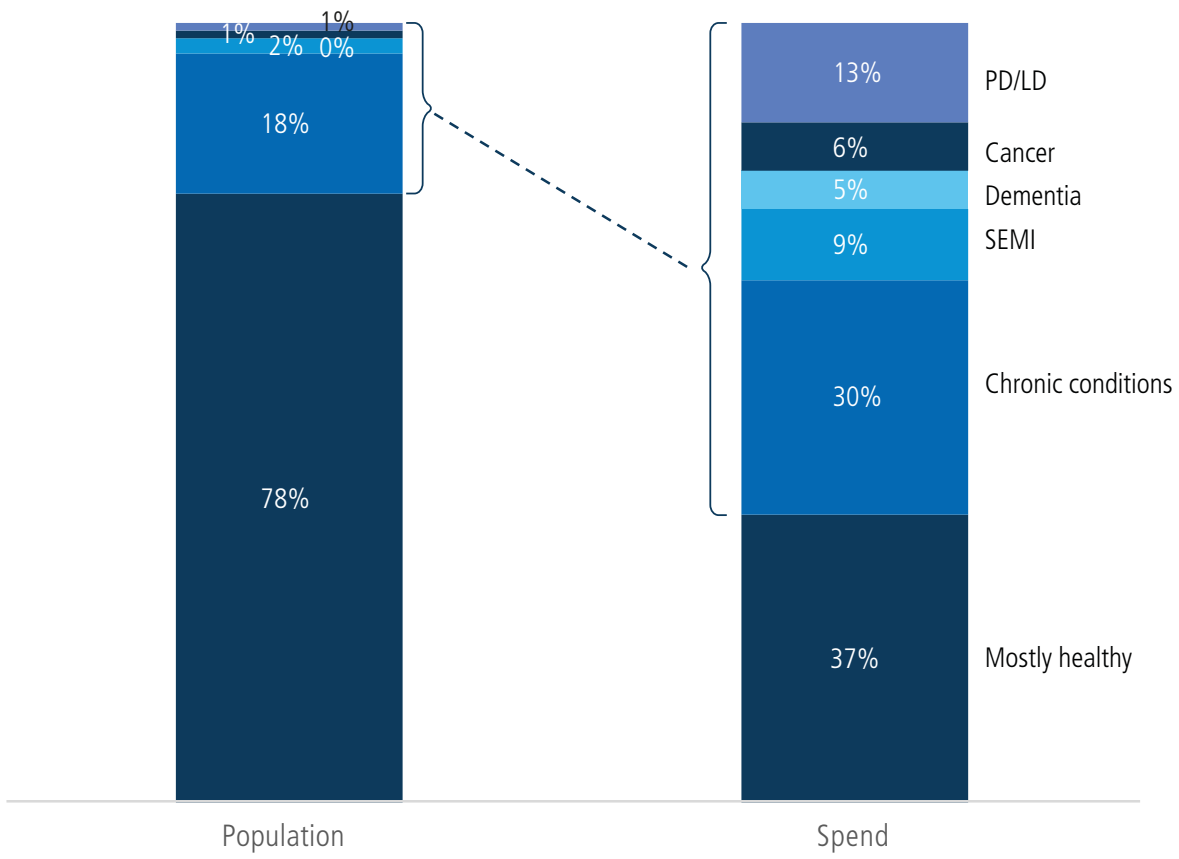
NCL	Mostly Healthy		Chronic conditions		Severe and enduring mental illnesses (SEMI)		Dementia		Cancer		Physical or learning disability (PD/LD)		High needs		Total	
Children 0 -15	Mostly healthy children 1,216		Children with chronic conditions 1,794		Children with SEMI 3,804		-		Children with cancer 16,727		Children with PD/LD 7,827		Vulnerable children -		-	
	258.3	314.2	9.4	16.9	7.2	27.4	0.0	0.0	0.1	1.6	1.2	9.1	-	-	276.2	369.1
Adults 16-69	Mostly healthy adults 472		Adults with chronic conditions 1,711		Adults with SEMI 9,716		Adults with dementia 10,400		Adults with cancer 5,145		Adults with PD/LD 17,711		Adults with Learn. disabilities -		-	
	818.1	386.0	166.9	285.5	12.3	119.2	0.4	3.8	8.4	43.3	5.0	88.9	-	-	1011.0	926.5
Elderly 70+	Mostly healthy elderly 2,577		Elderly with chronic conditions 4,297		Elderly with SEMI 16,317		Elderly with dementia 19,317		Elderly with cancer 8,034		Elderly with PD/LD 17,527		Elderly with Learn. disabilities -		-	
	21.8	56.1	70.5	302.9	1.7	28.1	5.4	104.8	9.3	74.5	9.0	156.9	-	-	117.7	723.4
Total	1098.2	756.2	246.8	605.3	21.2	174.7	5.8	108.5	17.8	119.4	15.1	254.8	-	-	1404.8	2,019.

1. Children with LD/PD figure does not include spend on education
2. Does not include NHS England specialised commissioning spend, meaning total is less that that given in Exhibit 1

Source: CCG 14/15 spend by POD, Monitor Ready Reckoner Tool, Carnall Farrar analysis

Exhibit 11 shows the same information in a different format. It shows that, in NCL, around 22% of local people use 63% of health and social care.

Exhibit 11 – Use of health and social care by different groups, 2014-15



Source: CCG 14/15 spend by POD. Monitor Ready Reckoner Tool, Carnall Farrar analysis

This suggests that the priority groups for focus are people with mental illness and people at risk of poor mental or physical health. It is also important to make sure high quality services are available when required for the majority of local people who are not high users of services. Consideration needs to be given to reducing health inequalities, the requirements of different ethnic groups and the significant movement of people into and out of NCL

4 Care and quality

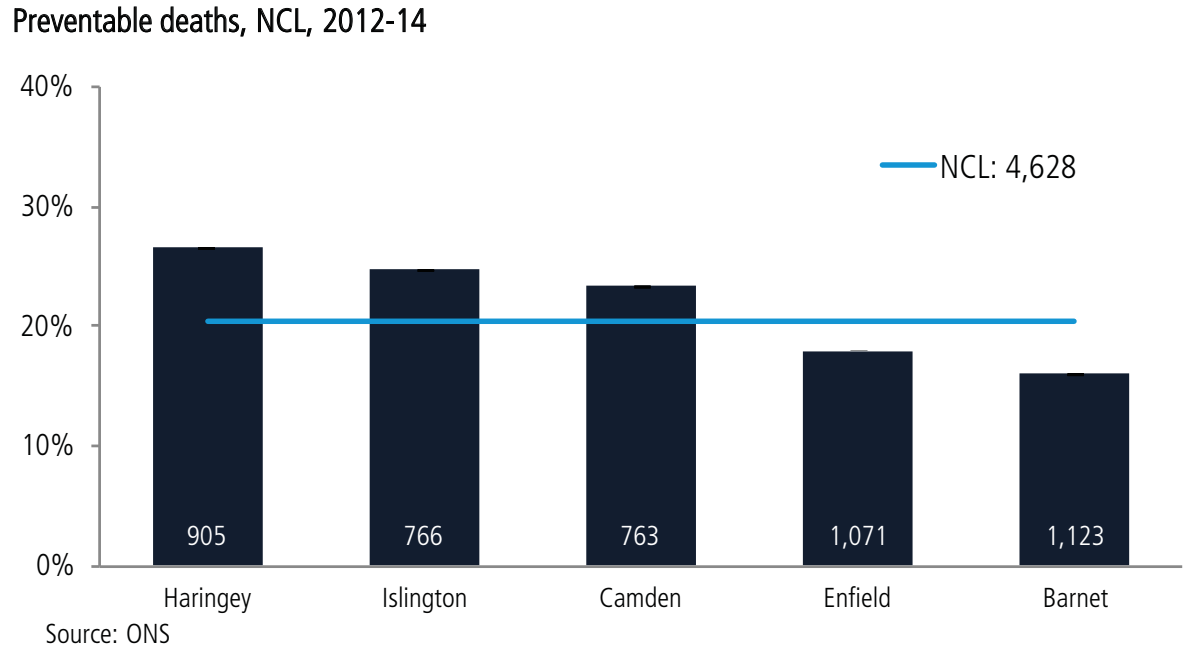
4.1. There is not enough focus on prevention

Many people in NCL are healthy and well – around 40% of adults locally have a healthy weight, do not smoke and do not have any clinical problems[34]. Empowering people, families and communities to stay healthy, including having good mental health, will help ensure they need less health and social care in future. However, many of these people, especially those aged 40+, are at risk of developing long term health conditions such as obesity, raised cholesterol and high blood pressure[35]. There is therefore an important opportunity for prevention of disease among these people.

Only 3% of health and social care funding is spent on public health in NCL[36]. Smoking is thought to cause over 9,000 stays in hospital amongst NCL residents each year[37]. However, in 2014/15, of the estimated 227,567 smokers in NCL, only 4% (10,979) received support through NHS stop smoking services, but of those, 52% (5,669) successfully quit smoking at four weeks.

Much of the ill health, poor quality of life and health inequalities across NCL could be prevented. Between 2012 and 2014, around 20% (4,628) of deaths in NCL were considered preventable[38]. Exhibit 12 shows that Haringey, Islington and Camden have particularly high levels of avoidable deaths, with around a quarter of deaths considered preventable.

Exhibit 12 – Preventable deaths in NC



Levels of avoidable deaths may be linked to the fact that NCL CCGs are in the bottom quintile for a number indicators relating to health and wellbeing, including the number of local people with chronic kidney disease and coronary heart disease[39].

In addition, the wider determinants of health such as poverty, housing and employment have a significant impact on individuals' health and well being.

This suggests a focus on health promotion, particularly focusing on those who are healthy and well but are at risk of developing long term health conditions.

4.2. Disease and illness could be detected and managed much earlier

Many people (including children) in NCL are unwell but do not know it, meaning they have undiagnosed conditions. For example, there are thought to be around 20,000 people who do not know they have diabetes[40] and, in one area of NCL, a quarter of people attending A&E because of chronic obstructive pulmonary disease (COPD) did not know they had the condition[41]. The level of undiagnosed conditions varies by borough and by GP practice, which may be caused by differences in approaches to care[42].

There are also opportunities for better, more systematic management and control of long term health conditions in primary care, in line with evidence-based standards. For example, within NCL in 2014/15 rates of blood glucose control for people with diabetes (important for preventing a worsening of the condition) ranged from 50% to 92% across GP practices[43], and 22% of all people with detected high blood pressure did not reach the required blood pressure levels (≤150/90 mmHg), putting them at risk of stroke and other acute problems[44].

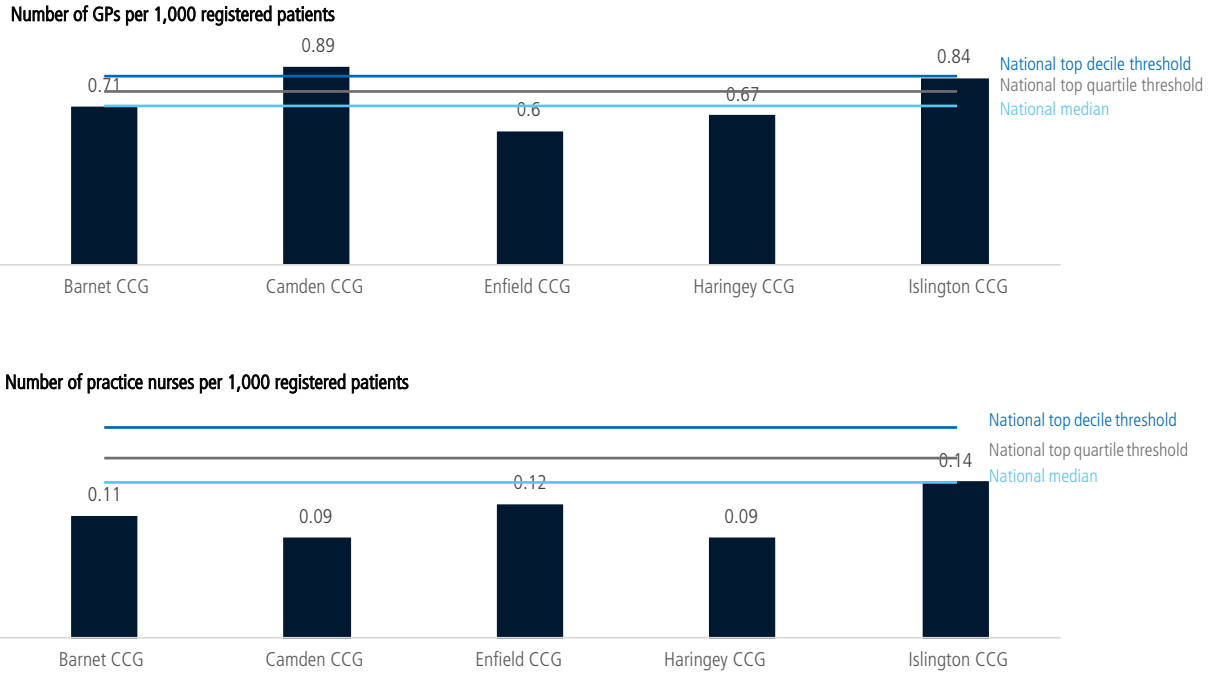
A focus on prevention and early intervention is very important in improving health and wellbeing for local people, reducing the need for health and care services both now and in the future.

This suggests a focus on early detection and management of disease and illness, especially through more systematic management and control of long term health conditions in primary care.

4.3. There are challenges in provision of primary care in some areas

As shown in Exhibit 13, there are low numbers of GPs per person in Barnet, and Enfield and Haringey and low numbers of registered practice nurses per person in all CCGs, but particularly in Camden and Haringey[45].

Exhibit 13 – NCL levels of primary care staff compared to national levels



Source: HSCIC, General Practice Census 2014 at Practice Level. Populations are unweighted.

Satisfaction levels and confidence in primary care among local people is mixed across NCL – there are issues across NCL around confidence in practice nurses and in Haringey with confidence in GPs[46]. Performance against quality indicators in primary care is lower than London and national averages, particularly in Haringey[47]. There are issues within NCL in accessing primary care during routine and extended hours, and only 75% of people in NCL have a named GP to provide continuity of care[48].

There are high levels of A&E attendances across NCL compared to other similar areas[49], and also very high levels of first outpatient attendances[50], suggesting that there may be gaps in primary care provision. Within CCGs, there are significant variations in levels of emergency activity, A&E attendances, planned care and outpatient referrals between practices[51]. There are also high levels of A&E attendances and high numbers of short-stay admissions in the over-75s compared to other similar areas[52].

