NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Friday 30 November 2018 10:00 a.m.
The Conference Room, Enfield Civic Centre, Silver Street, Enfield, Middlesex, EN1 3XA

Councillors: Alison Cornelius and Val Duschinsky (L.B.Barnet), Julian Fulbrook and Alison Kelly (Chair) (L.B.Camden), Huseyin Aknipar and Clare de Silva (L.B.Enfield), Pippa Connor (Vice-Chair) and Lucia das Neves (L.B.Haringey), Trish Clarke (Vice-Chair) and Osh Gantley (L.B.Islington)

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

AGENDA

1. NC LONDON JHOSC - AGENDA PACK (PAGES 1 - 126)

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 30 NOVEMBER 2018 AT 10.00 AM
CONFERENCE ROOM, ENFIELD CIVIC CENTRE, SILVER STREET, ENFIELD EN1 3XA

Enquiries to:	**Vinothan Sangarapillai, Committee Services**
E-Mail:	**vinothan.sangarapillai@camden.gov.uk**
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MEMBERS

Councillor Alison Kelly (London Borough of Camden) (Chair)
Councillor Tricia Clarke, London Borough of Islington (Vice-Chair)
Councillor Pippa Connor, London Borough of Haringey (Vice-Chair)
Councillor Huseyin Akpinar, London Borough of Enfield
Councillor Alison Cornelius, London Borough of Barnet
Councillor Lucia das Neves, London Borough of Haringey
Councillor Clare De Silva, London Borough of Enfield
Councillor Val Duschinsky, London Borough of Barnet
Councillor Julian Fulbrook, London Borough of Camden
Councillor Osh Gantly, London Borough of Islington

Issued on: Thursday, 22 November 2018

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 30 NOVEMBER 2018

THERE ARE NO PRIVATE REPORTS

AGENDA

1. APOLOGIES

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Members will be asked to declare any pecuniary, non-pecuniary and any other interests in respect of items on this agenda.

3. ANNOUNCEMENTS

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

5. MINUTES (Pages 7 - 14)

To approve and sign the minutes of the meeting held on 5th October 2018.

6. DEPUTATIONS

7. ADULT ORTHOPAEDIC SERVICES REVIEW (Pages 15 - 36)

To consider a presentation on the Adult Orthopaedic Services review.

8. FINANCIAL UPDATE: ESTATES (Pages 37 - 42)

To consider information on the capital receipts from NHS organisations in North-Central London and their use for revenue spend.

9. GENERAL PRACTICE AS THE FOUNDATION OF THE NHS: A STRATEGY FOR NORTH-CENTRAL LONDON (Pages 43 - 96)

To consider a presentation on the General Practice strategy.

10. FINANCIAL UPDATE: ROYAL FREE HOSPITAL

(Pages 97 - 106)

To consider an update from the Royal Free on their financial position.

11. WORK PROGRAMME AND ACTION TRACKER

(Pages 107 - 128)

To consider the work programme and action tracker for NCL JHOSC.

This includes a copy of the Adult Social Care workforce strategy (Annex A) and a copy of the letter sent to the five NCL Council Leaders in response to their letter on the STP (Annex B).

12. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

13. DATES OF FUTURE MEETINGS IN 2018-19

Dates for future meetings in 2018-19 are:

- Friday, 18th January 2019 (Haringey)
- Friday, 15th March 2019 (Islington)

14. PROPOSED DATES FOR MEETINGS IN 2019-20

Proposed dates for JHOSC meetings next municipal year (2019-20):

- Friday, 21st June 2019
- Friday, 27th September 2019
- Friday, 29th November 2019
- Friday, 31st January 2020
- Friday, 13th March 2020

AGENDA ENDS

The date of the next meeting will be Friday, 18 January 2019 at 10.00 am in Committee Rooms 1 & 2, Haringey Civic Centre, High Road, London N22 8LE.

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 5TH OCTOBER, 2018** at 10.00 am in Crowndale Centre, 218 Eversholt Street, London NW1 1BD

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Tricia Clarke (Vice-Chair), Pippa Connor (Vice-Chair), Huseyin Akpinar, Alison Cornelius, Lucia das Neves, Val Duschinsky and Julian Fulbrook

MEMBERS OF THE COMMITTEE ABSENT

Councillors Clare De Silva and Osh Gantly

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee and any corrections approved at that meeting will be recorded in those minutes.

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Clare De Silva.

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Cllr Pippa Connor declared she was a member of the RCN and that her sister worked as a GP in Tottenham.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

Members were notified that a deputation from the LUTS patient group had been accepted.

5. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

The committee received a deputation from Kate Dwyer, on behalf of the LUTS patient group.

Ms Dwyer reported that the clinic could only see 8 new patients a month and so the waiting list was growing. Some doctors were refusing to refer patients, so denying those patients the chance for what could be more effective treatment.

She added that child patients at Great Ormond Street Hospital were not receiving treatment according to the pathway that had been proposed earlier, as paediatricians did not wish to prescribe the antibiotics for treatment in the way that Professor Malone-Lee did in the clinic.

The Chair said that the Committee regretted the pain and distress that patients were going through. She asked that the deputee email her with information that could then form the basis of an email to the Great Ormond Street Chief Executive.

6. MINUTES

Consideration was given to the minutes of the meeting held on 7th September 2018.

Councillor Connor asked that more information be provided in the minutes about the back office savings that could result from joint working between the North Mid and Royal Free hospitals.

Councillor Cornelius asked that reference to “North Midds” be changed to “North Mid”.

Councillor Clarke asked that it be noted that it had been said that an increase in population would be likely to add to pressure on hospital services.

Members asked that it be noted that Enfield had stated that it wanted land sold to be used for health purposes.

Members asked that it be noted that the questions document circulated at the meeting was to be sent to the hospitals and be put online.

Members noted that there had been no response to some of the actions requested at the July meeting.

RESOLVED –

THAT the minutes of the meeting held on 7th September be agreed, subject to the amendments above.

7. EMBEDDING PREVENTION WITHIN NORTH LONDON PARTNERS STP

Consideration was given to a presentation from North London Partners.

Julie Billett, the Director of Public Health for Camden and Islington, introduced the presentation. She highlighted that a significant amount of ill-health was preventable.

There were marked differences in life expectancy between richer and poorer areas. These included significant differences in mortality from cardiovascular and respiratory diseases.

Ms Billett said officers wished to incorporate prevention into every clinical setting. The Memorandum of Understanding on London health devolution had included a prevention component.

Councillor Cornelius commented that there should be more mention of diet as part of the prevention agenda. She added there was a particular need to reach out to the parents of children who were obese, given the increase in childhood obesity.

Councillor Fulbrook emphasised the importance of reducing smoking. He stated that some local authorities in North America imposed by-laws preventing smoking in public parks and too close to building entrances. He asked that consideration be given to similar measures by boroughs in North Central London.

Members asked that consideration be given to air quality in the sub-region. Pollution could have a negative effect on child development and worsen respiratory conditions.

Councillor das Neves asked that consideration be given to the wider social context which meant that some individuals were likely to take up smoking and drinking to excess.

Members asked for data to be collected on which public health interventions on prevention were effective, and that attention be given to lessons that could be learned from public health initiatives abroad.

Ms Billett said that officers were looking at “superzones”, areas around certain schools, and investigating what could be done to improve the environment. Members noted, however, that healthy eating was not a licensing or planning objective and hence councils could not prevent fast food outlets from being opened near schools.

It was also noted that minimum alcohol pricing might discourage excessive alcohol consumption; however this was not currently permitted by legislation in England.

RESOLVED –

THAT the presentation and comments above be noted.

8. RISK MANAGEMENT: WORKFORCE

Consideration was given to a presentation from North London Partners.

Will Huxter, Director of Strategy (North Central London CCGs), introduced the presentation. He highlighted that the presentation would not cover all workforce initiatives, as many were being done nationally, London-wide or at a local level rather than at the North-Central London level.

It was noted that the health and social care sector workforce was large. About 1 in 8 of London's workforce worked in this sector.

Mr Huxter noted that North-Central London was a high cost of living area, and this contributed to problems with recruitment and retention. The North-London CCGs were undertaking staff engagement to identify staff concerns.

Health sector employers had concerns that there would be difficulties with the continued availability of staff from the EU in the future. They were thinking of how best to use the apprenticeship levy and how it could be used to expand the workforce and improve its skills.

With regard to social care, Mr Huxter said they had worked with care home providers on structured learning and leadership courses for their managers. There was also a social care recruitment portal being developed.

There was discussion about the Capital Nurse programme. Mr Huxter said one of the issues they were investigating was the high rate of nurses over 50 leaving the profession and seeing what could be done to encourage them to stay. He offered to send out more information on the Capital Nurse programme to members.

Members said it was important for London's health system to retain the workforce that it had.

Officers agreed with the importance of staff retention. They also emphasised the importance of improving staff skills so that patients could receive advice from the most easily accessible health professional. In some cases, patients could receive an answer to their health queries from an informed pharmacist, for example.

Members emphasised the importance of paying the London Living Wage to workers in the care sector. It was demanding work and they wanted workers to be paid fairly for it.

Officers noted the desire to increase the range of workers covered by the London Living Wage, but pointed out that it was difficult to impose this requirement on private providers in many cases. Members asked that it be put into the contracts that public authorities made with private providers.

A member commented on the detrimental effects on health of working night shifts. As many health workers were having to work shifts, this could be affecting their health and making them more likely to leave the sector.

There was also discussion by members of how stress or bullying or "change fatigue" could be pushing experienced workers out of the sector.

Councillor Clarke mentioned that there was no representative of the workforce or the private sector in North London Partners. She thought that representatives of these groups should be invited to participate.

Members asked for more information on the apprenticeship levy and how it was being used. They also asked for feedback from the care home provider workshop and the evidence base for new ways of working.

RESOLVED –

(i) THAT the presentation be noted;

(ii) THAT information be provided to members on the apprenticeship levy and its use

(iii) THAT feedback from the care home providers workshop be provided

(iv) THAT the evidence base relating to the introduction of new ways of working be provided

(v) THAT the Committee recommend the London Living Wage be included as a requirement in all contracts with private providers

(vi) THAT the Committee recommend that there be a care workers' representative on the Local Workforce Board

(vii) THAT North London Partners be asked to place increased emphasis on the training and support for care workers.

9. PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (POLCE)

Members expressed disappointment with the paper received. They felt that it did not answer the questions that members had had.

Members noted that the information on page 10 of the supplementary pack was incorrect. They had not given guidance at the 6th February meeting that there not be a formal public consultation.

Members noted that it was unclear whether proposals on this constituted a service change that required engagement and consultation or were just clinical advice to

clinicians on best practice to guide them in decision making. The Haringey Scrutiny Policy Officer advised that the Independent Reconfiguration Panel (IRP) advised the Secretary of State for Health in cases where HOSCs have referred contentious proposals by NHS bodies to him/her. It can also provide informal independent advice to NHS bodies and others on service change.

Jo Sauvage, the Chair of Islington CCG, said the emphasis of the work on PoLCE was to give guidance to GPs on how best to care for patients. It was about evaluating the clinical evidence, and work was being done on this nationally and locally. There was also the need to ensure value for money in the services provided. Dr Sauvage said there was a huge variation in the numbers of certain procedures carried out throughout the country.

Members expressed concern were different numbers of procedures listed nationally, London-wide and sub-regionally. They wanted to see consistency in this process.

The Chair added there needed to be democratic accountability if decisions were being made that affected residents, and that the democratic voice for elected members in the sub-region was the JHOSC.

Councillor Akpinar expressed concern about the quality of life of patients if recommendations were being made to not carry out treatments.

Members also asked that more information be provided about the budgetary constraints facing CCGs and the cost savings from the reduction in the use of certain procedures.

Councillor das Neves echoed the concerns about potential negative impacts on the quality of life of patients. She also asked that an Equality Impact Assessment be carried out, as certain groups might be more disadvantaged than others by the PoLCE approach.

Councillor Connor asked for more information about communications with GPs.

RESOLVED –

THAT JHOSC make the following recommendations:

(i) Future reports to the Committee be delivered on time and on the subject requested

(ii) PoLCE guidance must be evidence-based

(iii) There needs to greater co-ordination between PoLCE work locally, London-wide and nationally

(iv) Information is to be provided on Equality Impact Assessments of PoLCE recommendations

(v) Information is to be provided on the financial implications of PoLCE recommendations.

(vi) Advice is to be sought by the relevant health organisations from the Independent Reconfiguration Panel on whether this is a substantial service change that requires formal consultation.

10. WORK PROGRAMME AND ACTION TRACKER 2018-19

Consideration was given to a report on the work programme of the Committee.

The Chair asked that information be provided by health officers by the next meeting on what money from NHS land sales was being used for.

With regard to the maternity services item scheduled for November, members noted that the November agenda was rather large and so agreed to move that item to January 2019.

Members asked that the integrating health and social care item include public health.

Members agreed to postpone the “Best Start in Life” priority theme update as they felt it was unclear.

Members noted that there might be an item on Moorfields coming soon. The view was expressed that it could go to the joint Camden & Islington scrutiny committee as it related to the work being done on the St Pancras site.

With regard to the Child and Adolescent Mental Health item, Councillor Connor asked that information be provided on changes to the Children’s Safeguarding Board and any financial implications.

RESOLVED –

(i) THAT the maternity services item be postponed to the January meeting

(ii) THAT the Best Start in Life item be postponed

(iii) THAT it be recommended that the Moorfields item go to the Camden & Islington joint health scrutiny committee

The meeting ended at 12pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
Telephone No: **020 7974 4071**
E-Mail: **vinothan.sangarapillai@camden.gov.uk**

MINUTES END

Agenda Item 7

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
Adult elective orthopaedic services review	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 30 November 2018

SUMMARY OF REPORT

The presentation at Appendix A updates members on the draft case for change, engagement and next steps in relation to the adult elective orthopaedic services review.

Contact Officer:

Ally Round
Senior Policy and Projects Officer
London Borough of Camden
ally.round@camden.gov.uk
020 7974 5118

RECOMMENDATION

The Committee is asked to:

a) Discuss the progress that has been made on the review since the Committee's 23 March 2018 meeting.

b) Comment on how the review can continue to engage patients and residents in the subsequent stages.

c) Agree whether February 2019 feels like the right timing for a further update on the review.

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Adult elective orthopaedic services review

JHOSC Update, 30 November 2018

Page 15

Presenters:
Rob Hurd, SRO and CEO sponsor
Anna Stewart, Programme Director

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Purpose of paper:

- Update JHOSC members on the draft case for change, engagement and next steps
- Seek views about how to continue to work with patients and residents in the subsequent stages of the review

JHOSC members are asked to:

- **Discuss** the progress that has been made on the review since the March meeting
- **Comment** on how the review can continue to engage patients and residents in the subsequent stages
- **Agree** on whether February feels the right timing for a further update on the review

Page 16

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Introduction and context

23 March 2018…

- presentation to the JHOSC setting out suggested scope and process for the review and asking members for views about how to work with patients and residents on the proposed model of care

Since then we have…

- established Review Group and programme leadership
- carried out an equalities desk top review to ensure that the engagement was focused on the groups that would be impacted the most
- published and engaged on the draft case for change
- held five design workshops

Page 17

Stages of the Review

Stage 1
Obtain feedback on the draft case for change
Propose a service model describing how services might be delivered in future, informed by feedback

Engaging with:
- Patients & residents
- Providers
- Clinicians
- Clinical Commissioners

Page 18

Stage 2
Clinical commissioners consider the feedback from the engagement, agree a service model

Produce a pre-consultation business case

Leadership and Review Group - established

Chair: Professor Fares Haddad (UCLH)
CEO Sponsor and Project SRO: Rob Hurd (RNOH)

Review Group Members:

Clinical representatives from each of the five largest providers of adult orthopaedic services
Two clinical commissioning representatives from NCL CCGs
NHS England Specialised Commissioning
Two patient and public representatives (recruited by Healthwatch)
NHS England Strategy and Reconfiguration

In attendance:

Trust management leads from each of the five largest providers of adult orthopaedic services
Programme Director and Programme Manager
Other workstream leads as required

Page 19

Principles underpinning the review

- Co-production (everyone working collaboratively)
- Evidence based service model (using evidence from trusted sources)
- Clinically led collaborative approach which enables meaningful engagement with all stakeholders, particularly front line clinical staff and the public (people involved in delivering and receiving care)
- Independent experts to provide challenge and advice
- Sharing what we learn
- Clear separation of decision-making functions
- Flexible timelines to ensure we are properly engaging with stakeholders and the public

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Published our draft case for change

- Engagement from Friday 17 August 2018 to Friday 19 October 2018
- http://www.northlondonpartners.org.uk/orthopaedicreview
- Draft case for change
  - set out to **test the high level proposition** that by having a smaller number of larger centres carrying out elective care will reduce variation and improve patient outcomes, experience and value for money
  - deliberate decision to **engage very early in the process** with patients and residents before any decisions have been taken about the model of care, number of centres or their location
  - will be followed by an **independent evaluation**

Page 20

Adult elective orthopaedic services review

Our ambition is to create a comprehensive adult elective orthopaedic service for North Central London (NCL), which will be seen as a centre for excellence with an international reputation for patient outcomes and experience, education and research.

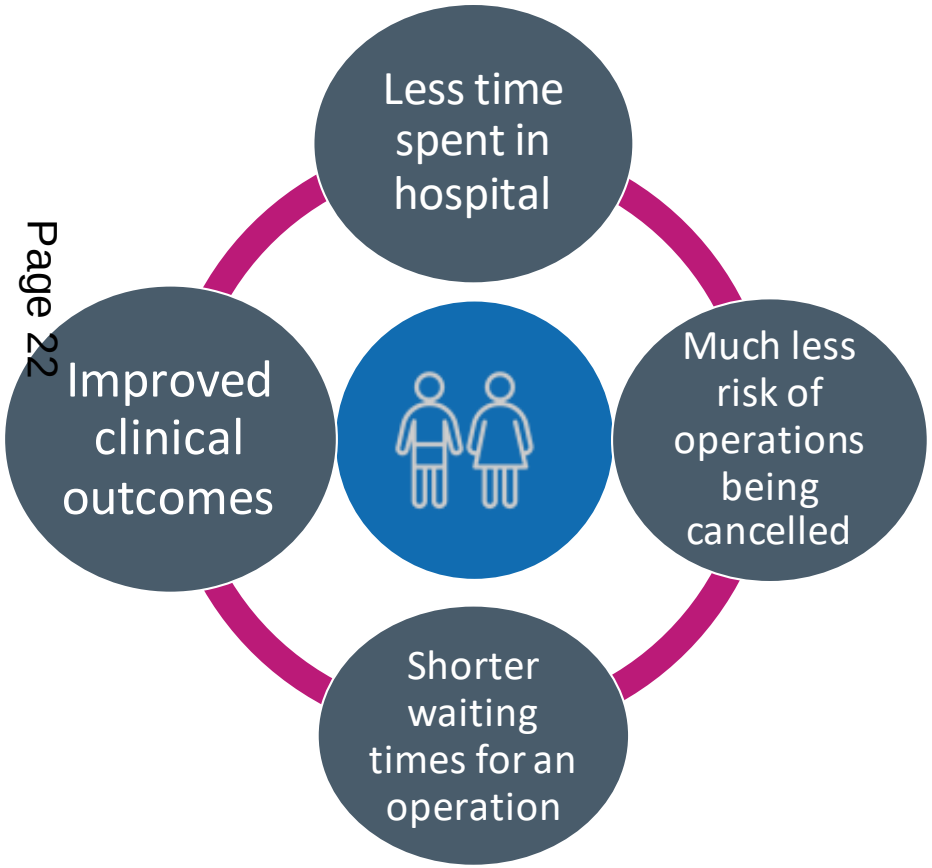
Our vision is to deliver services from dedicated state of the art orthopaedic 'cold' surgical centres, not linked to an existing A&E, but collocated with HDU*, with the size and scale to enable a full spectrum elective offering and a robust rota.