This suggests that a priority area for focus is the quality of primary care provision and the primary care workforce. It also suggests a focus on reducing variation between practices. This may reduce A&E attendances, short stay admissions and first outpatient attendances.

4.4. Lack of integrated care and support for those with a long term condition

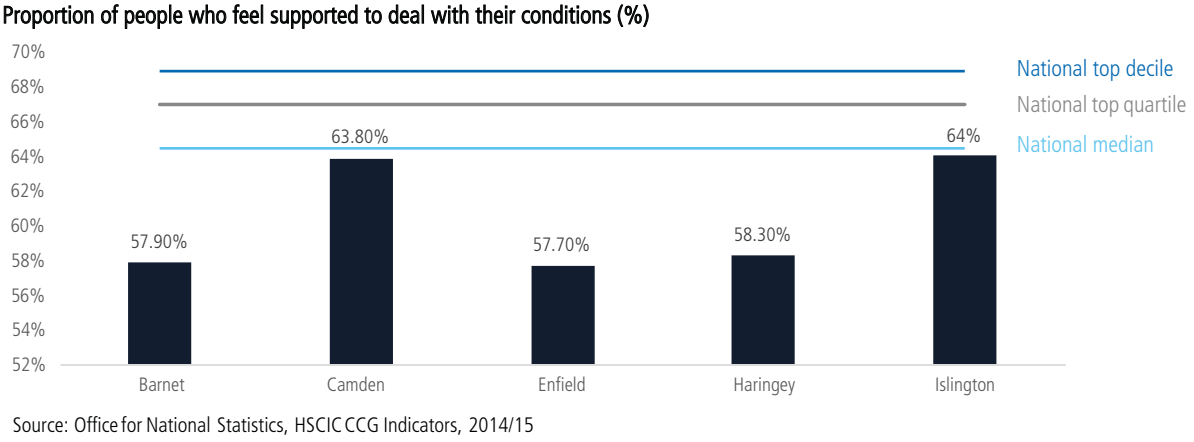
Levels of emergency admissions are similar in NCL to other areas of London[53]. However, there are many people with long term health conditions who end up in hospital, especially in Islington[54]. As shown in Exhibit 14, many people with long term health conditions – over 40% in Barnet, Haringey and Enfield, compared to 35% nationally – do not feel supported to manage their condition[55]. In addition, health related quality of life for people with long term conditions is much lower in Islington than the England average[56].

Insufficiently joined up services for older people

Arthur is 78 and lives alone. After falling at home and injuring his knee, he spent two nights in hospital before being discharged with no further support. Two weeks later, Arthur fell in the shower and fractured his hip. Unable to live independently, he was forced to move into a residential home after some initial rehabilitation in hospital.

Source: submitted by Barnet Integrated Locality Team

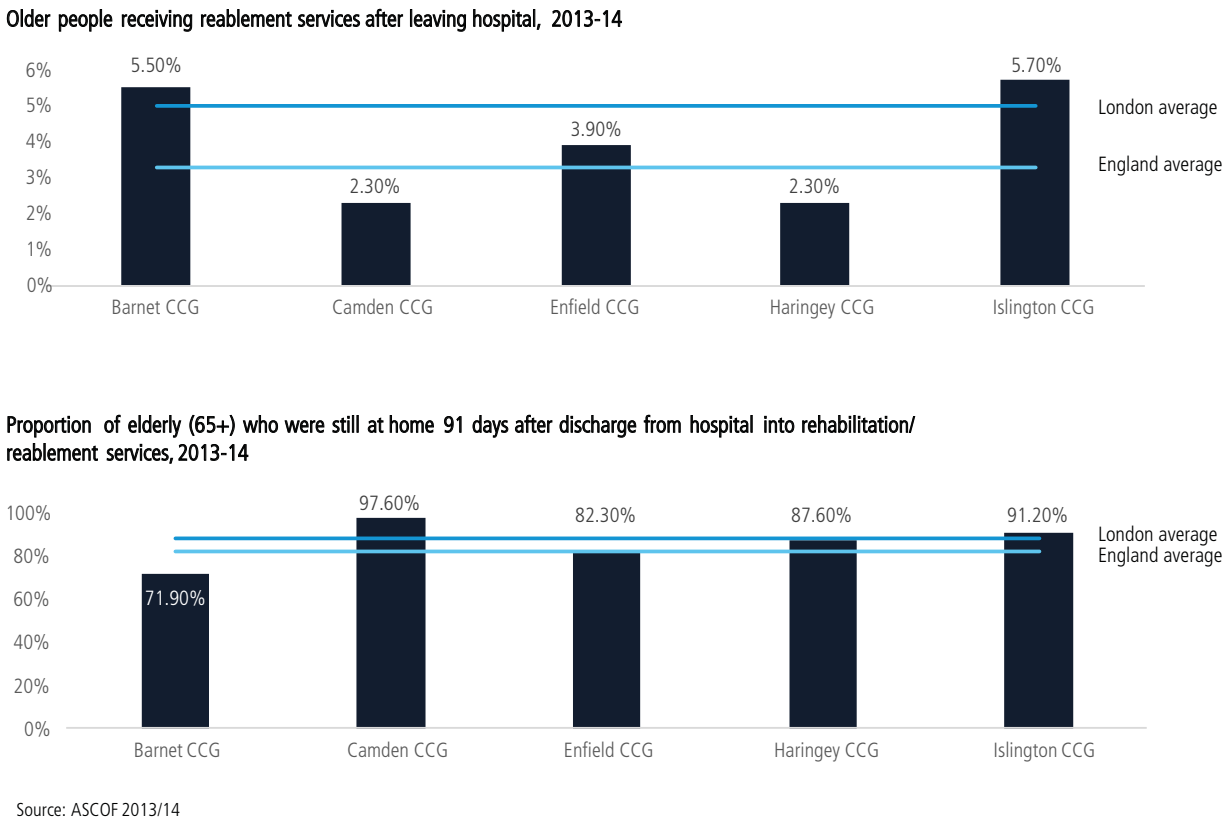
Exhibit 14 – NCL long-term conditions support perception vs national benchmark



Source: Office for National Statistics, HSCIC CCG Indicators, 2014/15

Once people leave hospital, access to social care reablement is lower in Haringey and Camden, while there is a high number of people being readmitted to hospital within 91 days of discharge into community rehabilitation services for people in Enfield[57]. This is shown in Exhibit 15.

Exhibit 15 – Indicators for provision of social services



Source: ASCOF 2013/14

There are also differing levels of admissions to care homes across NCL for older people. In particular, Exhibit 16 shows there are very high levels of permanent admissions to residential and nursing homes in Islington[58]. Reasons for this include the advice offered by doctors during hospital stays, and the availability of community-based support when people are ready to leave hospital

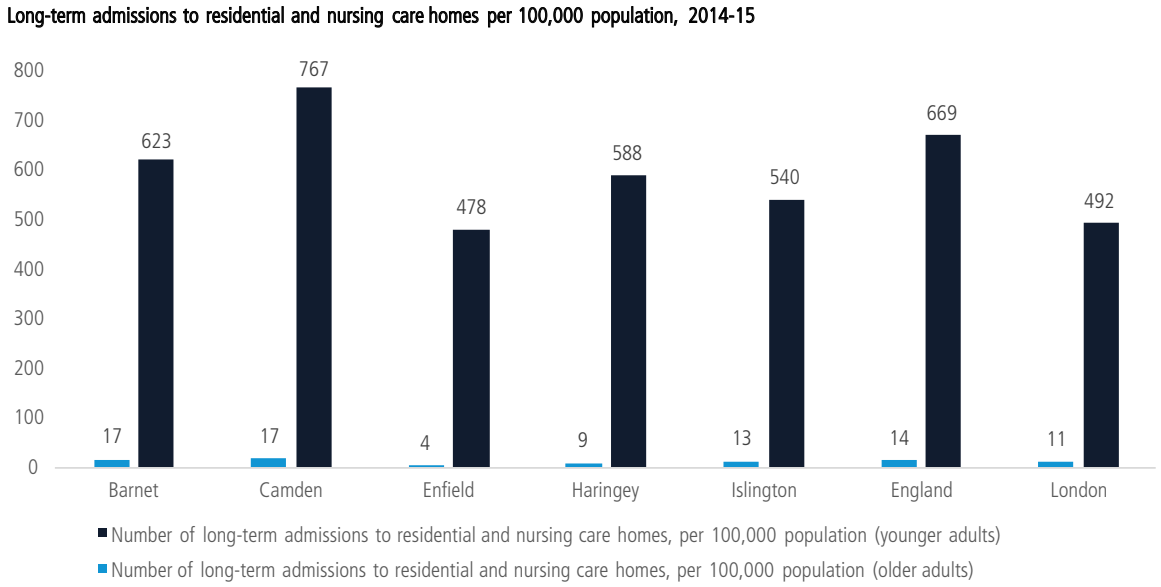
What good looks like: integrated services for older people

The Barnet Integrated Locality Team (BILT) aims to address these issues by coordinating care for older residents with complex medical and social care needs, as well as providing support to carers. The aim is to enable health and social care staff to help people stay healthy and independent. BILT offers a phone service to people who need it and can arrange for access to physiotherapy to assist elderly people regaining their mobility or home modifications such as the installation of a chairlift or a handrail in the shower.

As the number of elderly people in NCL increases, the demands on the health and care system are likely to increase. Services such as BILT can help keep people independent and well for longer, keeping them in their homes and helping them get back to normal life after spending time in hospital.

Source: submitted by Barnet Integrated Locality Team

Exhibit 16 – Long-term admissions to residential and nursing care homes per 100,000 people



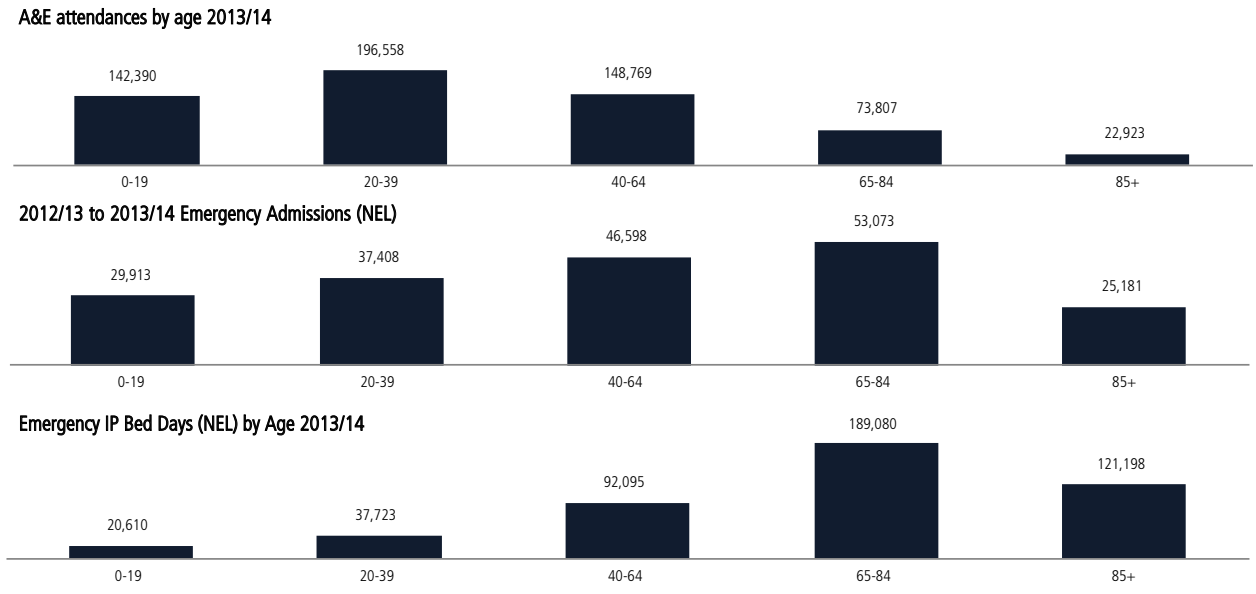
Note: Islington data is 15/16, as there was an error in the 14/15 submission to HSCIC which means 14/15 data cannot be used. The figures are not expected to be significantly different from 14/15 to 15/16.
Source: ASCOF (Adult Social Care Outcomes Framework) , HSCIC

This suggests that a priority area for focus is better integration of care for those with long-term conditions, and ensuring that suitable and sufficient social care is available. There also needs to be a focus on people in residential and nursing homes.

4.5. Many people are in hospital beds who could be cared for closer to home

Most people who stay for a long time in hospital beds are elderly. Exhibit 17 shows that in 2013/14, while 41% of people admitted to hospital in an emergency were aged 65 and over, they used 67% of the beds[59]. While the analysis is now slightly out of date, there is unlikely to have been significant changes to these activity patterns since 2013-14.

Exhibit 17 – Emergency activity in NCL by age



Source: NCL 5yr Planning Activity & Cost Analysis – 2013/14 actual data

More time spent in hospital does not necessarily mean better outcomes – often the reverse – and many people could be cared for sooner, at home. Longer stays are not always driven by medical need and can be seriously harmful to health – the longer the stay, the greater the risk of getting infections, muscle decline, becoming less able to walk or do everyday tasks, less able to return home and more likely to need residential or nursing care[60]. Also, fewer than 40% of people who die in NCL are able to do so at home[61] even though, given a choice, most declare their home to be their preferred place of death.

Delayed discharges (people who have been declared medically fit to leave hospital but have not been discharged) are high in some hospitals in NCL[62], but these numbers only show people who have actually been declared fit for discharge. The real number of people who could leave if services were available elsewhere is probably much higher[63]. As an example, a recent audit of people at Plymouth Hospital found that 27% (200) beds had people in them who were medically fit to leave[64]. This would mean around 600 people in local NCL hospitals if a similar pattern was found. Similarly, if 90% of all local people aged 65 and over were able to be discharged home after no more than 10 days in hospital, this would translate to 340 people every day who could be cared for closer to home[65]. Ensuring services are available outside hospital would mean people are able to go home at the right time and be cared for safely in their own homes. It would support people to get back to normal life more quickly, reduce their risk from staying in hospital too long and enable hospitals to work more efficiently to care for sicker people.

Insufficiently joined up services for care homes

Edna is 84 years old and lives in a residential care home. She was unable to see a GP after contracting a chest infection, due in part to difficulties getting to the GP practice and the lack of availability of the GPs to conduct home visits. Edna was admitted to hospital as suitable support was not available in the care home. After leaving hospital, the lack of coordination between care services in the community and primary care meant Edna did not receive the support she needed to assist her recovery and she was readmitted to hospital 10 days later.

Source: ICAT care home services

There are also a large number of people in local hospital beds whose admission to hospital might have been avoided altogether. Although the numbers of people who go into hospital in an emergency in NCL are similar to the England average[66], evidence from elsewhere suggests that 25-40% of these emergency admissions could be avoided if other care was available outside hospital[67]. Exhibit 18 summarises a selection of the key international evidence.

Exhibit 18 – International evidence of impact of integrated care

A review of the evidence base on integrated care shows a potential impact of 25–40% in cost reduction, for example

- 15–30% cost reduction through care coordination
- 50% reduction in acute admissions to hospital for patients with diabetes, through case-level care-planning and active disease management
- 23–40% reduction in admissions for CHD through best practice early management

Selected examples of integrated care	
GENERALITAT VALENCIANA	• Significant cost reductions and higher levels of productivity • 26% reduction in costs in districts with outsourced management • 76% increase in hospital productivity • 91% patient satisfaction rates
ChenMed	• ChenMed has 30% fewer emergency admissions than other primary care networks in the same geography • Compared to national averages for the population group, ChenMed reports 18% lower hospitalisation rate and 17% lower readmissions rates
NHS South Devon and Torbay Clinical Commissioning Group	• The number of patients with a care package in place within 28 days of assessment increased by 45% • Non-elective inpatient beduse in over-65s population reduced by 29%; length of stay reduced by 19% • Delayed transfers of care from hospital significantly reduced
CareMore	• Reduction in A&E visits and unscheduled patient admissions • 24% lower than avg hospitalisation; 38% shorter than avg hospital stays • 60% lower than average amputation rate among diabetics • 56% reduction in CHF hospital admits in 3 months • 50% reduction in renal hospital admission rates in 5 months

1 Dorling & Richardson, "McKinsey Evidence Base of Integrated Care", 2014

There are also already a number of places in NCL where services provide 'hospital' care outside of the hospital. These services are integrated across community services and social care, and provide proactive person-centred care. This can empower people to better manage their own health and wellbeing. However, there are differences in the availability of these services across NCL, and it is important to ensure that the services that work well are made available more widely.

This suggests that a priority area for focus is reducing the length of stay and avoidable admissions in acute hospitals, in partnership with social care.

What good looks like: in-reach services for care homes

An 'in-reach' team focused on supporting people to remain well in residential care (such as the Integrated Community Ageing Team, or ICAT) act as a liaison between community and acute hospital services. An ICAT is a consultant led multidisciplinary team (MDT) which specializes in geriatric assessment. With knowledge of each patient, and specialising in the care of elderly patients, the team is able to ensure that the needs of patients such as Edna are met upon returning to residential care homes from a spell in hospital. The team also helps to arrange appropriate palliative care to ensure that when the time comes, patients can die in their place of choice.

Demand for these types of services is likely to increase as the population ages, and NCL has an opportunity to build on examples of existing teams, such as those at the Whittington and UCLH, as part of the STP process.

Source: ICAT care home services

4.6. Hospitals are finding it difficult to meet increasingly demanding emergency standards

Local hospitals are finding it difficult to meet increasingly demanding clinical quality standards for emergency services. For example, as shown in Exhibit 19, according to a self-assessment conducted in 2015 the number of specialties where people are seen by consultants within 14 hours ranges from 20% in one hospital to 90% in another[68]. Three of the five acute hospitals in NCL do not provide 16-hour consultant presence in Emergency Departments at the weekends[69]. Within Emergency Departments there are shortages of middle grade doctors[70]. However, there are likely to have been improvements in adherence to the standards since the self-assessment was carried out; for example, at the Whittington Intensive Therapy Unit (ITU) patients are reviewed at least twice daily.

Exhibit 19 – Assessment of four London priority national seven day service standards

Note - this data was submitted to the national self-assessment in 2015. An updated self-assessment against these standards is being carried out for the NCL STP.

Standard	Measure	Barnet Hospital	North Middlesex Hospital	Royal Free Hospital	The Whittington Hospital	University College Hospital	NCL total
Standard 2: Time to Consultant Review	Percentage of specialties where patients are seen by consultants within 14 hours	50%	30%	80%	20%	90%	45%
Standard 5: Access to Diagnostics	Percentage of diagnostic services available 7 days per week	100%	71%	79%	79%	93%	87%
Standard 6: Access to Consultant-directed Interventions	Percentage of consultant-directed interventions available 7 days per week	89%	67%	100%	100%	100%	76%
Standard 8: Ongoing review	(Where applicable) Percentage of areas in which patients are seen and reviewed by a consultant twice daily	100%	100%	100%	25%	100%	88%

Areas included:

Standard 2 - Cardiology, General Medicine, General Surgery, Geriatric Medicine, Gynaecology, Intensive Care, Obstetrics, Paediatrics, Psychiatry, Respiratory Medicine, Trauma and Orthopaedics

Standard 5 - Biochemistry, Bronchoscopy, Chemical Pathology, Computerised Tomography, Echocardiography, Haematology, Histopathology, Magnetic Resonance Imaging (MRI), Microbiology, Radiology, Lower GI Endoscopy, Upper GI Endoscopy, Ultrasound, Xray,

Standard 6 - Cardiac pacing, Critical Care, Emergency General Surgery, Interventional Endoscopy, Interventional Radiology, Percutaneous Coronary Intervention (PCI), Renal ReplacementTherapy, Thrombolysis, Urgent Radiotherapy

Standard 8 - Acute medical unit, acute surgical unit, intensive care unit and other high dependency units

Source: National Seven Day Services Self-Assessment, 2015

In April 2016 none of the five Emergency Departments within NCL were consistently meeting the access standard to see people within 4 hours of arrival, as summarised in Exhibit 20 below. In particular, North Middlesex University Hospital (NMUH) had been recently issued with a Warning Notice by the Care Quality Commission that it needed to significantly improve the treatment of people attending the Emergency Department[71]. In April NMUH was seeing between 65-75% of A&E patients within 4 hours and was challenged in achieving key quality standards within emergency care. This was shown by the poor satisfaction ratings at NMUH; almost half of people attending the Emergency Department at the hospital would not recommend the Emergency Department to friends and family[72].

However since April 2016, considerable progress has been made at NMUH. The launch of the Safer, Better, Faster programme in May 2016 has led to improvements in ED staffing at NMUH; the development of a 'home first approach' to support earlier discharge of medical patients who need home care; increase patient flow through assessment units; and reduced delays for patients waiting for tablets to take away. Waiting time performance at A&E in NMUH has improved steadily as a result rising to over 90% of patients seen within 4 hours in early August 2016.

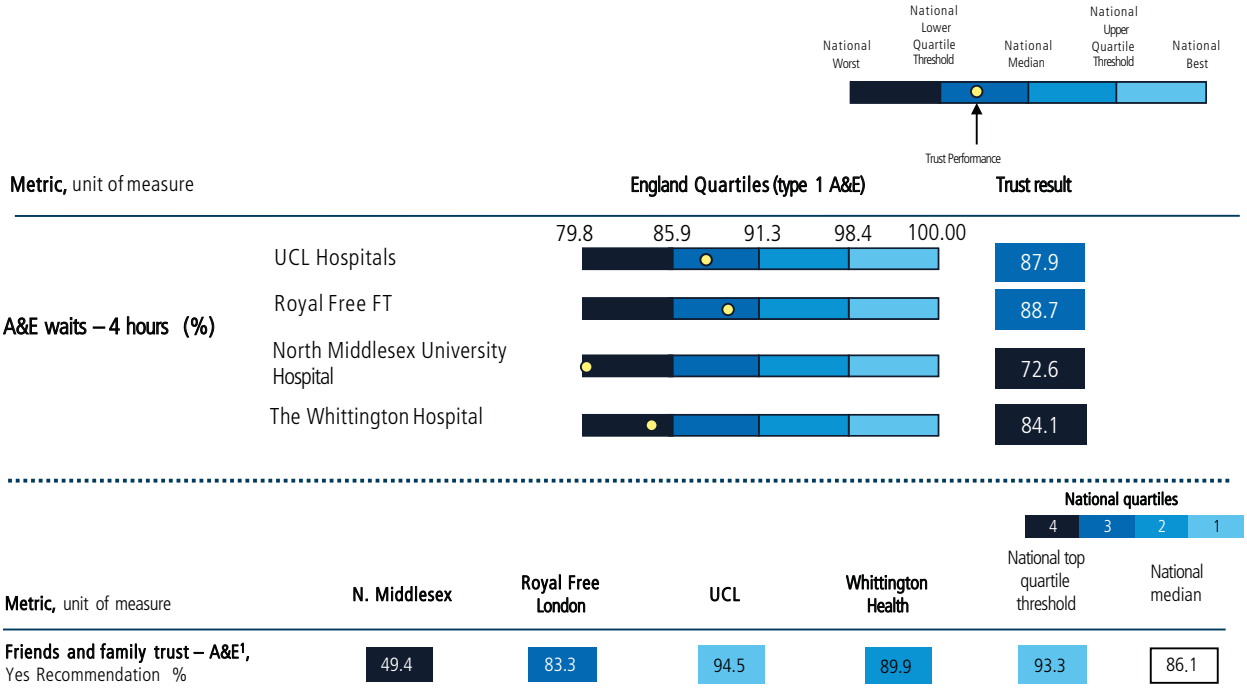
Access to secondary care

Sara had a cyst and she is still waiting for the local hospital to give her an appointment for the operation. Her English is limited and her children have to help her in interpretation, but she does not think that the hospital is giving her the best care.

Her son is helping her navigate the health services, but she feels shy having to be examined by a doctor in front of him. Especially as this cyst is on her uterus and the treatment is possibly a hysterectomy making me more anxious. Sara finds it difficult to talk about women's illnesses when there are men present, and it is especially hard when her son is also there and she has to explain everything to him. It takes a long time to get an appointment, and services need to improve the improve interpreting services available or hire some doctors who know different languages.

Source: Healthwatch Islington, Diverse Communities Health Voice

Exhibit 20 – Key A&E performance indicators



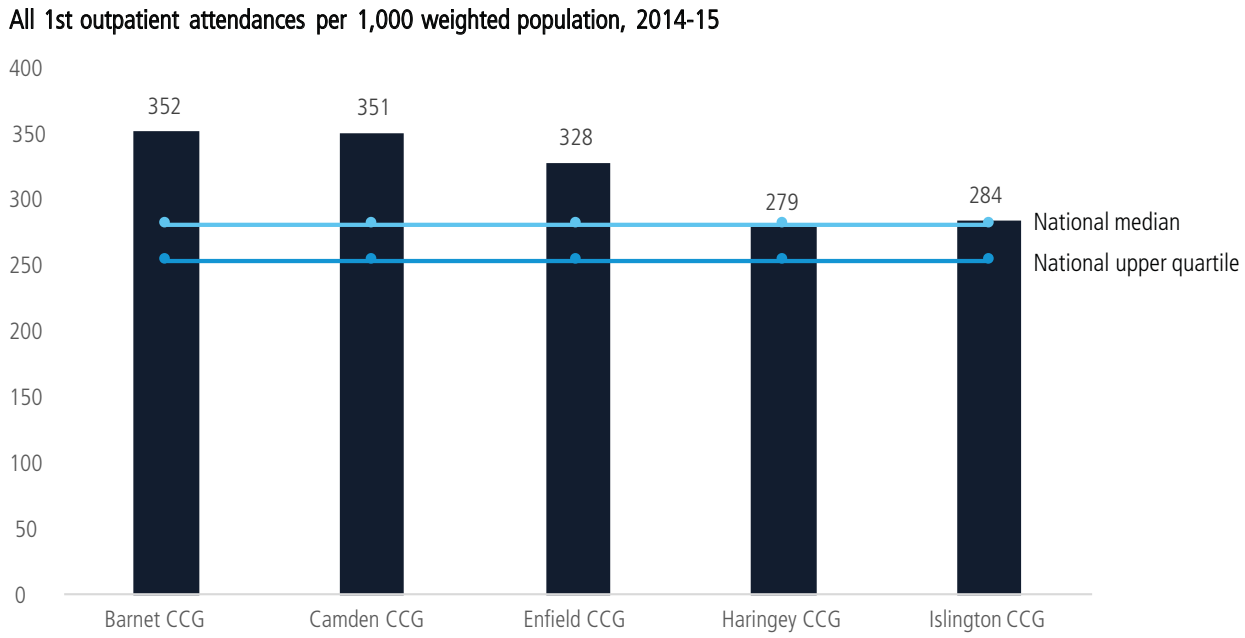
Source: A&E Waiting Time Analysis, April 2016; Friends and Family Test, April 2016

This suggests a need to focus on the delivery of emergency services in hospitals in NCL, addressing variation and, in particular, continuing attention to the Emergency Department at North Middlesex University Hospital. This should be underpinned by a NCL-wide approach to supporting all organisations to deliver, with a strong focus on the development of improving access to primary care.

4.7. There are differences in the way planned care is delivered

There are differences in the way planned care is delivered across NCL. This may reflect different levels of patient need, or it may be due to differences in clinical practice between doctors and nurses at any point where care is given. For example, as shown in Exhibit 21, the number of people seen as outpatients in Barnet, Camden and Enfield is high compared to other similar areas and when compared to the England average. This could be for a number of reasons, including differences in the health needs of local people, the skills and experiences of GPs, or the ability of GPs to get a specialist opinion or access diagnostics in primary care.

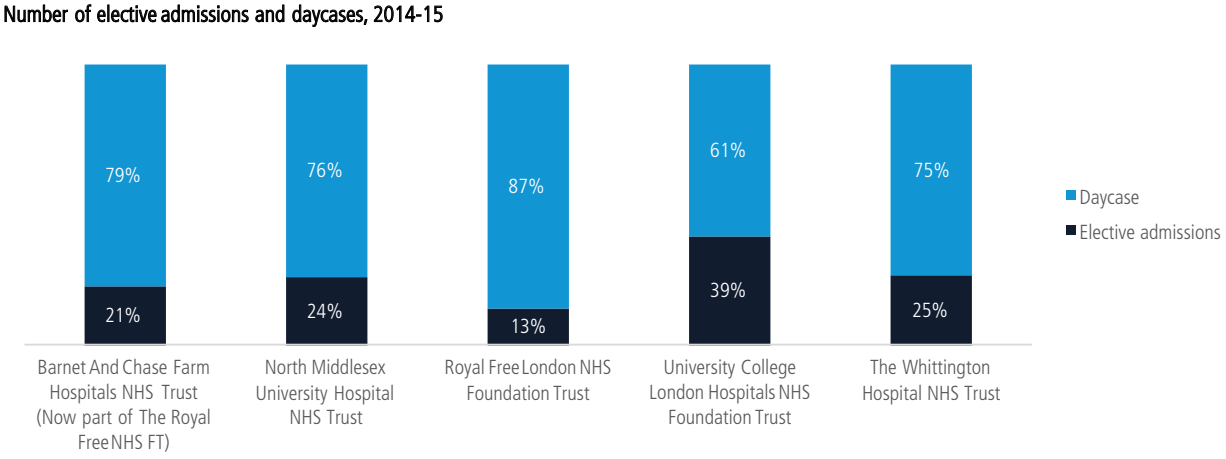
Exhibit 21 – Outpatient activity in NCL



Source: NHS England Monthly Activity Data 2014/15

There are also differences between hospitals in the delivery of planned care. For example, there are differences in the number of referrals of people between consultants (particularly at UCLH and North Middlesex), the number of follow-up appointments that people have (particularly at UCLH) and the amount of planned care that is done as a daycase without an overnight stay (shown in Exhibit 22)[73]. Further work is being done to understand these differences and their causes in more detail.