Draft case for change (August 2018)

* High Dependency Unit

Page 21

The benefits for patients



Opportunities for improvement

- Patients report different **experiences and outcomes** at different hospitals
- Some hospitals carry out **small numbers of some operations**, leading to inconsistent approaches (ie - elective knee replacements in those who had an arthroscopy)
- **Variation in 'revision rates'** (ie – a follow-up procedure being needed if the first one didn't work as expected)
- **Variations in the length of hospital stay**, following an operation
- **Readmissions vary** (but are low) (ie– a patient who has been discharged is admitted back to hospital)
- **Infection rates vary** (but are low)
- **Waiting times vary and targets are being missed**

Page 22

Adult elective orthopaedic surgery currently takes place at ten different hospital sites in north central London

Around 23,000 operations each year

Page 23

Aiming for excellence

The International Society of Orthopaedic Centres considers a **centre of orthopaedic excellence** meets the following criteria:

Source:
www.isocweb.org

Page 24

Rationale supporting change

"Separating elective care from emergency pressures through the use of dedicated beds, theatres and staff can… achieve a more predictable workflow, provide excellent training opportunities, increase senior supervision of complex / emergency cases, and therefore improve the quality of care delivered to patients"

The Royal College of Surgeons

Page 25

Page 25

"there is evidence that separation of the elective surgical workload can improve efficiency and avoid the cancellation of elective activity. However, the efficiency gains can be affected by patient case-mix and demand. Evaluation of the operation of the independent sector treatment centres has also suggested separating elective surgical care from emergency services could improve the quality of care"

The King's Fund and Nuffield Trust qualitative analysis of National Clinical Advisory Team reviews

Ideas from around the country….

South West London Elective Orthopaedic Centre (SWLEOC):

- surgeons from local hospitals use the centre for all their planned routine procedures
- most day cases take place at local hospitals (a few are now moving to SWLEOC)
- all preoperative, post operative and emergency care happens locally
- opened in 2004 – 14 years in operation
- clinicians, providers and patients who have used the service would find it hard to go back to the pre-SWLEOC arrangements

Manchester is exploring a 'layered' approach with:

- One 'super specialist' centre doing the most complex operations
- 'Specialist' centres doing complex care
- 'Joint centres' doing non-complex primary procedures and day-cases
- local hospitals doing day-cases, outpatient and follow-up care and trauma

Page 26

Outline thinking in the draft case for change

Learning from the best, we believe that by consolidating adult elective orthopaedic surgery from multiple hospitals to a smaller number of larger units we could further improve care.

Page 27

Separate emergency and planned care

- Elective surgery split from non-elective emergency surgery for efficiency and quality improvements
- Elective beds separated from non-elective beds to prevent cancellations and reduce the incident of hospital acquired infections

Expansion of 'joint school'*

- improve quality of care through greater patient engagement and education
- leading to faster recovery and improved patient experience

Best possible after-care

- for faster recovery
- better outcomes
- less time in hospital

Co-located specialist high dependency unit

- enables all cases to be done on one site

Access to innovations

- such as robotic surgery
- likely to deliver better outcomes
- Links to research and clinical trials

*Joint school is a service specifically for people who are about to undergo a hip or knee replacement. It focuses on patient education and lets patients know what to expect through the various steps they will experience, from preparing for admission through to recovery at home

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Design workshops

- **Session #1** – Learning from others (18 July)
- **Session #2 –** Developing the vision and high level operating principles for NCL service (12 September)
- **Session #3** – Managing dependencies and identify factors that might undermine a new model working (19 September)
- **Session #4** – Ensuring alignment with pre and post-operative pathways (31 October)
- **Session #5** – Plenary session feeding back the themes from all the design workshops and outlining key areas where input is still needed (7 November)

Page 28

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Programme Engagement

Face to face communication

Engagement Forum	Meetings/Events	Numbers
Patients and Public	13	181
Commissioners	7	54
Providers	10	287
Local Authority	6	22
Total	**36**	**544**

	Meetings/Events	Numbers
Workshops and plenary	5	63

Written Communication

Channel	Organisational Channels
Written feedback	**7**
Website Feedback	**78**

Proactive Promotion

Reach	Organisational Channels (Electronic and print newsletters, mail outs, bulletins)	Social Media (Facebook, Twitter)
58,710	**28,796 ***	**29,914**

* For example Camden Voluntary Action News (mailing list 10,000) and UCLH internal staff briefing (distribution 8,000)

Page 29

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Programme Engagement: patient and public meetings

Camden
- ✓ Camden CPEG
- ✓ Camden Healthwatch Group
- ✓ Camden Carers Group

Islington
- ✓ Islington Over 55s Group
- ✓ St Luke's, Islington Group

Haringey
- ✓ Haringey Adult Social Care Joint Partnership Board
- ✓ Haringey CCG public events (x2)

Enfield
- ✓ Enfield CCG Voluntary Community Stakeholder Reference Group
- ✓ Patient and Public Engagement Event Enfield
- ✓ Enfield Healthwatch public event

Barnet
- ✓ Barnet Healthwatch meeting
- ✓ Having A Say Group

Page 30

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Key engagement themes – headlines

- **Many people in all three engagement categories** (residents, stakeholders, staff) welcomed the proposal to create specialist orthopaedic elective centres
- **The exercise was large-scale and participants engaged positively** – we received a wide range of views and comments which will help to shape future plans and focus engagement
- **It is early in the process**, and the engagement response supports the programme continuing to explore the potential for specialist centres
  - Where participants had concerns, these were often questions or related to issues / caveats to be addressed later in the review
- **Feedback included** comments on:
  - The review process (e.g. rationale for review, draft case for change)
  - Communications and engagement with the review (both at this stage and later)
  - Views relevant to the model of care – design principles (see next slide)

Page 31

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Key engagement themes – design principles

- Travel and transport
  - particularly for patients with mobility impairments and economically deprived people
- Workforce
  - skills, training and cross-site working
  - Practicalities – rotas, separating 'hot' and 'cold' sites
- Building a sustainable system (e.g. financial, partnership)
- How to manage complex patients/patients with comorbidities
  - clinical treatment and management of care
  - supporting vulnerable patients across wider, complex system (e.g. notes, IT)
- Patient pathways
  - what is local, what is central and how do they align?
  - continuity of care / joined-up working, including social care

Page 32

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Next steps

- **November Review Group** to consider recommendation of design principles to present to the Joint Commissioning Committee (JCC)
- **Joint Commissioning Committee**:
  - receive output from the Review Group and evaluation of the engagement in December
  - consider and agree next steps, and governance for stage two of the review in January
- If JCC decides to develop this concept further then a **detailed service model and evaluation criteria** would need to be developed which could feed into an options appraisal and pre-consultation business case
- If **public consultation** is required, this will be later in 2019, and we would want to seek early advice from the JHOSC

Page 33

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North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
Finance update: Estates	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 30 November 2018

SUMMARY OF REPORT

Following the presentation of the estates strategy to the JHOSC meeting on 20th July 2018 there was a request to understand how much of the capital receipts from NHS organisations in north central London (NCL) had been used for revenue spend. The presentation at Appendix A summarises the information from across all NCL NHS providers for the first full financial year since the STP was established (2017/18).

Contact Officer:

Ally Round
Senior Policy and Projects Officer
London Borough of Camden
ally.round@camden.gov.uk
020 7974 5118

RECOMMENDATION

The Committee is asked to consider and comment on the update.

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North Central London's sustainability and transformation partnership

NHS

Finance update: estates

Joint Health Overview and Scrutiny Committee

Page 37

Presenters:
Will Huxter, Director of Strategy
Richard Dale, Director of Programme Delivery

30th November 2018

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Purpose of paper:

- Following the presentation of the estates strategy to the JHOSC meeting on 20th July 2018 there was a request to understand how much of the capital receipts from NHS organisations in north central London (NCL) has been used for revenue spend.
- This paper summarises the information from across all NCL NHS providers for the first full financial year since the STP was established (2017/18).

N.B NHS Improvement (NHSI) is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

Page 38

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NCL NHS Providers- 17/18 gains on disposal and 17/18 NHSI incentive scheme

1. In 17/18 trusts developed financial plans, any financial improvements over and above this plan received additional funding from NHSI, matched to the level of financial improvement.
2. In 17/18 NCL provider trusts recorded £102.8m gains on disposal of assets as shown in the table on page 4.
3. This resulted in approximately an additional £55m additional income for NHS trusts across NCL. The Royal Free's disposal was already part of their plan so didn't attract additional money.
4. A condition was that the funding received by NHS trusts was not spent or invested in that year.
5. Therefore, at this point in the year, it is not possible to report on the exact use of these funds, the use of which is overseen by individual NHS trust boards.

Page 39

NORTH LONDON PARTNERS in health and care

5. This was the case with all gains on disposal listed in the table below except for the Chase Farm disposal as this was originally included Royal Free's 17/18 financial plan so did not attract the incentive funding.

6. Assets disposed of were surplus to provider Trust requirements and decision to dispose of these assets was signed off by individual NHS trust boards.

Page 40

Gains on disposal - figures from 17/18 annual accounts

Provider Trust	Description	17/18 Gains on disposal
		£m
Barnet, Enfield & Haringey Mental Health	Part of St. Ann's site	18.6
Camden & Islington Mental Health	Tottenham Mews	5.7
Camden & Islington Mental Health	Hanley Road	0.2
Royal Free	Part of Chase Farm site	47.7
University College London Hospital	Tranche 1 Eastman Dental	25.7
University College London Hospital	Disposal of stake in a radiology joint venture	4.8
North Central London Total		102.8

Agenda Item 9

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
General practice as the foundation of the NHS: a strategy for North Central London	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 30 November 2018

SUMMARY OF REPORT

North Central London CCGs have developed a strategy to support the future development of general practice across the area. This paper introduces both a presentation on the strategy's key messages and the full strategy, which are at Appendix A.

Contact Officer:

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RECOMMENDATION

The Committee is asked to consider and comment on the strategy.

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NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

General practice as the foundation of the NHS: a strategy for north central London

Page 43

Presenters:

- Dr Katie Coleman, Clinical Lead for the Health and Care Closer to Home programme and Islington GP
- Sarah Mcilwaine, Programme Director for the Health and Care Closer to Home programme

Joint Health Overview and Scrutiny Committee 30th Nov 2018

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NHS

Purpose of paper

- North Central London CCGs have developed a strategy to support the future development of general practice across the area.
- This paper summarises the key messages of the strategy on slides 3-9 and the full strategy is outlined the appendix 1.
- We want to share the strategy with the JHOSC ahead of local implementation plans being developed.