Exhibit 22 – Daycase rates by provider in NCL



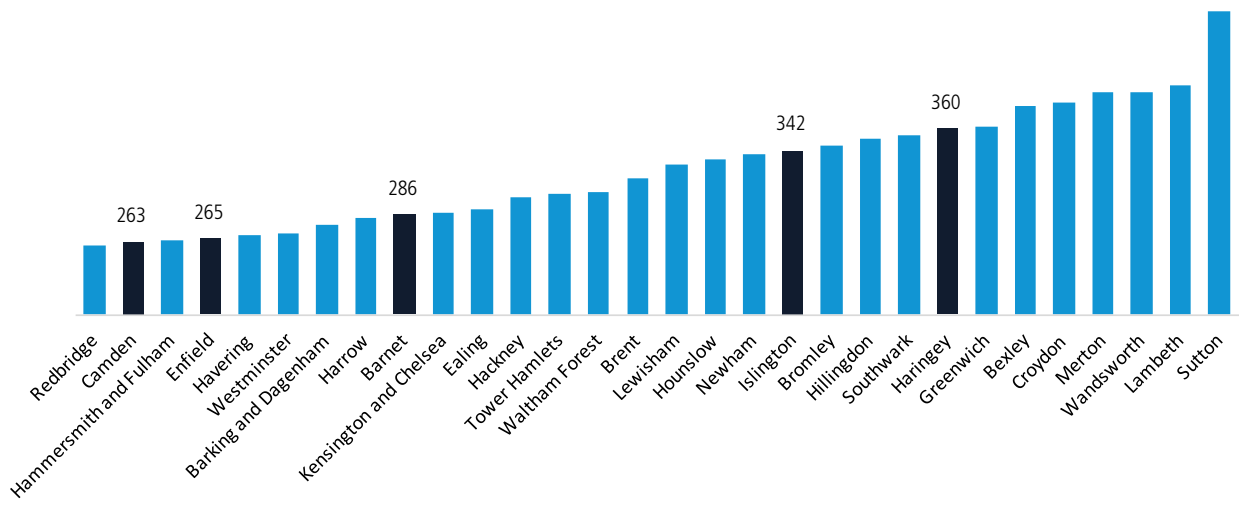
Source: HSCIC Hospital Episode Statistics

This suggests a focus on the differences in referrals into planned care, and the differences in the delivery of planned care within hospitals.

4.8. There are challenges in mental health provision

There are very high levels of mental illness in NCL, both serious mental illness and common mental health problems, with high rates of premature mortality, particularly in Haringey and Islington, as shown in Exhibit 23. While the causes of premature mortality are broader than just mental health conditions, the links between poor mental health and premature mortality are well-established.

Exhibit 23 – Premature (<75) mortality in adults with serious mental illness, rate per 100,000 people, 2013-14



Source Public health outcomes framework 2013/14

There is still a lot of stigma associated with having a mental illness, and many people either do not know how, or do not want, to access mental health services. Information on help and support within local communities is not available everywhere. There are groups of people who are at higher risk of having a mental illness, such as people who are in debt, unemployed, homeless, have a long term condition, or have drug and alcohol problems.

Demand for mental health services has increased, due to social pressures related to reduced funding for public services, increasing numbers of people, higher public expectations and changes to legislation. Community-based teams cannot manage people with the most serious issues and therefore high numbers of people are admitted to hospital. During a crisis, service users prefer to be helped by teams who they know rather than being referred to a new team. Camden and Islington have amongst the smallest community mental health services per person in England[74]. Community teams reduce the number of people with a mental illness ending up in hospital.

Most mental health problems are managed within primary care, and psychological therapies (IAPT) services are in place to manage mild to moderate mental health problems. However, mental health services based in primary care with specialist workers who can manage moderate to severe mental illnesses are only just beginning to develop in NCL and are limited in who they can treat. Without this expertise in primary care, more people are referred to hospital-based services who might otherwise have been managed within the community.

Access to psychological therapies

'There is a need for psychological therapies that have less restriction on who they can see, as IAPT are unable to see clients who have suicidal thoughts, have a history of drugs or alcohol abuse, or a history of longer-term mental health issues.' (Carer)

Source: Healthwatch Enfield

In recent years there has been a big increase in the numbers of people receiving a first diagnosis of a serious mental health condition in A&E, and around 38% of people admitted to inpatient hospital wards in Camden and Islington are new to mental health services[75]. These issues are partly related to the large number of people moving in and out of NCL, with significant differences between daytime and night time populations. This creates a burden on both mental health and A&E services, and indicates that prevention and early detection of mental health conditions needs to improve, along with greater capacity to manage these conditions in the community. There is no high quality health-based place of safety in NCL to receive people detained by the police under Section 136.

There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care. For example, most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight[76].

What good looks like: improving access to psychological therapies

Yorkshire and Humber Commissioning Support worked on review and redesign of Hull's Improving Access to Psychological Therapies (IAPT) services and access to mental health services. A revised IAPT+ service, known as the Depression and Anxiety Service, improved choice and access to Psychological Therapies. The service involves timely, evidence-based interventions according to the needs of individuals and does not require individuals to be referred through secondary mental health services to be able to access these services. The new service model is tariff-based and incentivises both patient choice at every point on the pathway and the achievement of demonstrable clinical outcomes.

The improvements other regions have made to their IAPT services are likely to provide learning opportunities for NCL to improve the accessibility and effectiveness of its IAPT services as well.

Source: Yorkshire and Humber Commissioning Support

Although all five boroughs achieve dementia diagnosis rates above the national average, there is great variability across NCL[77]. There is the expertise in NCL to achieve high diagnosis rates, as demonstrated by Islington. The availability of post-discharge treatment and support services for people with dementia varies greatly despite the good evidence for their effectiveness.

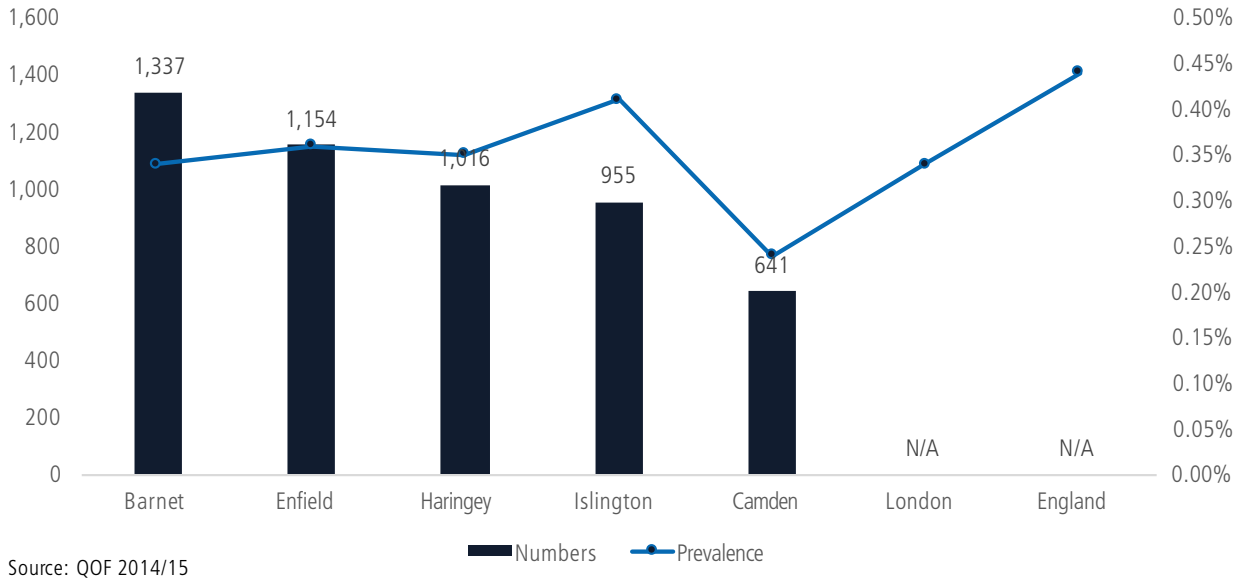
This suggests a focus on the provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis, access to integrated services and child and adolescent mental health services.

4.9. There are challenges delivering services for people with learning difficulties

As shown in Exhibit 24, the number of adults with learning disabilities varies across NCL from 0.41% of people in Islington, to 0.24% in Camden. Often people are not recorded as having learning difficulties, especially when they are mild.

As elsewhere in England, the number of people with learning disabled is increasing, partly due to the rising numbers of young people with complex needs surviving into adulthood, and also due to the increased life expectancy of the learning disabled population. The rate of increase is estimated to range from 1.2% to 5.1% (average 3.2%) per year[78].

Exhibit 24 – Number of people with a learning disability, registered population, 2014/15



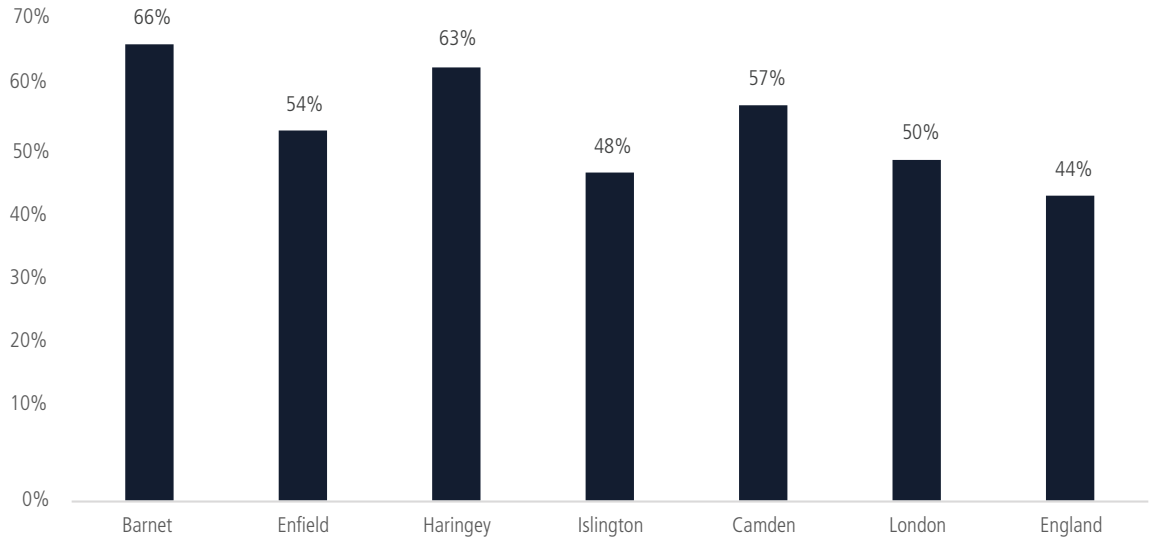
Source: QOF 2014/15

People with learning disabilities tend to have poorer health than the rest of the population, much of which could be prevented. This is partly because of the barriers faced by people with learning disabilities in accessing timely, appropriate and effective health care. As well as having a poorer quality of life, people with learning disabilities die at a younger age than the general population[79]. Men die, on average, 13 years younger than other people and women die 20 years younger.

People with learning disabilities are more likely to have specific health issues including epilepsy, sensory impairment, respiratory disease, coronary heart disease and mental illness[80].

Annual health checks for these individuals are have been shown to be effective in identifying and helping to manage previously undetected health problems. As shown in Exhibit 25, the number of adults in NCL with learning disabilities who have had a health check is higher or similar to the England average; nonetheless, around half have not had one.

Exhibit 25 – Percentage of eligible adults with a learning disability having a GP health check

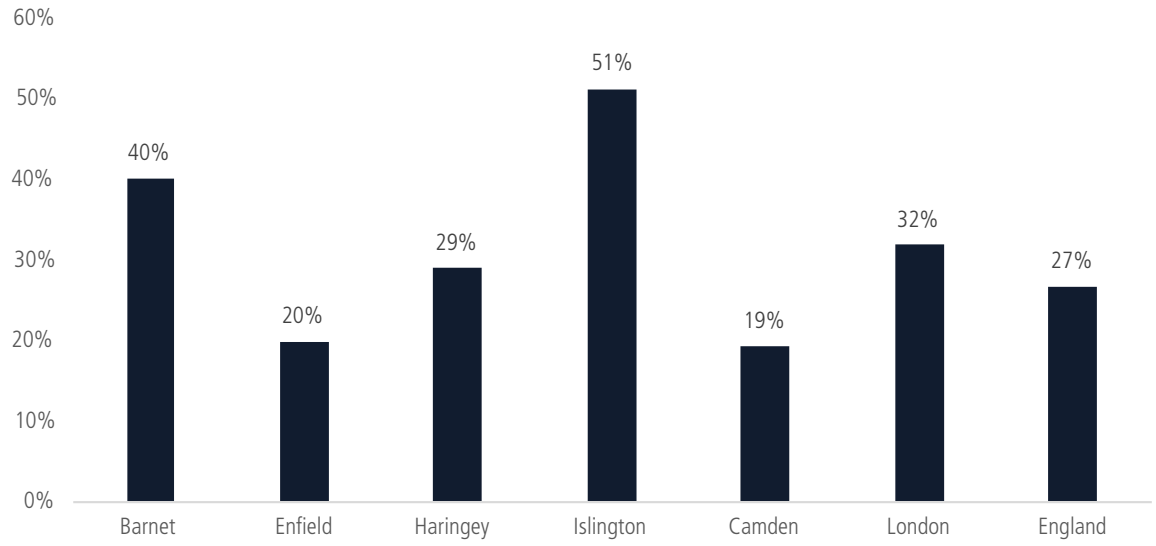


Source: Public Health England, learning disability profiles

Suitable, local accommodation with care and support is required to make sure people with learning disabilities can remain part of their communities and get the health care they need. This includes accommodation that is self-contained and is suitable for people who also have physical disabilities, and young adults with complex health care needs.

As shown in Exhibit 26, the number of adults with learning disabilities receiving long term support who live in unsettled accommodation, meaning the person might be required to leave at short notice, is much higher in Barnet and Islington compared to the England average, whereas for Camden it is lower.

Exhibit 26 – Percentage of adults with learning disabilities receiving long term support living in unsettled accommodation, 2014/15



Source: Public Health England, learning disability profiles

In October 2015, a national plan ('Building the Right Support') and a national service model for learning disability services was published. This was intended to help Transforming Care Partnerships (TCPs) meet national commitments to reduce the length of stay in hospitals and reduce admissions

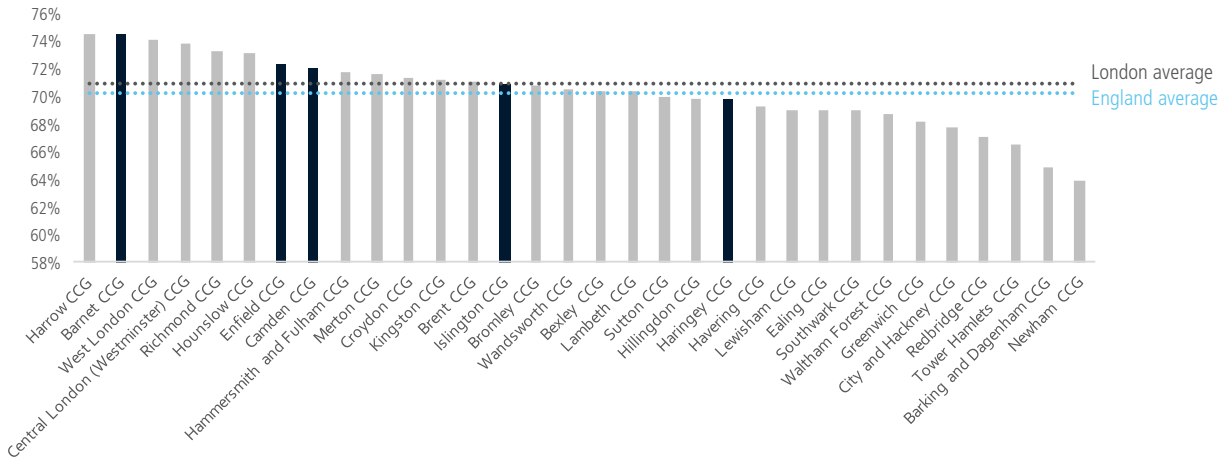
to assessment and treatment units (such as the former Winterbourne Unit) for people with learning disabilities. The NCL TCP implementation plan is currently being developed, to be in place by July 2016 for delivery by March 2019.

This suggests a focus on prevention services for the learning disabled population, such as annual health checks, and provision of more suitable accommodation for people with learning disabilities.

4.10. There are challenges in the provision of cancer care

There are many opportunities to save lives and deliver cancer services more efficiently in NCL. Cancer is a major cause of death, with around 29% of deaths caused by cancer in England[81]. One-year survival rates in NCL are similar to other parts of London[82], as shown by Exhibit 27. However, compared to other countries such as Sweden, the UK has much lower survival rates, suggesting that improvements could be made[83].

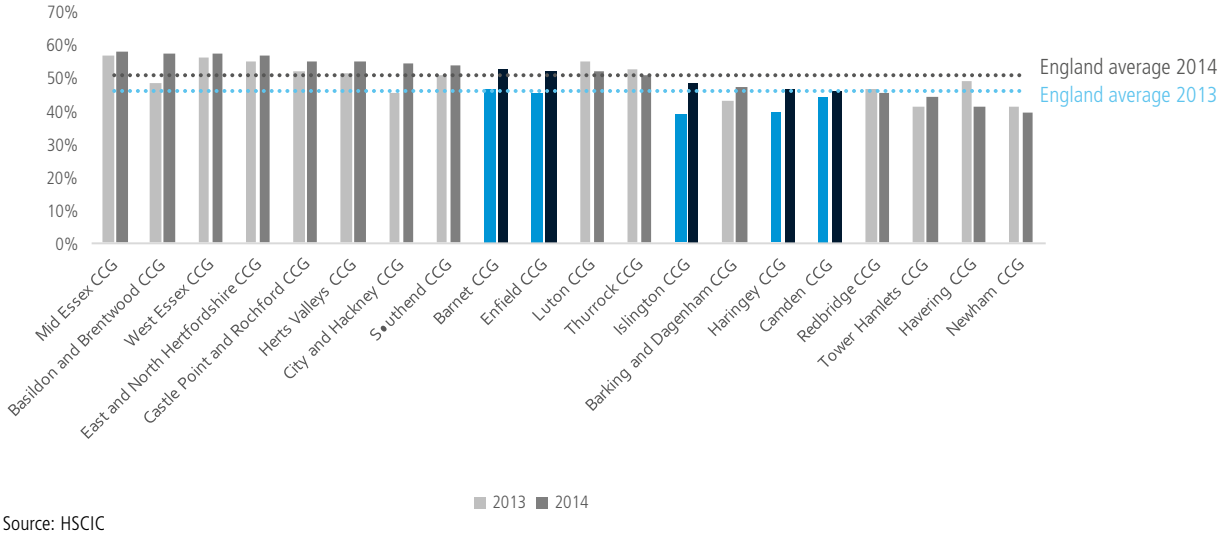
Exhibit 27 – One-year survival rates across London for all cancers, 2013 diagnoses



Source: ONS, Index of cancer survival for CCGs in England

Late diagnosis of cancers is a particular issue that contributes to lower one-year survival rates. Exhibit 28 indicates that the percentage of cancers detected at an early stage is low, especially in Haringey, Camden and Islington, although Islington has improved significantly between 2013 and 2014[84].

Exhibit 28 – Percentage of cancers detected at stage 1 and 2 in London, 2013-14



Source: HSCIC

One issue is that levels of screening for cancer are generally low. For example, in NCL less than half the target number of people get screened for bowel cancer[85]. Around 20% of people do not have their cancer diagnosed until they arrive in A&E with a serious problem[86], and there is a lack of awareness of the symptoms of cancer, especially among black and minority ethnic groups[87].

What good looks like: improving early detection of cancer

The Multidisciplinary Diagnostic Centre (MDC) at UCLH offers rapid diagnostic services for patients with so-called 'vague' symptoms which do not point towards a specific underlying cancer type. GPs can refer patients to the MDC, eliminating the need to fill out referral forms for multiple specialties and diagnosis and/or management plans can be provided by the MDC to be carried out in primary care. This means patients need only visit their GP for their symptoms to be investigated rapidly.

This is one example of a service which, if replicated throughout NCL, could improve patient experience, increase early detection and cancer survival rates, and decrease the number of emergency admissions of patients with unrecognized and late stage cancer.

Source: adapted from UCLP Annual Review, June 2015

Once cancer is suspected, waiting times to see a specialist and then for treatment can be long and vary between hospitals[88], as shown in Exhibit 29.

Exhibit 29 – Cancer wait times compared to peer median and average (providers)

National quartiles: 4 3 2 1

Metric, unit of measure	UCLH	R. Free	N. Midd.	Whitt.	National median	National upper quartile
Two week wait from GP urgent referral to first consultant appointment, %	92.9%	95.0%	93.2%	93.2%	94.7%	96.5%
Two week wait breast symptomatic (where cancer not initially suspected) from GP urgent referral to first consultant appointment, %	96.8%	99.3%	94.6%	97.2%	96.3%	97.9%
31 day wait from a decision to treat to a first treatment for cancer, %	90.5%	99.5%	97.3%	100.0%	98.6%	99.6%
31-day wait from a decision to treat to a subsequent treatment for cancer (surgery), %	87.6%	98.2%	96.9%	100.0%	98.2%	100.0%
62-day wait from GP urgent referral to a First treatment, %	72.6%	76.5%	76.0%	91.7%	85.2%	88.8%

Source: NHS England, Cancer Waiting time Statistics Q3 14/15-Q2 2015/16 by Provider. Available at: www.england.nhs.uk

The number of referrals to cancer specialists have almost doubled over the last five years[89], which may be partly due to current guidance but may also reflect difficulties accessing diagnostic tests or specialist advice in primary care. Once a person has been seen by a specialist, there are delays in transfer between hospitals and long waiting lists for diagnostics[90]. There is an estimated shortfall of 17 MRI, 7 CT scanners, 149 radiographers, 43 consultants and 22 sonographers for cancer diagnosis and treatment in NCL by 2020[91]. Satisfaction with services is often low – there is particularly low satisfaction with how well hospital and community services work together[92]. Many community cancer services are open only 9-5 during the week and there is very little coverage during the weekend[93].

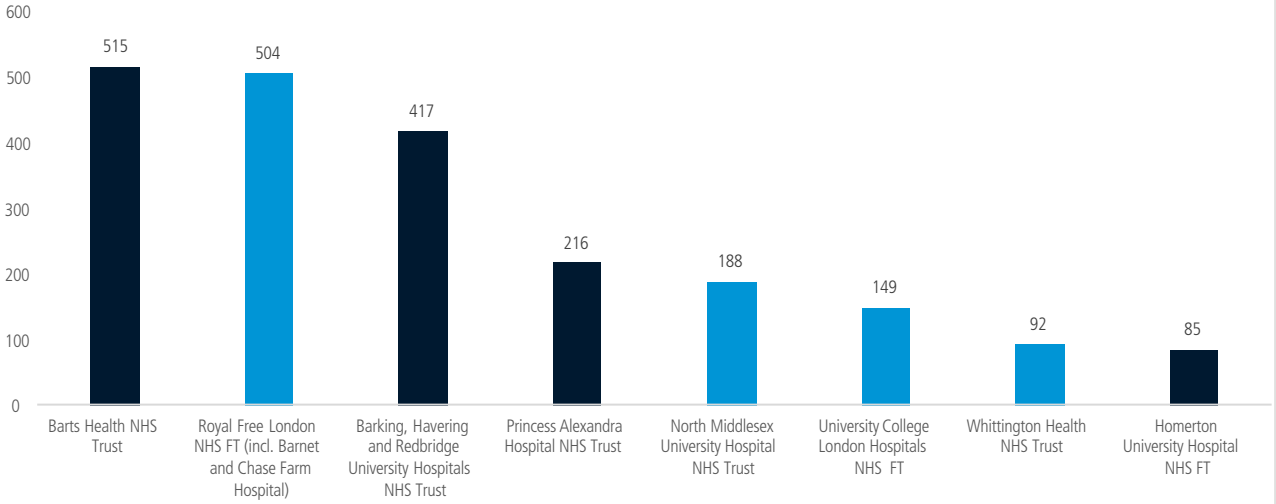
Improving early detection of cancer

Anne, 56, visited her GP complaining of abdominal pain and unexplained weight loss, and was then referred to a number of different specialties without a successful diagnosis. Four months later, she attended A&E with symptoms including jaundice, vomiting, fever and itching. After a series of tests, she was diagnosed with pancreatic cancer.

Source: adapted from UCLP Annual Review, June 2015

There a number of issues with hospitals seeing small numbers of some types of cancer patients, lower than NICE guidelines of 150 minimum cases per year[94]. For example, as shown in Exhibit 30, Whittington Health provides the second smallest breast cancer service in London, with under two patients a week on average. In addition, North Middlesex provides the second smallest lung cancer service[95], also seeing less than two patients a week on average.

Exhibit 30 – Number of new breast cancer patient treated in London cancer services



Source: Public Health England, 2014

This suggests a focus on the cancer pathway across primary and acute providers.

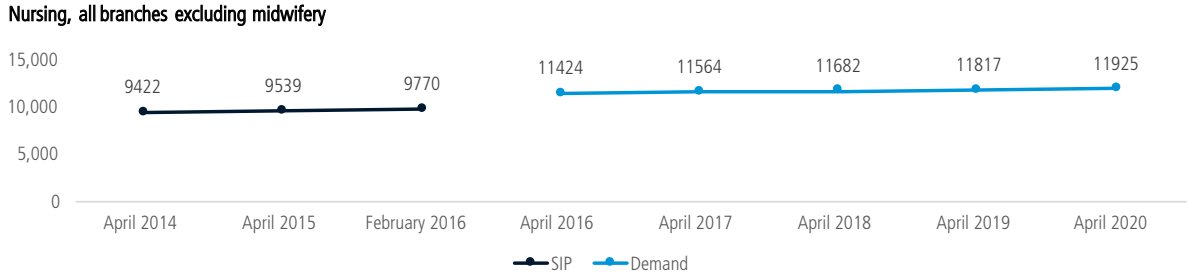
4.11. There are workforce challenges

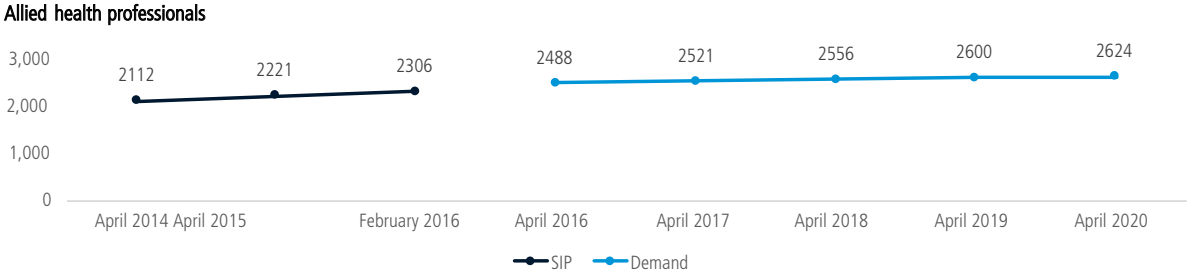
There are a number of workforce challenges in NCL. These include attracting the right health and care professionals to NCL, retaining the existing workforce, and shortfalls in GPs, practice nurses and social workers.

Attracting healthcare professionals to NCL

There is predicted to be a 22% shortfall in nurses and a 14% shortfall in allied healthcare professionals (AHPs) across NCL by 2020[96], as shown in Exhibit 31. The high and increasing cost of living in NCL makes it difficult to attract and retain the required workforce.