Page 44

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Our story so far

- The strategy for general practice aims to consider what is important to and for the people living in north central London (NCL), and sets out the vision from a patient and system perspective.

- It recognises the challenges facing general practice in NCL and acknowledges that we must preserve the its strengths, including continuity of care, a real understanding of the family or personal support network that patients are part of, and the relative ease and accessibility of services.

Page 45

- General practice is also facing unprecedented pressure. Demand is set to increase further as people live longer with greater complexity and patient expectation grows. These pressures are further compounded by an aging workforce, fewer doctors and nurses choosing general practice as their destination of choice and losing newly qualified general practice staff to other more attractive health services across the globe.

- The context and landscape have changed significantly since the previous strategy, including an increasing financial challenge, with the 'do nothing' gap for NCL expected to be £811m deficit by 2020/21. There is now an increased focus in general practice on quality improvement, with local investment in dedicated quality improvement support teams aiming to reduce unwarranted variation in each CCG area.

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NHS

Our story so far (cont.)

- There is an increased focus on collaboration, both within general practice, and with other partners, and working at scale to deliver the best benefits for the population and for practices.

- There are new and increased challenges in terms of building, recruiting and retaining sufficient numbers of healthcare professionals to work in general practice, and more GPs are opting for salaried positions and portfolio careers, meaning a need to consider new and alternative employment models. There have been significant advances in technology, with the introduction and increased use of patient apps, the ability to book appointments online, and products such as Symptom Checker.

- Partners in NCL have a history of collaborative working in primary care, including the production of previous strategies for primary care. The previous NCL strategy was produced in 2012 and expired in 2016.

- In December 2017, leaders of the five CCG and GP federations agreed to nominate representatives to co-produce a refreshed strategy for NCL.

Page 46
Page 46

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

National voices: changes to general practice

A report from National Voices highlights that people want to do more for themselves. They recognise the NHS is under pressure, but we can help by playing a bigger role in looking after our own health and wellbeing (1).

What would this look like?

I want to be listened to and heard

- I won't have to rely as much on my GP to interpret information for me
- I'll be able to access the information and advice I need to make more decisions for myself
- I'll understand which services to use and when
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me

Services will work better for me

- My health records will be up to date and services that help me will be able to access them
- I will tell my story once
- The professionals involved with my care talk to each other; we all work together as a team

I'll have easier access to the support I need to stay well

- I won't have to go to hospital so much
- Investigations such as blood tests and ECGs can be done in alternative places to the hospital

I'll be able to do more online

- I can book and cancel appointments online, when it suits me; I won't have to visit the GP, miss appointments I don't need or wait for the post to get my test results
- I can order repeat prescriptions online; I don't need to make a special trip to my surgery to place the order
- I can see my health and care records and can decide who to share them with. I can correct any mistakes in the information.

(1). Source: National Voices – person-centred coordinated care; Better Conversation: Better Health

Page 47

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Case study: Peter

Page 48

Peter is 12 years old and in Year 7 of secondary school. He has had asthma and eczema since early childhood.

He lives with his mother, who has mental health problems and a mild learning disability. She does not work. His asthma has previously been well controlled, but he has missed a lot of school during the last year. He has gained weight and is missing sports lessons because of the asthma.

Peter will have access to a nurse specialist in the community. At school he will be seen by an asthma nurse. This is more convenient, improves Peter's ability to self-manage and involves less time in hospital.

CASE STUDY

Peter and children like him will:

- require fewer A&E attendances and admissions
- become involved in care, and able to manage
- be supported by people who know him and his family
- miss less school
- have improved fitness and confidence

Page 48

6

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North Central London's sustainability and transformation partnership

NHS

Where we are now: progress so far

- Appointments with general practice are available 8am-8pm seven days a week. Instead of people only being able to access their own GP during core hours, people now have access to appointments with general practice from 8am-8pm seven days a week (since April 2017 in NCL). There may be opportunities to promote these services even more widely, so that everyone is aware of them. We also know that some people still report dissatisfaction getting through to their practice on the phone, and there is more progress to make in this area.

- Most practices now work in an integrated way, to some extent, and many of the GP federations hold contracts ranging from ear nose and throat and community gynaecology services to providing quality improvement support teams, or focusing on GP retention.

- Also in place are Care and Health Integration Networks (health and care partners working together to deliver care to a cohort of patients).

Page 49

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

What we want to deliver

Given the needs of the local population and the challenges facing general practice, over the next three years we want to achieve:

Resilient, sustainable and thriving general practice

Resilience: a systematic and data-driven approach to practice resilience, using local intelligence and NHSE data, reducing the need for CCG intervention – developed by GP federations working in partnership with their CCGs

At scale working: For federations to collaborate to develop at scale solutions to drive efficiencies and productivity, e.g. education and training, GP retention, back office functions, delivery of outcomes, population health management

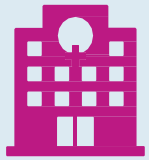
Resourcing: To be in the top x% of STPs nationally in our investment in primary care (£ per patient), working to reduce variation between boroughs in north central London

High quality, equitable and person-centred safe care

Access: To use a Safer Staffing tool (or similar) to identify and agree on the minimum safe healthcare professional staffing levels in general practice, and work towards achieving these over the life of this strategy; to achieve (% of respondents reporting good on ease of access or telephone access to appointments)

Quality improvement: For all NCL practices to be in the top 25% of best performing practices over x period on agreed markers

Estates: To keep services local in premises that are fit for purpose for the delivery of primary care services



Page 50

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

What we want to deliver (cont.)

Proactive, accessible and coordinated care

Access: To see a step change in the roll out and uptake of digital technology in general practice (for patients and professionals), recognising the scope of digital technology to be used from ordering repeat prescriptions online, to online booking, the ability to check symptoms and have a consultation with a healthcare professional

Strengths-based approach: GP practices to support people to address the social determinants of health, with the aim of everyone with a long term condition to have the opportunity for an annual care planning conversation

Integrated services that respond to the needs of the patient and the population

Strengths-based approach: GP practices to support people to address the social determinants of health, with the aim of everyone with a long term condition to have the opportunity for an annual care planning conversation

Resourcing: integrated working between GP practices and other community-based providers, supporting new roles into the wider GP team

Prevention: To systematically embed high impact prevention interventions into everyday practice, in order to prevent ill health and promote wellbeing, with a focus on smoking, blood pressure, overweight, physical inactivity, and alcohol

Page 51

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Next steps

- Each CCG will develop plans describing how they will deliver the ambitions outlined in this strategy.

- A key part of developing these local plans will be engaging with local people to understand their views, opinions and needs.

Page 52

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Appendix:

General practice as the foundation of the NHS

A North Central London Strategy for General Practice (full strategy document)

Page 53

NORTH LONDON PARTNERS in health and care

Central London's sustainability and transformation partnership

NHS

DRAFT

General practice as the foundation of the NHS

A North Central London Strategy for General Practice

2018 - 2021

Page 54

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

NHS

Version control

Version	Date	Author	Changes/ comments
0.1	2/5/18	S. Mcilwaine	-
0.2	11/6/18	S. Mcilwaine	Feedback and comments from Task and Finish Group 2/5/18 and early draft comments from LMC
0.3	5/7/18	S. Mcilwaine	Includes initial feedback and comments from Primary Care Committee in Common, Camden CCG and early comments from Directors of Public Health, and NCL STP Primary Care Commissioning Development Group
0.4 0.4a	16/7/18 19/7/18	S. Mcilwaine	Feedback from Health and Care Closer to Home Programme Board and meeting with NCL GP federations (July 2018) Contract details edited
0.5	31/7/18	S. Mcilwaine	Implementation edits
0.6	14/8/18	S. Mcilwaine	Estates info from draft NLP estates strategy Edits to Delivering these Aims
0.7-0.9	18/8-31/8/18	K. Bowers	Formatting
0.10	3/9/18	S. Mcilwaine	Comments from HCCH board – draft statements
0.11	12/9/18	S. Mcilwaine and K. Bowers	Feedback and formatting
0.12	19/9/18	S. Mcilwaine	Comments from CCG Governing Body members, HCCH clinical lead, further comments from local engagement, initial comments from Health and Care Cabinet
0.13	26/09/18	S. Mcilwaine	Comments from Health and Care Cabinet, College Open day, further comments – member practices
0.14	2/10/18	S. Mcilwaine	Comments from Whittington Health, NCL SMT, workforce detail, Enfield, finances, local authority – integration, workforce detail, digital slides
0.15	4/10/18	S. Mcilwaine	Workforce detail
0.16	08/10/18	S. Mcilwaine	Further workforce detail, overall review and formatting, including title
0.17	18/10/18	S. Mcilwaine	Edits following NCL Primary Care Committee in Common
0.18	29/10/18	K. Bowers	Minor adjustment to Camden delegated investment
0.19	14/11/18	S. Mcilwaine	Edit to introduction and estates detail: Camden CCG GB, Islington CCG GB

Page 55

DRAFT

Contents

Introduction

Our context – our demographics and the challenges

Our vision for general practice and our priorities

Our enablers

Page 56

Page 56

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Introduction

Page 57

DRAFT

Introduction: purpose

Every day thousands of people in general practice work hard for the residents of North Central London (NCL). Together, the care they deliver is seen as the foundation of the NHS; without this care and support the health service we have all come to cherish would not be viable. From the receptionist, the administrator and the practice manager to the practice nurse, sessional GPs and GP partners – general practice staff consistently rise to the challenges demanded of them, in order to keep the front door open.

General practice as a career provides the perfect balance of long-term trusted relationships, opportunities to work in partnership to improve care, and a constant source of intellectual challenge.

However, due to the diminishing share of the NHS budget and a workforce under significant strain, general practice as we know it is experiencing unprecedented pressure.

Funding for general practice services, as a proportion of the national share of NHS funding has fallen from 9.6% in 2005/6 to 7.9% in 16/17[1], yet evidence suggests that demand has increased by 16% in the 7 years up to 2014, with more frequent and longer consultations[2]. Demand is set to increase further as people live longer with greater complexity and patient expectation grows.

These pressures are further compounded by an aging workforce, fewer doctors and nurses choosing general practice as their career, and losing newly qualified general practice staff to other more attractive health services across the globe.

The traditional model of general practice is no longer fit for the 21st century; there is a real tension in managing rapidly escalating demand to offer quick access for unplanned care needs against the growing burden of chronic disease management, frailty and dementia as people live longer and for whom continuity really counts. The one-size-fits-all approach, that general practice has historically offered, is no longer viable.