Exhibit 31 – Supply and demand for nurses and AHPs



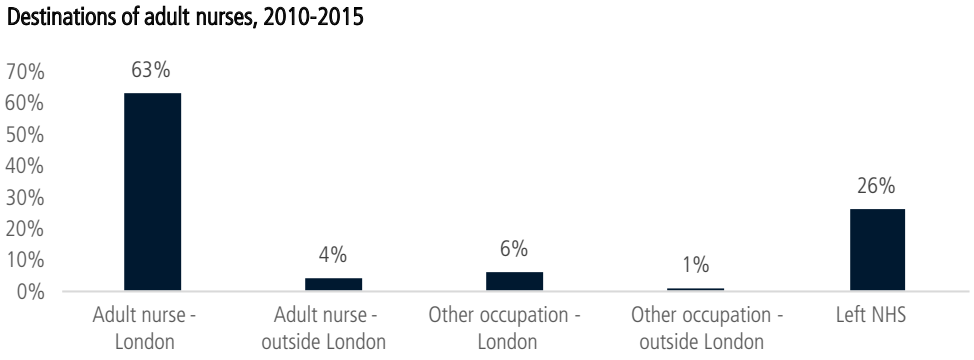


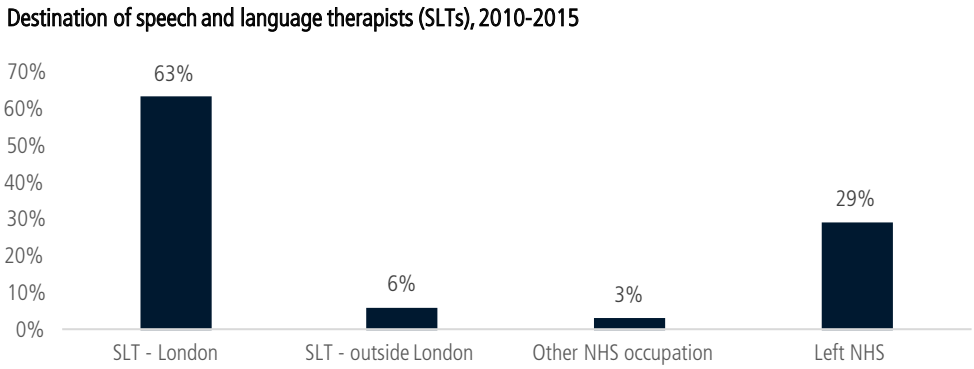
Source: NCL aggregated 2015/16 workforce planning data

Retaining the existing NHS workforce

The ageing of the workforce, and increasingly attractive career opportunities outside the NHS or outside London, make the recruitment and retention of staff one of the biggest challenges. Many people leave not only the local workforce but the NHS altogether, the majority being well under retirement age. For example, Exhibit 32 shows that 26% of adult nurses and 29% of speech and language therapists left the NHS entirely between 2010 and 2015[97].

Exhibit 32 – Destinations of adult nurses and speech and language therapists

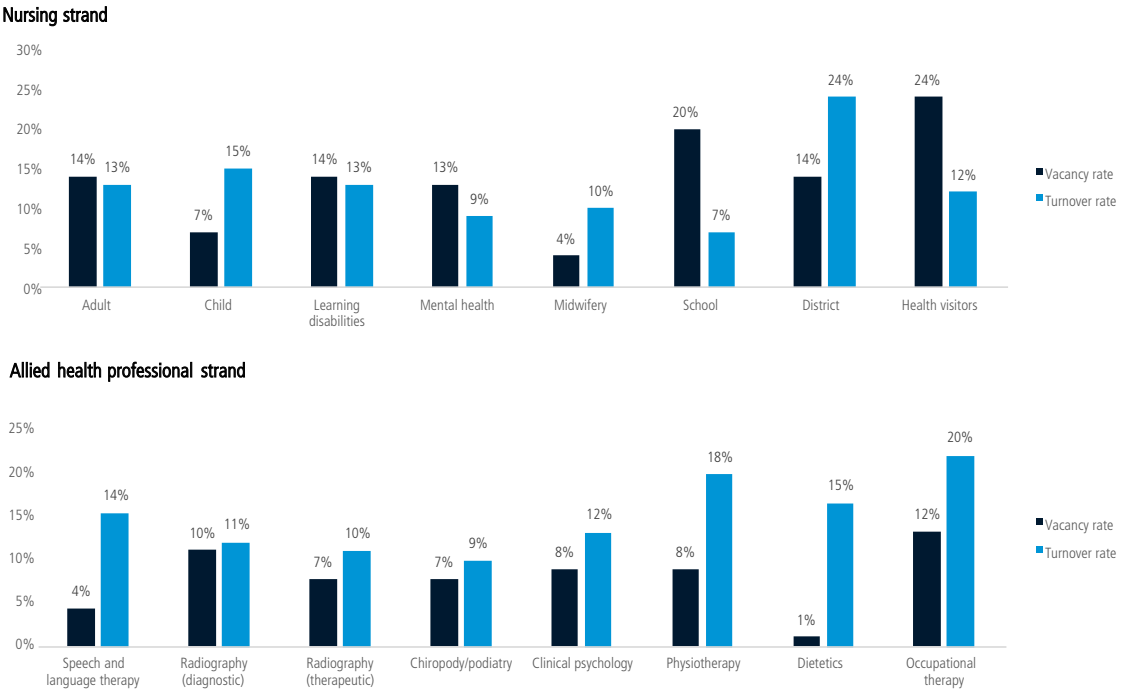




Source: Workforce Migration tool, 2015

There are high vacancy and workforce turnover rates locally, as shown in Exhibit 33. A particular issue is the high turnover rates in child nursing, radiography, mental health nursing and learning disability nursing, especially given that locally there is a children's hospital, a number of specialist cancer sites, and a number of mental health trusts. There are also high turnover rates in physiotherapy, occupational therapy and district nurses, which will impact on the delivery of additional community and primary care services[98].

Exhibit 33 – Health workforce vacancy and turnover rates in NCL



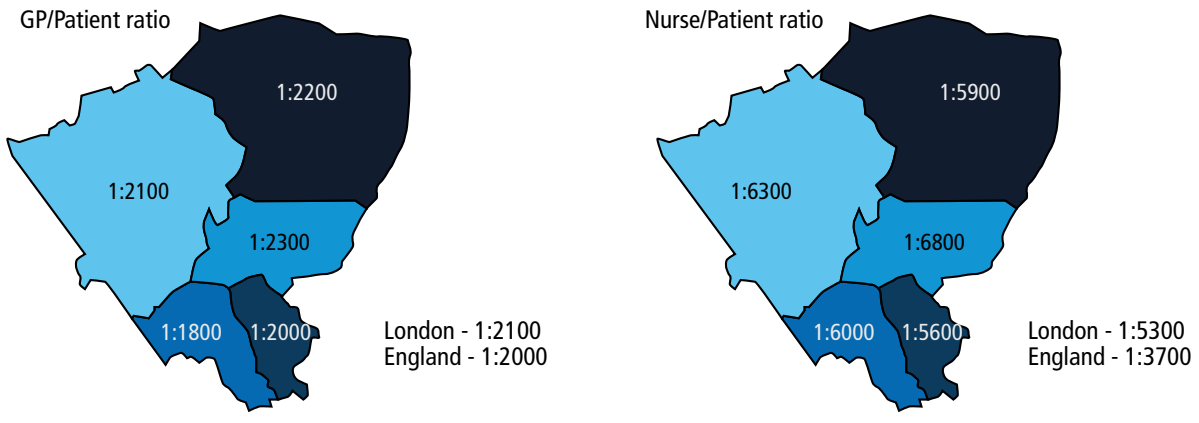
Source: 2015/16 Workforce Planning Data

NCL and North East London spend £735m a year on temporary and overseas staff, which represents 11.45% of staffing costs[99]. A reduction in staff turnover of just 1% could reduce costs by £87.6m[100].

GPs and practice nurses

The number of General Practitioners (GPs) and practice nurses across NCL is growing, but there is also unprecedented increase in demand[101]. As shown in Exhibit 34, there are also fewer GPs and nurses per person in some parts of NCL, especially Haringey[102]. Increasing the number of GPs to meet current levels of demand is not affordable, and alternative workforce models will need to be explored.

Exhibit 34 – GPs and practice nurses per person in NCL

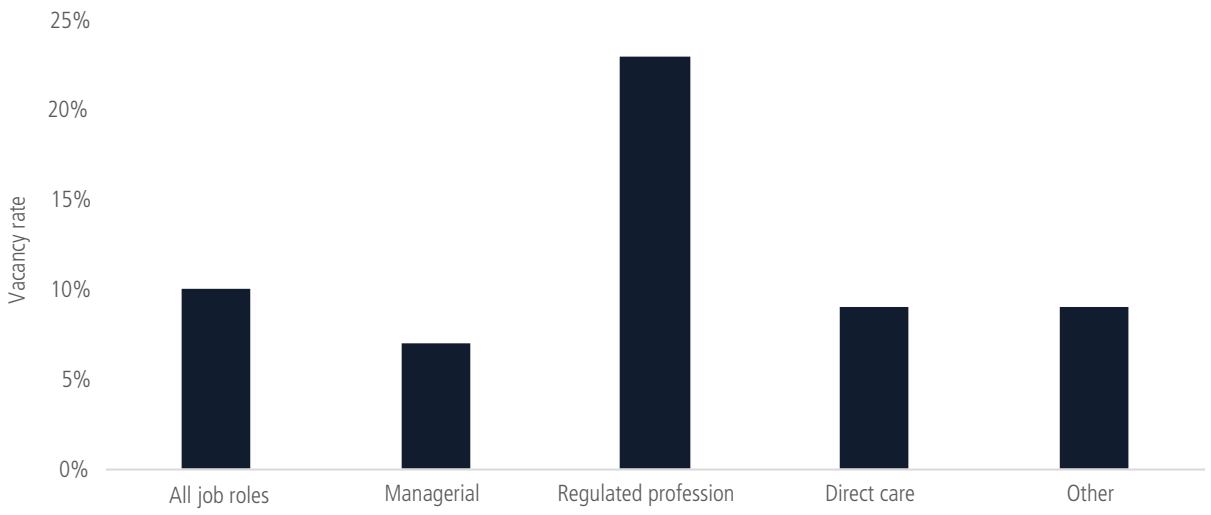


Source: National list size data

Social care workers

There are 35,000 people working in social care in NCL, with 1,500 staff in regulated professions (such as social workers) and 25,000 others providing direct care. As shown in Exhibit 35, vacancy rates across the regulated professions are around 23.5%, higher than any NHS staff group[103]. This shortfall of staff contributes to delays in discharge for people in hospital beds. There are also large differences in pay and conditions for the social care workforce, with 43% of the workforce on zero-hour contracts and many personal assistants employed directly by service users.

Exhibit 35 – Social care vacancy rates

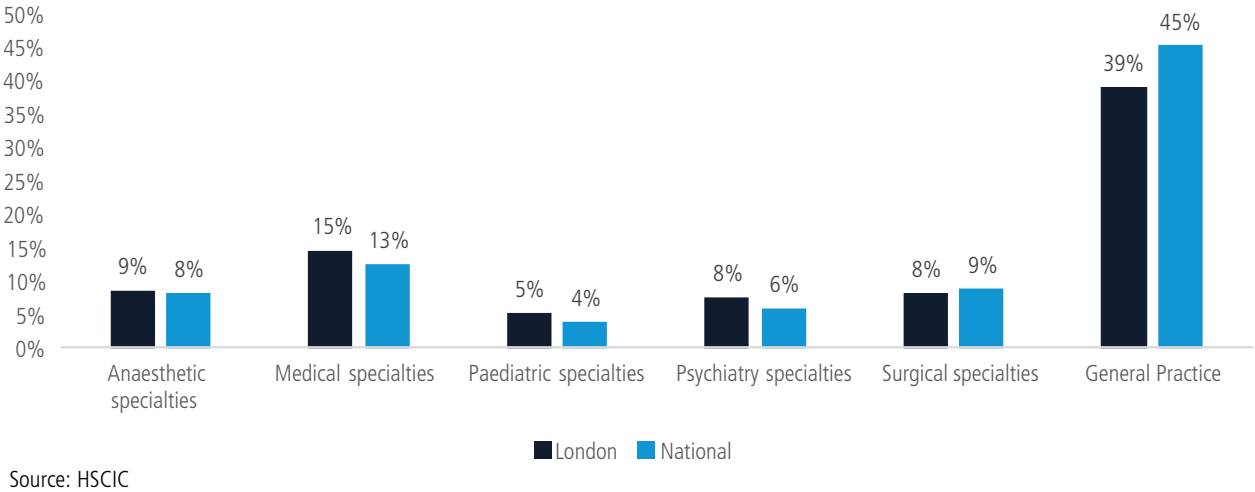


Source: HSCIC

Junior doctors and consultants

Between 2009 and 2014, the number of consultants in the London workforce increased by an average of 20.1% against a national average of 17.8%, and the number of Certificate of Completion of Training (CCT) holders continues to rise. As shown in Exhibit 36, London has a similar consultant workforce to the rest of the country, but a lower number in some specialties, particularly general practice[104].

Exhibit 36 – Proportion of the consultant workforce by selected specialty compared to England



Source: HSCIC

Over the next six years, there will be a large increase in the number of CCT holders[105]. It will be important to consider how these doctors are used to deliver more care in out of hospital settings.

This suggests a focus on recruitment and retention of the workforce, particularly where there are high vacancy and turnover rates or shortages in staff. It also suggests a focus on developing the existing workforce through new skills and ways of working, as well as adapting roles to changing requirements.

4.12. Some buildings are not fit for purpose

The availability of good quality buildings is very important in delivering new types of health and care services in NCL. Good quality buildings that are fit for purpose reduce infection and the length of time people stay in hospital, make it easier for staff to do their jobs, and are a more pleasant environment for people in hospital and reduce costs[106].

The quality of the NHS estate is very variable. Across London, more than half of NHS hospitals are over 30 years old and more than a quarter pre-date the founding of the NHS in 1948. Addressing maintenance issues across these hospitals would cost around £658 million[107]. These issues are particularly stark in NCL. Over the past two decades a number of major developments have taken place locally: rebuilding North Middlesex University Hospital (NMUH); rebuilding University College London Hospital (UCLH); and the development of the UCLH cancer centre. However, Chase Farm Hospital was mostly built before 1948.

Estates not fit for purpose

'We found that patient experience is compromised by the poor environment, with some patients having to share four-bedded dormitories, and with limited access to secure outdoor space.' (From an Enter and View visit)

Source: Healthwatch Enfield

It is thought that 15% of NHS building space in London is not actually being used[108]. The unused NHS buildings in NCL are worth an estimated £198m and cost the NHS £20m-£24.5m to run[109]. One example is St. Ann's Hospital where many of the current buildings are either vacant or partially occupied and are expensive to maintain. Major changes are required to improve the health facilities at St Ann's – planning permission has been granted to develop the site, but is subject to approval of the business case.

There are also issues in primary care, where a large number of existing primary care buildings in London are not fit for purpose. Around 33% of GP premises need replacing, whilst 44% need significant improvement to meet equalities laws[110].

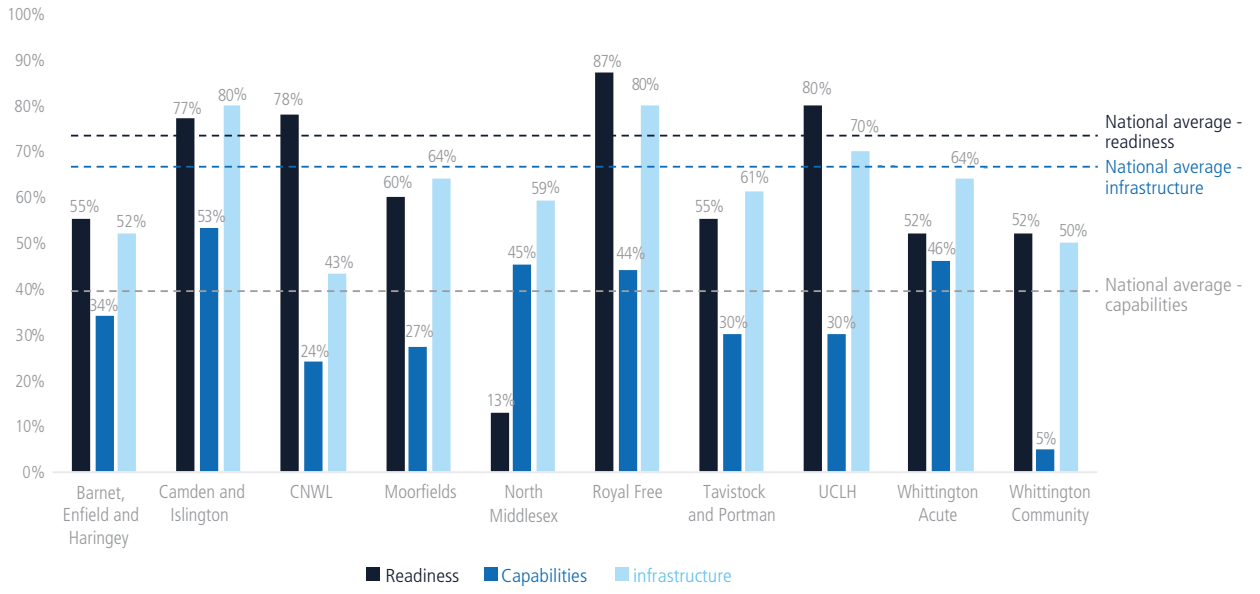
This suggests a focus on buildings that are old, expensive to run and not fit for purpose, and developing buildings that support patient and clinical needs.

4.13. Information technology needs to better support integrated care

Information sharing between people and between organisations is essential to deliver safe, effective and efficient care. Information sharing supports people to stay healthy, multi-professional teams to deliver integrated care and organisations to identify opportunities to reduce variation, waste and clinical harm. Patients and the public expect to be told who is using their information, why it needs be shared, who has access to it and what safeguards have been put in place to keep it secure. They also increasingly expect information to be shared with them, in a format they understand, and to help them to contribute their own data and let their care preferences be known.

As shown in Exhibit 37, the level of digital maturity of provider organisations across NCL is variable, with most below the national average for digital capabilities and particularly poor in terms of their capability to share information with others and adoption of national standards[111]. Data collection in primary care is much more developed than other areas of the NHS, but the quality of data and information still varies between practices, and the number of people digitally accessing their own GP records remains low[112]. Local authorities mainly have stand-alone systems, with limited ability to digitally share information with NHS providers or with other boroughs.

Exhibit 37 – Digital maturity assessment



Source: NHS England Digital Maturity Assessment 2015

The workforce needs to be connected all day, every day. They need to be able to access people's data and tools to assist clinical decision making in real time and collect and view data wherever they are working. While the use of mobile devices to view and capture data is gradually improving, there are still many areas where the workforce across NCL is not properly informed and supported[113].

The current situation has mainly been developed because of the need to meet regulatory requirements. More recently, integrated digital care records have been created to facilitate integrated care within individual CCGs in Camden and Islington. However, there is no NCL-wide governance structure or leadership team to implement digital transformation across NCL, and individual organisations continue to operate independently within their own areas with resultant fragmentation, lack of joined up information flows and duplication of effort.

This suggests that a priority area for focus is developing system wide governance and leadership to support the implementation of integrated information sharing and technology.

5 Financial challenge

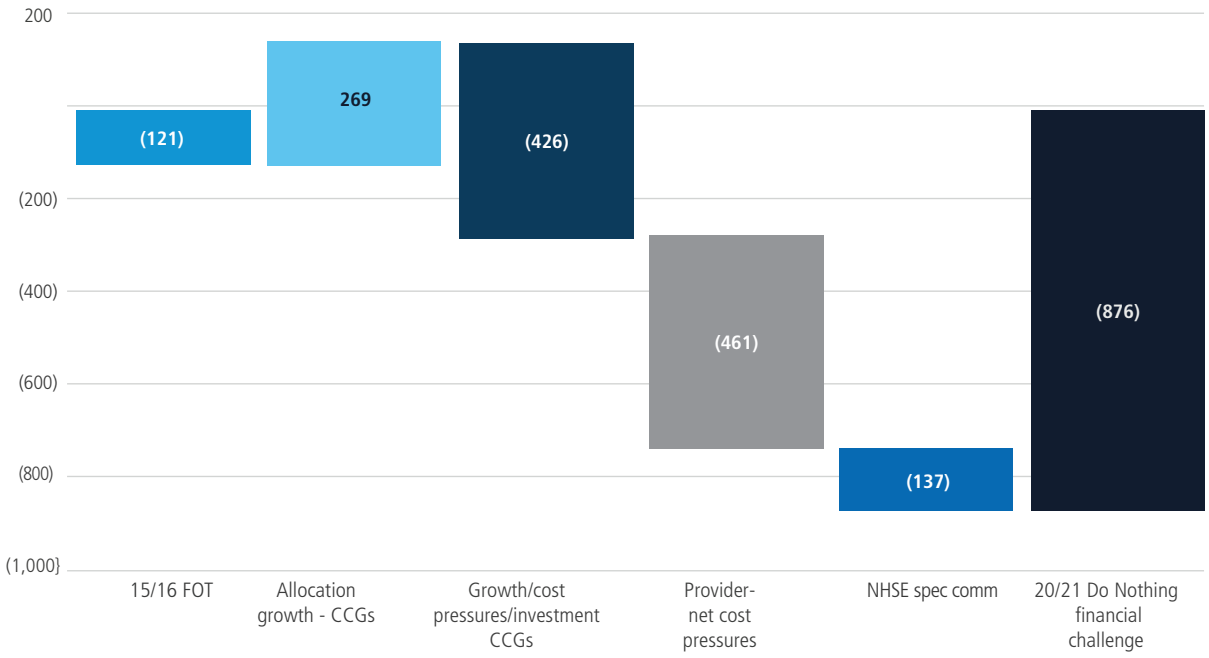
Funding increases in NCL of £269m over the next 5 years will not meet the likely increases in numbers of local people and growth in demand for health services of £426m, plus increases in the cost of delivering health care of £461m.

This means that there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers are already £121m in deficit in 2015/16 and, if nothing changes, will be £876m in deficit by 2020/21. This includes £137m in relation to specialised commissioning.

The health budget impact of the local authority financial challenge has not been calculated and so is not included in the 'do nothing' financial gap.

Exhibit 38 summarises the 'do nothing' financial gap for NCL.

Exhibit 38 – NCL forecast financial gap



Source: NCL finance base case analysis

The consequence of doing nothing is that local health and social care services would not be maintained. A new way of providing services is needed, that can be delivered within the funding available. This cannot be done by one organisation, but needs to be done across health and social care, with everyone working together.

6 Next steps

Recognising the significant scale of the challenges faced, and the urgency with which they need to be addressed, NCL has come together as a strategic planning group to create a 5-year Sustainability and Transformation Plan (STP). The aim of the STP is to meet the challenges outlined in this Case for Change, delivering clinical and financial sustainability for health and social care in NCL and, most importantly, improving the quality of care and outcomes for local people.

Leaders representing all aspects of health and social care in NCL – people that work in health commissioning, hospitals and local authorities, local GPs, and people that represent patients and the public – are working together to tackle the issues. They recognise that something radically different needs to be done in order to make sure local people have access to care when they need it, in the most appropriate place. This about promoting independence, health and wellbeing for everybody in NCL, whether they live in Enfield or Islington. It can only be done by working together, building trust between organisations that aren't necessarily used to doing so, and considering solutions across NCL. There may be things that can be done to improve health and care which are better delivered at a local, neighbourhood level. But it is important that there is a common vision across NCL in order to deliver maximum possible impact.

There is already lots of good work to build on in NCL. For example, UCLH and the Royal Free have set up an innovative joint venture with The Doctors Laboratory to run pathology services, which is at the cutting edge of new partnerships in health. There are existing schemes in NCL that could be further developed: the first Multidisciplinary Diagnostic Centre for cancer in England opened at UCLH, for example, and GP practices across NCL are already working together in GP Federations, meaning that they can deliver more services than they would be able to alone. Nationally, two 'vanguard' sites have been established in NCL – one looking at how hospitals can work together better, and one looking at what can be done to improve the end-to-end experience for people with cancer, from prevention to recovery. In addition, the Haringey devolution pilot, focusing on prevention, is exploring the licensing and planning powers needed to shape healthy environments; and support for people with mental health conditions who are on sickness absence but not yet unemployed[114]. In individual boroughs, great work has been done to meet the needs of local people and bring together health and care into a seamless service. This includes strengthening the role of the voluntary sector in providing services and caring for people and their families.

Local leaders are currently establishing the key pieces of work that will really make a difference and have a positive impact on lives in NCL. The ideas being explored include:

- developing new models of care for particular groups of people, making sure that they are tailored to the particular groups' needs;
- working with people from an early age through schools and communities to prevent them from getting sick;
- investing in primary care to make sure that people get to see a GP when they need and that more care can take place in the community, closer to home;
- addressing the issues that are present in hospitals, such as high infection rates and long waiting times;
- making sure that mental health and physical health are considered together and that this is reflected in the way that people with mental health problems are treated; and
- making sure that hospital treatments are delivered safely and efficiently.

The impact of these pieces of work will mean that people stay healthier for longer, and are able to play more of an active role in their own care if they want to. It will mean that more care can be provided at home or in the community, and that interactions with health

and care professionals will be different. In some cases, people might want contact with a named professional who knows them. In other cases, they might want access to a GP or the ability to make an appointment online. When people do need to go to hospital, they will only be there for as long as they need to be, and the connection between hospital professionals and community care professionals will make sure people are supported when they go home – making sure they have some food in the fridge when they get back, for example. All of this should reduce complications or difficulties that are caused from confusion, bureaucracy and lack of communication, meaning that people are less likely to end up in hospital when it could have been prevented.

Local leaders are also looking at ways to reduce avoidable costs through improving productivity and efficiency across NCL; for example, by bringing together administrative functions. This will mean that hospitals will have more money to spend on patients and care. Finally, the programme will consider what is required to deliver change. Examples of this include using technological advances to improve care, such as improving access to the latest diagnostic tools which pick up cancer at an early stage, or providing people with an electronic patient record that they can share with any health and care professionals they come into contact with so that their full history is known. Local leaders will also review the health and care buildings across NCL, identifying those that are not fit for purpose or not being used fully, and finding the best way to get maximum value out of these in order that they support new ways of working – or developing new, accessible buildings that are paid for by the money released from unsuitable sites. It will also be essential to develop the leaders of tomorrow – making it attractive and affordable for talented people to live and work in NCL, rather than depending on temporary staff, who can often be expensive.

The initial, high-level Sustainability and Transformation Plan will be developed by the end of June 2016, and further work at a more detailed level will continue to the end of 2016. Improvements will start to be made immediately, and completed by 2020/21. To get this right, patients, people who use services, carers and local residents will be involved in producing this plan. This Case for Change provides a platform for transformation, and will be referred back to over the coming years to ensure any proposed change is heading in the right direction. The data analysed in this document represents a point in time, and will be updated as required. Should new key issues, themes or gaps in care be identified as a result of this, local leaders will work together to respond to these.