This document is an ambitious commissioning strategy, intended for commissioners and GPs, and sets out the North Central London overall direction for general practice. A Plain English version will also be available.

In the document we consider different service configurations that will be locally determined; identifying approaches that in turn will reduce unwarranted variation, improve quality and patient experience and bring the joy back to general practice. However, to change and adapt takes time, money and a workforce, all of which must be addressed, and all of which are in short supply.

The five Clinical Commissioning Groups (CCGs: Barnet, Camden, Enfield, Haringey and Islington) share the intent of improving health outcomes, reducing inequalities and delivering financially sustainable NHS services to our population; local general practice is critical to the success of this intent, and key to closer working across health and social care.

The NHS was established 70 years ago, at a time when services were primarily targeted at managing acute disease in hospitals and patients were perceived to be passive recipients of care. General practice accounts for more patient contacts than all forms of hospital care combined, and only 5% of contacts in general practice are passed to a specialist. This initial gatekeeping role means that the delivery of primary care – which in the NHS mainly means general practice – is important for achieving value in the NHS. As Roland and Everington note (2016), if primary care fails, the whole NHS fails.[3]

The roles of health and care services have changed significantly since this, and society is changing; there are over 15 million people with long term conditions (e.g. diabetes, chronic obstructive pulmonary disease) in England. Care for these people accounts for about 50% of all GP appointments and 70% of all inpatient episodes[4,5]. In total, people with long term conditions account for over 70% of the total NHS and social are expenditure, and as the number of people with long term conditions is set to increase then these costs will rise accordingly in future years[6]. Yet, patients with long term conditions spend only a few hours with GPs or other healthcare professionals each year and spend the majority of their time managing their own conditions[7]. General practice can play a greater role in prevention and managing the health of the whole population. It also makes sense for general practice to work with patients and carers, and with strong community networks and the voluntary sector, to encourage people to be informed and engaged, to facilitate them to manage their conditions to the best of their ability.

DRAFT

Introduction: purpose

The NCL CCGs have previously collaborated on strategy, we are increasingly working in partnership across services, and this strategy reads across to local plans. With this strategy, we are refreshing our commitment to working together to improve general practice for the people of north central London, and building on our previous work. We want to make sure registered patients have equitable access to sustainable, high quality services, provided in line with the core values of general practice, and that we maintain what works well in general practice.

There are many examples of excellent care delivered across the area. However, there also continues to be too much unacceptable, unwarranted variation, ranging from how people are able to access services, to the quality of the services received, to variation in historical levels of funding. This strategy aims to raise standards further.

The strategy aims to consider what is important to and for the people living in north central London. It recognises the challenges facing general practice in NCL and acknowledges that we must preserve the strengths of general practice, including continuity of care, a real understanding of the family or personal support network that patients are part of, and the relative ease and accessibility of services. It also provides a direction of travel for general practice across Barnet, Camden, Enfield, Haringey and Islington. It should be read in conjunction with plans for other work programmes for North London Partners (STP), including local (CCG) plans for general practice and primary care. The success of the strategy will also be dependent on the wider system.

This is a purposefully short term document, to better reflect the fast-changing environment in which we are working, and to enable local flexibility to respond to developments, including the NHS 10-Year Plan and the allocation of primary care budgets. It builds on the aspirations and developments of the last strategy, recognising the different contexts and starting points within NCL. It reflects the recommendations of both national and local policy documents, and the learning from other primary care providers across the country and within NCL. It aspires to respond to the voices of local stakeholders, aims to prioritise those areas perceived to be most challenging to the long-term viability of general practice, and champions the shift of investment into general practice, in order to realise the ambitions of the strategy.

The four overarching aims are:

- **Resilient, sustainable and thriving general practice**
- **High quality, equitable and person-centred safe care**
- **Proactive, accessible and coordinated care**
- **Integrated services that respond to the needs of the patient and the population**

There is no single intervention that will deliver on these aims; we need to recognise that this requires a whole-system approach, and that delivery will be through a combination of CCG and working in partnership across NCL. We will need to be brave and bold, we need to work with each other, forming trusted relationships, sharing risk for the good of the NHS, so that the people we serve will continue to benefit, so we can all continue to enjoy good health and wellbeing.

The core values of general practice
London-wide Local Medical Committee

1. The **registered list** – individuals and practice population
2. **Expert generalist** care of the whole patient
3. The **consultation** as the irreducible essence of delivery
4. Take into account **socio-economic and psychological determinants** of disease and the inverse care law
5. The **therapeutic relationship**
6. Deliver safe, effective long term and **preventative** care, balanced with timely **episodic** care by promoting access to relationship continuity
7. **Advocacy and confidentiality**

Where we have come from

Extended access

Instead of people only being able to access their own GP during core hours, people now have access to appointments with general practice from 8am-8pm seven days a week (since April 2017 in NCL). Where practices were previously responsible for managing their own access, the extended access service is provided in hubs.

Working at scale

There are six GP federations in NCL, four of which are co-terminous with the borough, with two federations in Camden. Most practices in NCL now work in an integrated way, to some extent.

Many of the GP federations hold contracts ranging from Ear Nose and Throat and community gynaecology services to providing quality improvement support teams, or focusing on GP retention. Also in place are Care and Health Integration Networks (health and care partners working together to deliver care to a cohort of patients).

Digital

Digital developments since the earlier strategy include the ability for people with healthcare concerns to access NHS111 on the phone or online, to get direct access to advice and guidance for non-emergency conditions, and for signposting to appropriate services. Some GP practices also offer Patient Online, so enabling online appointment booking, ordering repeat prescriptions and access to their medical records.

The **context and landscape** have changed significantly since the previous strategy (written in 2012). CCGs in NCL are now part of North London Partners (STP). There have been improvements in access, with appointments available 8am-8pm seven days a week through extended access hubs. In terms of policy, we have seen a continued focus on improving the availability and use of **technology**[8], ranging from GP online services, the introduction and increased use of patient apps, the ability to book appointments online, and products such as Symptom Checker. The **GPFV** was published (2016), focusing on priorities including improving patient care and access, and investing in new ways of providing primary care. The General Practice Nurses (GPN) 10 point plan focuses on improving the workforce of nurses in primary care. There is more **collaboration,** both within general practice and with other partners, and on working at scale to deliver benefits for the population and practices. There is an increased focus in general practice on **quality improvement**, with local investment in dedicated quality improvement support teams aiming to reduce unwarranted variation in each CCG area. There is an increasing financial challenge, with the 'do nothing' gap for north central London expected to be £811m deficit by 2020/21. There are also new and increased challenges in terms of building, recruiting and retaining sufficient numbers of **healthcare professionals** to work in general practice, and more GPs are opting for salaried positions and portfolio careers, meaning a need to consider new and alternative employment models.

The earlier strategy referenced the significant variation in general practice size, the number of single-handed GP practices and that much of the primary care estate was not fit for purpose. At that time, there were 258 general practices with 1,413,086 registered patients, excluding the three GP-led health centres and PCT Special Practice. Each practice was responsible for managing its own access. The previous document referred to integrated care networks, in which general practice would see itself at the hub of a wider system of primary care, taking responsibility for coordination and signposting to services beyond health care – in particular, social care, housing and benefits.

General practice is the foundation of the NHS and the main point of entry for patients. This strategy focuses primarily on **general practice** within the wider context of primary care, and the importance of ensuring robust, sustainable general practice as the foundation of the NHS. Traditionally, primary care has been defined as general practice, community pharmacy, dental and optometry services. The scope of primary care however is much wider and could also include appropriate self-care interventions, mental health support and community health care teams, which incorporate nursing and other multidisciplinary care.

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Context – our demographics and the challenges

Page 61

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

NHS

Our context: the challenges facing general practice

Growing demand for services: many people have more complex needs, health inequalities persist and there are high levels of long terms conditions and rising expectations of general practice. The population is growing and people are living longer but in poor health and with greater complexity; older people in north central London are living their last 20 years of life in poor health, which is worse than the England average. The King's Fund has shown how consultations are outstripping population growth (source: King's Fund, 2016- Strategic Commissioning Framework). There are poor indicators of health for children – childhood obesity is high while immunisation levels are low. Investment has fallen and the unwarranted variation in outcomes and historical funding need to be addressed. We will not be able to manage the expected growth in demand for healthcare if we do nothing.

A workforce under pressure: NCL faces significant challenges for its future workforce from GPs to general practice nurses and other primary care professionals. 25% of the GP workforce is over 55 and therefore likely to retire within the next 10 years, and there is a shortage of general practice nurses; all London CCGs are below the national average.
A recent NCL Local Medical Committee (LMC) survey collected data showing that 45% of responding practices are due to lose one or more GPs to retirement in the next three years. This, along with an ever-growing and more diverse population, demonstrates the need to develop and grow the NCL GP workforce significantly over the next few years.
Fewer GPs are looking for partnerships, and there are recruitment and retention challenges. There are low numbers of GPs per patient in Barnet, Enfield and Haringey, and low numbers of practice nurses in all CCGs in north central London. Low morale is not unusual; GPs, nurses and practice managers report being more stressed than ever before. We need to value the existing workforce and attract and retain new professionals.

An evolving health and care landscape: Sources of information, advice and support regarding patients' health and well-being are more varied; patient expectations change in line with social and technological advances. There is renewed importance on the role of general practice in providing and coordinating trusted accessible, proactive care that is integrated across all parts of an increasingly complex health and care system. Patients are being increasingly supported to self-care and there is more technology available to support this and health services more generally. More services are moving to being provided in the community (not in hospitals)

A financial challenge: There is an increasing financial challenge in north central London, and a need for ambitious and transformation programmes in order to address a recurrent financial shortfall.

Unwarranted (unnecessary) variation, ranges from **patient satisfaction** in how easy it is to get an appointment to availability and use of technology for GP services, to unwarranted variation in **clinical outcomes**, e.g. identification and anticoagulation of people with atrial fibrillation. There is also variation in the historical levels of **funding** in primary care, to variation in funding for locally commissioned services. There is variation in the condition of primary care estate. There is also variability in ownership of the **primary care estate** across individual GPs, GP partnerships, private sector, NHS Property Services (NHSPS) and Community Health Partnerships (CHP).

Page 62

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

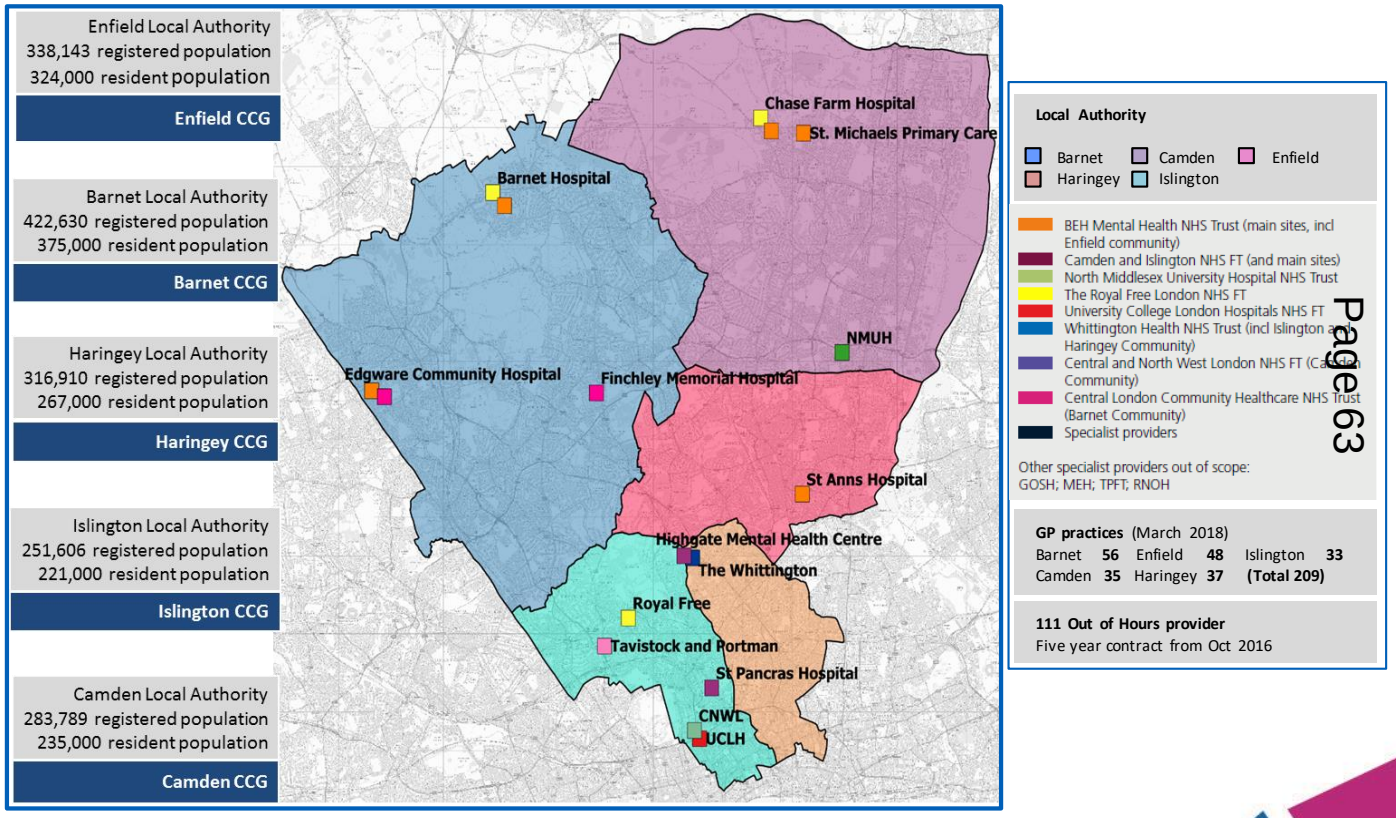
NHS

Our context: population size and life expectancy

All NCL residents have seen an increase in life expectancy over the past ten years; current life **expectancy** for men and women across NCL is higher than England, with the exception of **Haringey** and **Islington**.

Overall residents spend approximately 20 years of their life living in poor health. Trends in healthy life expectancy show that there has been **no significant change** in the number of years people are living healthy lives.

There are **stark differences** in life expectancy between those living in the most affluent areas compared to the most deprived. **Camden** has the highest **life expectancy gap** for men with people living in the most deprived areas living on average 10 years less than those in the least deprived. The gap in life expectancy is smaller for women overall.



Sources: Open Exeter, 2017, GP Patient Survey

Page 63

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

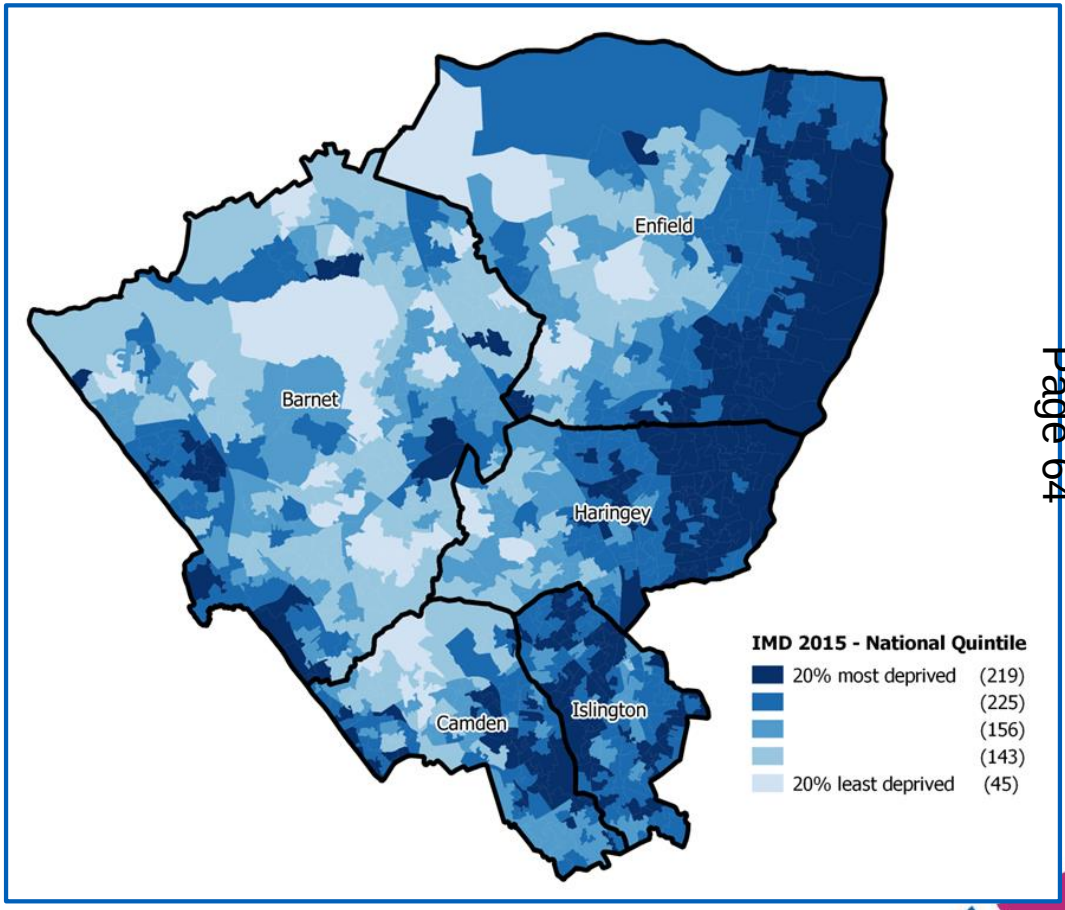
NHS

Our context: poverty and deprivation

Poverty and deprivation are key determinants of poor outcomes in health and wellbeing. NCL is a diverse area containing some of the most deprived (east and south) and more affluent (west and north) areas in the whole country.

Higher levels of deprivation are linked to numerous health and social vulnerability including chronic illness and poor lifestyle choices. 30% of children in NCL are growing up in poverty. Islington, Enfield and Haringey have the highest rates of deprivation relative to the national picture, although pockets of deprivation are dispersed throughout all areas across NCL.

For most aspects of health, there is a close relationship between deprivation, the need for health and social care services and higher rates of ill health and premature mortality. Poor health and risk of poor health is unequally distributed in NCL. Actions to improve the wider determinants of health such as good housing and income are needed alongside targeted healthcare provision, working closely with local government and other key services. We have a track record in NCL of working with partners in this way.



Sources: Open Exeter, 2017, GP Patient Survey

Page 64

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

NHS

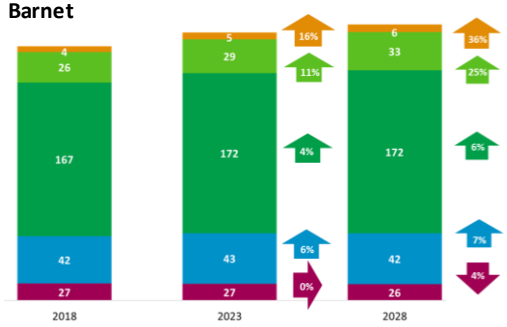
DRAFT

Our context: borough population growth

Overall the population in NCL is expected to increase by 6% over the next decade. The majority of this growth (71%) is expected in the first five years. The fastest growth is amongst the elderly population, with the proportion of those over 65 expected to grow by 26% (from 181,000 to 227,000) in the next ten years. The population aged 0-4 is expected to decrease by 3% over the same period.

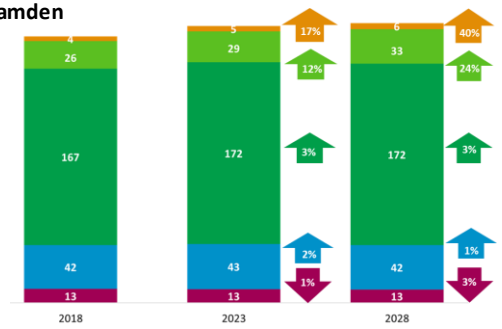
A larger population and an older population is likely to mean increased demand for primary care services.