Appendix 1: data segmentation methodology

Method	• Use Monitor Care Spend Tool as the structure of model, which allocates spend to cluster and then across age and condition bands • Splits spend by POD by age band • Assigns each individual to a condition in descending rank order of intensity • Applies pattern of resource consumption intensity by segment based on previous applications of matched patient-level data sets
Inputs	• Population by year and age band (ONS) • Distribution of condition by age band (Monitor tool) • Prevalence of health conditions in the locality (QOF) • Mapping of conditions by age band making use of Monitor peer group and QOF • CCG spend by POD for 2015/16 • LA spend by ASC
Outputs	• Breakdown by age and condition at with population, spend per capita, total spend plus breakdown by POD and segment for per capita and total spend • Locality level output dependent on data availability
Limitations	• Monitor peer group analysis limited to set age bands, does not have perfect match for the locality population and is therefore based on archetypal comparator areas • The analysis excludes children's social care • Is not actual patient level data specific to the locality

Endnotes

1 An estimated 181,000 in total in NCL by 2020, an additional 26,000 over 5 years

2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

3 PHE 2015, HSCIC 2015

4 CQC care directory

5 All numbers from ONS unless otherwise referenced.

6 http://patient.info/doctor/diseases-and-different-ethnic-groups

7 GLA 2014 Round SHLAA Capped Ethnic Group Borough Projections (October 2015)

8 Census 2011

9 Census 2011

10 Nomis official labour market statistics, November 2015

11 Public Health Profiles Data Tool, PHE, 2014/15

12 IMD 2015, ONS

13 All numbers from ONS unless otherwise referenced.

14 http://www.lse.ac.uk/geographyAndEnvironment/research/London/pdf/populationmobilityandserviceprovision.pdf

15 https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

16 https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

18 Camden and Islington GP Linked Dataset projected to NCL level

19 Public Health Profiles Data Tool, PHE, 2014-15

20 Local analysis using Camden and Islington GP Dataset, 2012

21 http://ash.org.uk/files/documents/ASH_107.pdf

22 http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000019/iid/91414/age/1/sex/4

23 http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000019/iid/22401/age/27/sex/4

24 Public Health Profiles Data Tool, PHE, 2014-15

25 2014 Round of Demographic Projections - SHLAA-based population projections, Capped Household Size model, short-term migration scenario

26 ONS, mid-year population estimates

27 Public Health Outcome Data Tool, PHE, 2013

28 Public Health England 2015

29 Public Health England 2014

30 QOF 2014-15

31 http://www.ash.org.uk/current-policy-issues/health-inequalities/smoking-and-mental-health/the-stolen-years

32 NHS England Dementia Diagnosis Monthly Workbook, April 2016

33 NHS England Dementia Diagnosis Monthly Workbook, April 2016

34 Camden and Islington GP Linked Dataset, 2015, projected to NCL level

35 Camden and Islington GP Linked Dataset projected to NCL level

36 Based on 2015/16 public health budget of each NCL council

37 http://www.tobaccoprofiles.info

38 Public Health Profiles Data Tool, PHE, 2012-14

39 NHS Right Care, 2015 NHS Atlas of Variation

40 APHO modelled expected prevalence (2011)

41 Local audit of hospital admissions at the Whittington

42 APHO modelled expected prevalence (2011)

43 Quality and outcomes framework, 2014-15,

44 Quality and outcomes framework, 2014-15,

45 HSCIC, General Practice Census 2014 at Practice Level. Populations are unweighted.

46 GP Patient Survey (Q4; 2014-15

47 NCL Primary Care Joint Committee, March 2016

48 NCL Primary Care Joint Committee, March 2016

49 RightCare Atlas of Variation in Healthcare, September 2015

50 NHS England Monthly Activity Data 2014-15

51 SLAM Data (2014/15); provided by NEL CSU (analysis undertaken for Enfield CCG only)

52 NHS Right Care, 2015 NHS Atlas of Variation

53 HES 2013-14

54 Office for National Statistics, HSCIC CCG Indicator 2.6, 2014-15

55 Office for National Statistics, HSCIC CCG Indicators, 2014-15

56 Office for National Statistics, HSCIC CCG Indicators, 2014-15

57 ASCOF 2013-14

58 ASCOF 2013-14, HSCIC 2014-15

59 NCL 5yr Planning Activity and Cost Analysis – 2013-14 actual data

60 For example, regional geriatric programme of Toronto

61 People who die in their usual place of residence, ONC, 2014-15

62 NHS England Delayed Transfers of Care Data, 2014-15

63 Carter Review, 2016

64 Devon acuity audit, October 2015

65 SUS 2014/15. 10-day trim applied to all NCL CCG patients aged 65 and over staying more than 10 days. 90% bed occupancy assumed based on actual average bed occupancy 2014-15.

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70 NCL clinical workshop, 20 April 2016

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73 HSCIC Hospital Episode Statistics 2014-15

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77 NHS England Dementia Diagnosis Monthly Workbook, April 2016

78 Emerson E and Hatton C, Estimating future need for social care among adults with learning disabilities in England: an update. 2011

79 http://fingertips.phe.org.uk/profile/learning-disabilities

80 Emerson E and Baines S, Health inequalities and people with learning disabilities in the UK. 2010

81 ONS, national population projections, 2015

82 ONS, Index of cancer survival rates, 2012 diagnosis

83 International cancer benchmarking partnership 2000-2 to 2005-7

84 39.4% in Haringey and 38.9% in Islington in 2013 compared to 46.7% in Barnet, HSCIC CCG outcome indicator set 1.18: percentage of cancers detected at stage 1 and 2.

85 Open Exeter / national screening service, December 2014

86 For example, over 25% of people with colorectal cancer in UCLH Vanguard diagnosed in an emergency presentation between 2006 and 2013: NCIN, Public Health England

87 http://www.cancerresearchuk.org/sites/default/files/public_awareness_of_cancer_in_britain_dh_report.pdf

88 NHS England, Cancer Waiting time Statistics Q3 14-15-Q2 15-16 by Provider

89 National cancer intelligence network, 2009-10 to 2014-15

90 UCLH cancer vanguard: imaging demand and capacity, 2020 Delivery, December 2015

91 UCLH cancer vanguard: imaging demand and capacity, 2020 Delivery, December 2015

92 National patient experience survey, 2014

93 As at 31 March 2014. A review of specialist palliative care provision and access across London, September 2015, London Cancer Alliance (Appendix 4)

94 NICE guidance

95 Number of new lung cancer patients treated (patient first seen in 2013), Lucada

96 NCL aggregated 2015-16 workforce planning data

97 Workforce Migration tool, Health Education England 201

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99 An economic analysis of the North Central and North East London workforce, Health Education England 2016

100 An economic analysis of the North Central and North East London workforce, Health Education England 2016

101 General Practice and Workforce statistics, Health and Social Care Information Centre workforce data, Sept 2015

102 General Practice and Workforce statistics, Health and Social Care Information Centre workforce data, Sept 2015

103 Workforce Census, Skills for Care, July 2015

104 General Practice and Workforce statistics, Health and Social Care Information Centre workforce data, Sept 2015

105 HEE (London) trainee numbers, February 2016

106 For example, Health and Care Infrastructure Research and Innovation Centre, 2010

107 RIC returns, 2014-15 - significant, high and moderate risk backlog maintenance

108 http://www.londonhealthcommission.org.uk/wp-content/uploads/Unlocking-the-value-of-NHS-estates-in-London-.pdf

109 Carnall Farrar, 2016, based on 14-15 ERIC data for acute/MH and 12-13 data for community

110 Better Health for London

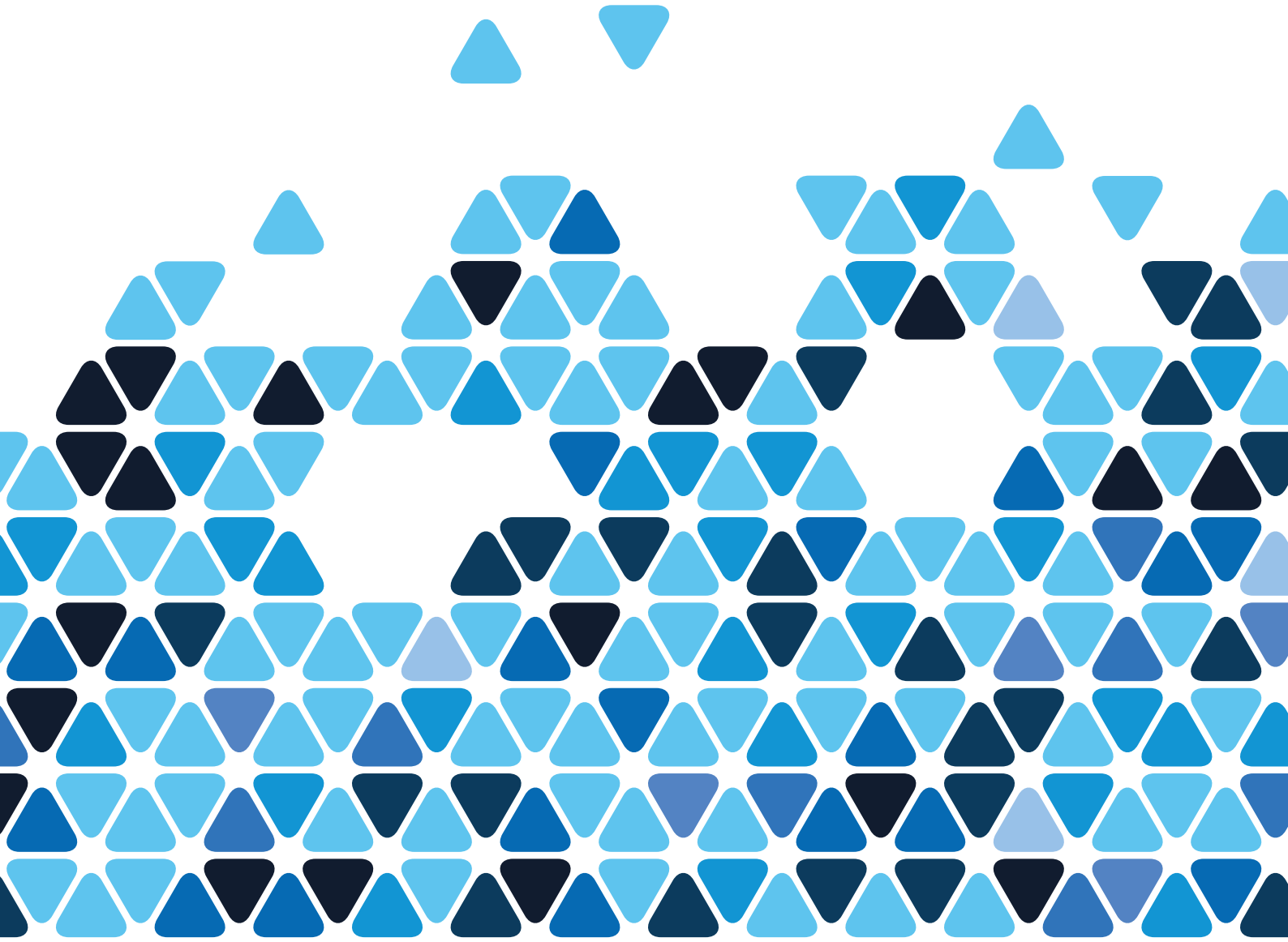
111 NHS England Digital Maturity Assessment 2015

112 NHS England Digital Maturity Assessment 2015

113 NHS England Digital Maturity Assessment 2015

114 London Health and Care Devolution Bulletin, June 2016

North Central London Sustainability and Transformation Plan



Report for: Health and Wellbeing Board – 3 October 2016

Title: Future Joint Health and Wellbeing Board Meetings

Report authorised by : Debra Norman, Assistant Chief Executive (Governance and HR), Islington Council

Bernie Ryan, Assistant Director, Coporate Governance, Haringey Council

Lead Officer: Jonathan Moore, Senior Democratic Services Officer, Islington Council

Stephen Lawrence-Orumwense, Assistant Head of Legal Serivices, Haringey Council

1. Describe the issue under consideration

1.1 The London Boroughs of Islington and Haringey have developed a joint health and care initiative known as the Islington and Haringey 'Wellbeing Partnership'. The 'Wellbeing Partnership' is the coming together of NHS organisations and local authorities in Haringey and Islington. It is driven by a shared recognition that major changes are needed to ensure that health and care services are of the right quality and capable of meeting the future needs of our local communities. To continue to develop this partnership arrangement, the Islington and Haringey Health Wellbeing Boards are asked to consider the frequency of joint meetings and the possibility of formalising joint arrangements. This will enable joint consideration of health and care issues, provide effective oversight of the Wellbeing Partnership, and support the development of cross-borough working relationships.

2. Recommendations

2.1 To determine the frequency of joint meetings between the Islington and Haringey Health and Wellbeing Boards and the need for a joint committee.

3. Background Information

3.1 Haringey and Islington have set up a wellbeing partnership. The current Wellbeing partner organisations are: Haringey Council, Islington Council, Whittington Health, Camden & Islington NHS Foundation Trust, Islington Clinical Commissioning Group, and Haringey Clinical Commissioning Group. It is envisaged that other health providers and stakeholders will join the partnership. The partnership have agreed the following principles:

a) Partner organisations will work together for the benefit of local people;
b) We will involve local people in our design, planning and decision-making;
c) Partner organisations will find innovative ways to cede current powers and controls to explore new ways of working together;
d) We will be open, transparent and enabling in sharing data, information and intelligence in all areas including finance, workforce and estates;
e) Partner organisations have agreed to find ways to 'risk share' during transformational change;
f) We will find ways to share joint incentives and rewards;
g) Partner organisations will make improvements by striving to be the best, together; and
h) We will be rigorous in ensuring value for money and financial sustainability.

3.2 To continue to develop and strengthen the partnership, both the Haringey and Islington Health and Wellbeing Board have decided to convene this joint meeting to discuss, amongst other matters, the partnership initiative in the context of other developments in the health and care economy. As Islington and Haringey have not entered into formal joint arrangements these are technically separate meetings of each Board held concurrently. Each Board may make decisions related to its own functions, but functions cannot be exercised jointly. The usual procedure rules governing each meeting are applicable, including quorum and voting rights. Separate minutes will be produced for each meeting.

3.3 The Boards are invited to consider the frequency of the joint meetings. It is suggested that three or four joint meetings in the municipal year would be appropriate. They will be held as separate but concurrent meetings of each Board unless it is decided to enter into formal joint arrangements. With these additional meetings, the Boards may wish to adjust the frequency of their usual meetings schedule.

3.4 It is proposed for the joint meetings to be hosted alternately by Islington and Haringey to ensure a balanced use of resources.

<u>Formalising Joint Arrangements</u>

3.5 The Haringey and Islington Health and Wellbeing Boards may wish to give consideration to formally establishing a joint committee. This could further strengthen the wellbeing partnership and provide a platform for joint working and oversight and decision-making in the future. The establishment of a joint committee would require consideration of matters such as terms of reference, decision-making powers, membership, quorum, meetings, voting, administrative support and lead borough arrangements.

3.6 Any joint committee would need to be established in accordance with the constitutional requirements of both authorities. The arrangements for the joint committee including the terms of reference would require the approvals of both authorities and may require amendments to parts of their Consitution relating to the Health and Wellbeing Board.

4. Contribution to strategic outcomes

Strategic outcomes

4.1 Both Islington and Haringey Health and Wellbeing Boards have expressed their support for the Wellbeing Partnership. The Partnership is intended to support the populations of both boroughs to live healthier, happier and longer lives; improve health and care services so that people experience more joined up, better quality services at the right time in the right place; and make sure the local health and care system delivers high value care, and is financially sustainable. Islington and Haringey have similar populations, with similar health and care needs, and a shared ambition and vision to provide high-quality, integrated, people-centred services.

5. Statutory Officer Comments (Legal and Finance)

Finance

5.1 Holding joint meetings will have resource implications which will need to be met from existing budgets. However, the Wellbeing Partnership will support the financial sustainability of local health and care services.

Legal implications

5.2 Section 198 of the Health and Social Care Act 2012 provides that two or more Health and Wellbeing Boards may make arrangements for any of their functions to be exercisable jointly. In addition,Section 102 of the Local Government Act 1972 enables two or more local authorities to set up a Joint Committee to discharge their functions jointly. As mentioned above, the establishment of and the arrangement for the joint committee would require the approval of both local authorities.

6. Environmental Implications

None.

7. Resident and Equalities Implications

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

The holding of joint meetings is a governance matter and does not have direct resident and equalities implications. However, the Wellbeing Partnership will help to tackle health inequalities in both Islington and Haringey.

8. Use of Appendices

None.

9. Background papers

None.