Barnet



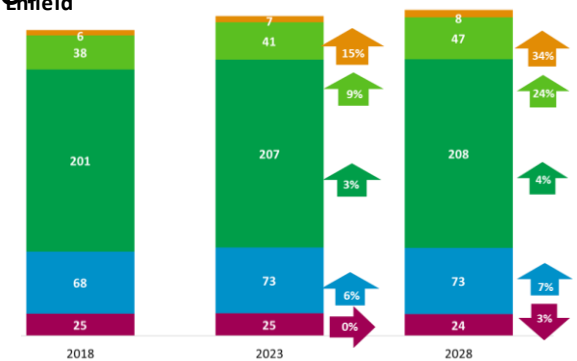
Expected to have proportionally the largest overall population growth in NCL in the next decade (9%). 62% is expected within the first 5 years.

Camden



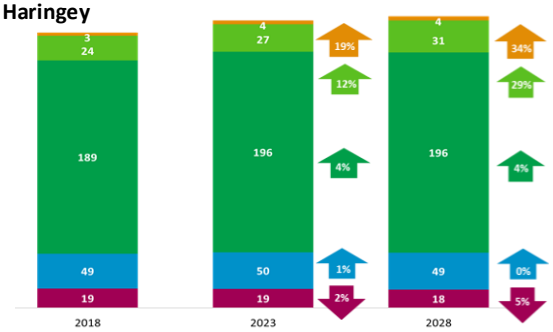
Expected to have largest growth (40%) in the 85+ age category over the next decade. After initial growth in the under 65s, it is expected that this population will decrease by 1%. In the second half of the decade.

Enfield



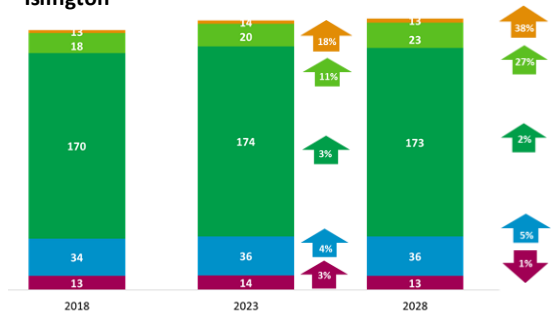
In Enfield it is estimated that 69% will occur in the first five years.

Haringey



Expected to have the proportionally largest decrease in the 0-4 aged population (5%) over the next decade.

Islington



Of the expected growth in Islington over the next decade, approx 80% is expected to occur in the first five years.

Source: GLA, 2016

Page 65

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

NHS

Our context: growing demand for services

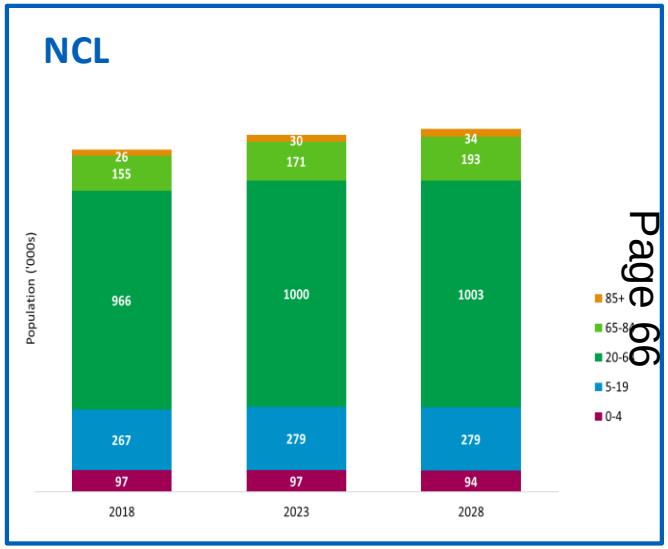
The populations of NCL are living longer, growing and constantly changing. The fastest growth is expected amongst the elderly population; health service use, including both planned and emergency admissions, are much higher in this population group. Conditions such as stroke, dementia, some cancers, falls and fractures, as well as the need for the management of degenerative disease, e.g. major joint replacement, are strongly linked to increasing age.

Overall the age structure of NCL will continue to be dominated by a young working age population. A younger population profile presents a significant opportunity for prevention of conditions that are significant contributors to death and disability. Earlier identification of risk, screening, improved early diagnosis of long term conditions and behaviour change, e.g. stopping smoking, healthy eating and physical activity or reducing alcohol consumption, in this age group will be key in improving premature mortality rates in the short to medium term. General practice, primary care and community services will need to cope with more people requiring lifestyle risk assessments, behaviour change support, earlier diagnosis of long term conditions and cancer screening.

Lifestyle factors, often linked to deprivation, are important sources of inequalities and poorer health outcomes.

Alcohol related issues are most prevalent in Haringey and Islington so efforts on alcohol prevention need to be focussed on these areas. Cancer screening rates and vaccination coverage are low across all of NCL and action needs to be focussed on increasing these rates.
Primary and community services will need to cope with more people requiring lifestyle risk assessments, behaviour change support, earlier diagnosis of long term conditions and cancer screening.

Good service provision needs to be maintained for the youngest children (under fives), including universal and other community health services as well as acute services, and ensure healthy development, including good childhood immunisation uptake rates and breastfeeding. Levels of emotional health and obesity among children and young people will be important, and are correlated with childhood poverty. Children and young people's outcomes, particularly younger children, may be particularly vulnerable to the impact of austerity on households experiencing economic distress, disability or worklessness.



Source: GLA, 2016

Page 66

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

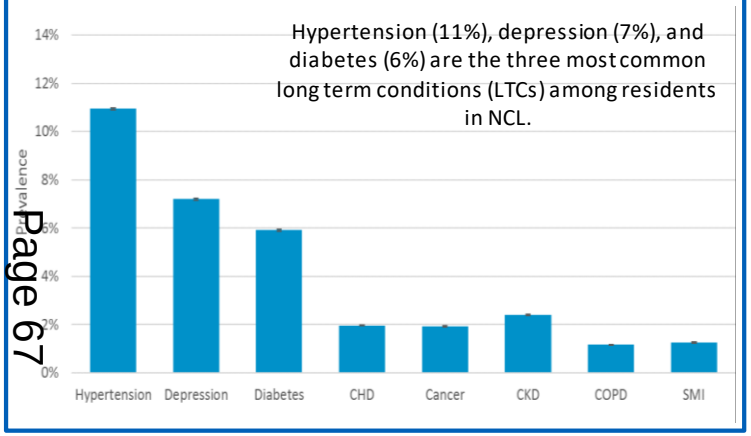
NHS

Our context: prevalence of long term conditions (1)

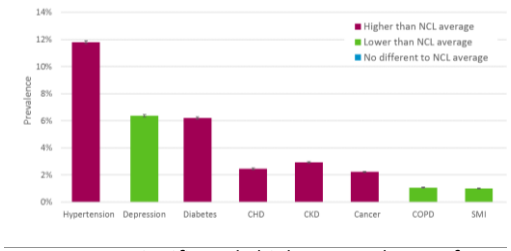
People with long term conditions (LTCs) are the most intensive users of health services, particularly primary care. There will remain a significant number living with one or more LTCs, and a need for support to help people manage their own condition through self-care, take the correct medication or access therapies. Community networks and the voluntary sector play a key role in supporting people with LTCs, as part of the wider system.

Smoking, obesity and lack of physical activity are significant contributors to the development of LTCs; most of NCL performs poorly or similarly to indicators relating to these areas compared to England. More action is needed to improve outcomes.

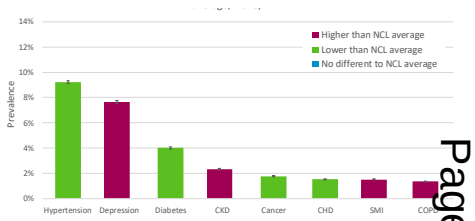
NCL – prevalence of major long term conditions in 2016/17



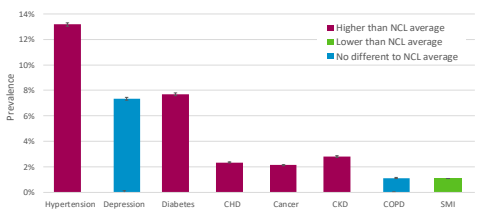
Hypertension (11%), depression (7%), and diabetes (6%) are the three most common long term conditions (LTCs) among residents in NCL.



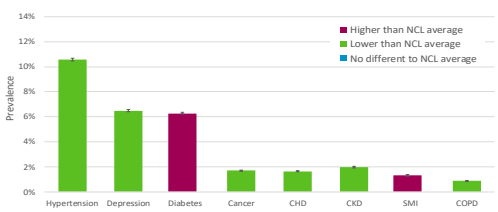
Barnet: significantly higher prevalence of hypertension, diabetes, CHD, CKD, and cancer than the NCL averages.



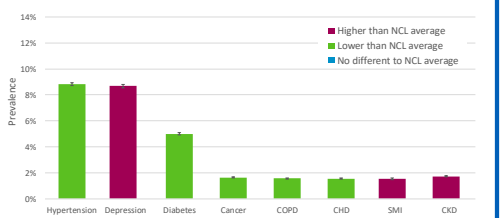
Camden: significantly higher prevalence of Depression, CKD, serious mental illness, and COPD than the NCL average.



Enfield: significantly higher prevalence of hypertension, diabetes, CKD, cancer, and CHD compared to the NCL average.



Haringey: significantly higher prevalence of diabetes and serious mental illness compared to the NCL average.



Islington: significantly higher prevalence of depression, serious mental illness and CKD compared to the NCL average.

Higher than
Lower than
No different to NCL average

Source: GLA, 2016

Page 67

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

NHS

DRAFT

Our context: prevalence of long term conditions (2)

Indicator		Barnet		Camden		Enfield		Haringey		Islington		London		England
		Current value	Progress	Current value	Progress	Current value	Progress	Current value	Progress	Current value	Progress	Current value	Progress	Current value
Reducing death rates from the top 3 killers	Cancer													137
	Cardiovascular diseases													73
	Respiratory diseases													34
Children and young people have the best start in life	Infant mortality													4
	Child weight management - Reception		↓		↓		↓		↓		→		↓	23
	Child weight management - Year 6		→		→		↑		→		→		↑	34
	School readiness - Reception		↑		↑		↑		↑		↑		↑	71
	School readiness - Year 1		↑		↑		↑		↑		↑		↑	81
	Oral health (dental decay)													1
Residents lead active lives and eat well	Adult weight management													61
	Physical activity													65
Fewer residents are harmed by tobacco	Smoking quits													51
Fewer residents are harmed by alcohol and drug misuse	Premature liver disease mortality													18
	Alcohol related hospital admissions													636
Residents have good sexual health	Teenage pregnancy		↓		↓		↓		↓		↓		↓	21
	Teenage abortion		↑		↑		→		↑		↑		↑	51
Residents have good mental health and wellbeing	Suicide													10
	Excess deaths in serious mental illness													370
People with long conditions are diagnosed earlier	CKD		→		↓		→		→		→		→	4
	Diabetes		↑		↑		↑		↑		↑		↑	7
	COPD		→		→		→		→		→		→	14
	Hypertension		→		↑		→		→		↓		→	14
	CHD		↓		↓		↓		→		↓		→	3
Support residents to age healthily	Healthy life expectancy at birth - men													63
	Healthy life expectancy at birth - women													64

Current performance
NCL boroughs compared to national average

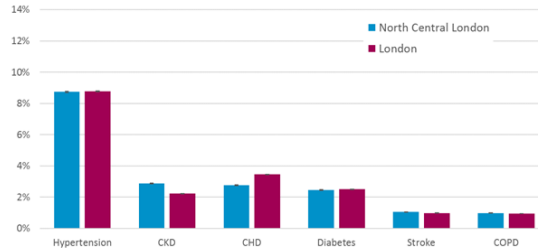
- Significantly better
- Not significantly different
- Significantly worse

Progress in performance
NCL boroughs compared to performance in previous years

- Increasing/decreasing and getting better
- No change \
- Increasing/ decreasing and getting worse

Smoking, obesity and lack of physical activity are significant contributors to the development of long term conditions, and most of NCL performs poorly or similarly to England for indicators relating to these problems.

Estimated percentage of undiagnosed LTCs in NCL compared to London (registered population, 2016/17)



Hypertension is estimated to be the most under-diagnosed long term condition across NCL, with 8.7% of the total registered population of NCL estimated to have the condition without a diagnosis.

The undiagnosed prevalence of CKD, COPD and Stroke are significantly higher than the London average. The undiagnosed prevalence of CHD and Diabetes is significantly lower than the London average.

There is a relatively high number of people in NCL who are unaware they are living with a disease (undiagnosed prevalence). Early deaths amongst people, living with cardiovascular disease, cancer and respiratory disease are the key drivers of the life expectancy gap in NCL.

Diagnosing these and other long term conditions (such as diabetes) earlier, better supporting people living with them to adopt healthier behaviours and manage their conditions, and ensuring they receive optimal management and care should help to improve both the length and quality of their lives. The trend for early diagnosis of diabetes shows that all five boroughs, and London, are performing worse than in previous years, so more focus may be required to reverse this trend.

Sources: QOF, 2016/2017, PHOF, 2017 NB blank cells signify where comparisons to historical data cannot be made due to methodological changes to data sources

Page 68

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT 27

NHS

Our context: a workforce under pressure- GPs (1)

The NHS spends almost 65% of its operational budget on its most valuable asset; our staff. More than 50% of today's workforce will still be working in the health service in 2032. With the transformation in the way services are delivered to patients, with a greater focus on out of hospital care, it is imperative that we are proactive in sustaining and developing a workforce to support this. NCL faces significant challenges for its current and future GP workforce; workforce transformation is an essential and urgent requirement and is rooted in current initiatives. New models of GP delivery need to address both workforce and workload.

There is a shortage of GPs

NCL's ever-growing and more diverse population, demonstrates the need to develop and grow the NCL GP workforce significantly over the next few years. **The number of patients per practice** is variable; Islington, Barnet and Enfield have on average fewer patients per practice than Camden and Haringey, suggesting a greater proportion of smaller practices in Islington, Barnet and Enfield. The number of **practitioners per practice** is also variable, with the smallest number of professionals per 100,000 patients in Enfield and Haringey.

Borough/ CCG area	Average number of patients per practice	GP Headcount *	FTE*	Practitioners per 100k patients (headcount)*
Barnet	7,121	272	199	64.7
Camden	8,368	193	146	67.8
Enfield	7,080	177	133	52.8
Haringey	8,599	163	119	51.23
Islington	7,418	156	122	61.8

*data as at March 2018, excludes registrars, retainers and locums

Patients per practice

Up to **9,250** in **Camden and Haringey**

Up to **7,750** in **Islington, Barnet and Enfield**

GPs are retiring

25% of the GP workforce is over 55 and **therefore likely to retire** within the next 10 years. A recent NCL Local Medical Committee (LMC) survey collected data showing that 45% of responding practices are due to lose one or more GPs to retirement in the next three years.

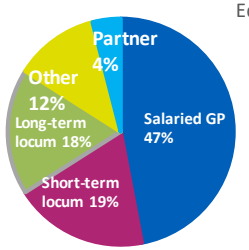
Borough / CCG area	% of GPs aged over 55	B/W/S than London average*
Barnet	27%	Worse
Camden	16%	Better
Enfield	32%	Worse
Haringey	32%	Worse
Islington	19%	Better

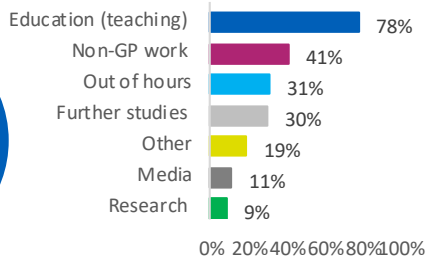
*RCGPs: London average is 22%

One in four GPs is aged over 55

New GPs want a different way of working

A recent survey of GP trainees demonstrated the need to consider **different employment models** and **portfolio careers**. The majority of GP trainees (93%) want a portfolio career with 78% wanting to be involved in education and teaching. The same survey showed that nearly half of GPs wanted a salaried role. An added pressure to the recruitment problem facing general practice is the draw on the GP workforce to innovative roles across organisational interfaces, such as urgent treatment centres, or new models of provision, which offer more attractive salary scales. Finally, there is evidence that the trend towards more part-time or portfolio-working is being driven by a *push* away from general practice by the unattractive aspects of the job rather than a *pull* towards the alternative options; this aspect must not be overlooked.





Sources: London GP Trainee (ST3) survey July 2017 (n. 58), HEE, Draft health and care workforce strategy for England, Source: NHS Digital, 2017. NB Workforce data on 5% of GP practices in NCL were unknown and excluded from this chart

Page 69

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

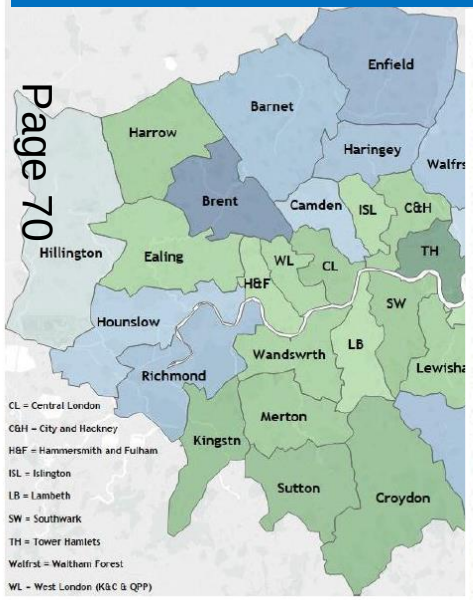
NHS

DRAFT

Our context: a workforce under pressure (2)

"We know we cannot work any harder, so we have to find ways to work differently"
Dr Arvind Madan, Director of Primary Care, NHS England, 2016

General Practice Nursing: Heat Map Analysis



Tower Hamlets (NEL)	1:3900
Bexley (SEL)	1:4200
Croydon (SWL)	1:4600
Kingston (SWL)	1:4600
Sutton (SWL)	1:4600
Havering (NEL)	1:4700
Southwark (SEL)	1:4800
Central (Westminster) (NWL)	1:4800
Merton (SWL)	1:4900
Harrow (NWL)	1:4900
City and Hackney (NEL)	1:5000
Lewisham (SEL)	1:5000
Wandsworth (SWL)	1:5000
West London (NWL)	1:5100
Ealing (NWL)	1:5100
Islington (NCL)	1:5200
Hammersmith and Fulham (NWL)	1:5300
Lambeth (SEL)	1:5300
Greenwich (SEL)	1:5400
Hillingdon (NWL)	1:5600
Newham (NEL)	1:5700
Barking and Dagenham (NEL)	1:5800
Camden (NCL)	1:5900
Hounslow (NWL)	1:6000
Waltham Forest (NEL)	1:6200
Barnet (NCL)	1:6300
Richmond (SWL)	1:6300
Haringey (NCL)	1:6300
Bromley (SEL)	1:6300
Enfield (NCL)	1:6600
Redbridge (NEL)	1:7000
Brent (NWL)	1:7300
London average	1:5300
National average	1:3600

Nurse: Patient ratio

3,665 — 7,295

A shortage of general practice nurses

There is a shortage of general practice nurses (GPNs). All London CCGs are below the national average. To achieve the national average, London needs to recruit 700 additional nurses into primary care. With population growth from 2016-21, this suggests an additional 838 full time equivalent nurses are required to achieve the national ratio. 40% of the general practice workforce is aged 50-59. 33.4% of GPNs are due to retire by 2020 (QNI, Nurses in General Practice Survey 2015). There are not enough nurses to meet current demand – we will need even more of them to meet future demand.

The wider general practice workforce

True assessment of workforce demand is complicated, and there may be under utilisation of nurses and other professionals in general practice. Notwithstanding the national campaigns to train more, or recruit overseas doctors to work in general practice in the area, it is clear that the future model of general practice cannot be delivered with the expectation of recruiting more GPs and practice nurses alone.

We recognise that there will be greater utilisation of different skills in order to be more productive and deliver better quality of care, with patients seeing the best person to manage their problem at the outset, without need for duplication. The GP workforce of the future will need to collaborate across specialisms in order to achieve this, with the greatest opportunities for delivering true population health being through collaboration and working at scale.

Headspace for GPs will be achieved through task substitution, better use of integrated IT and patient activation to increase levels of self-care.

We have not yet consistently maximised the opportunities for bringing in other clinical professionals into general practice in NCL e.g. pharmacists, dental health practitioners, paramedics to undertake home visits. We know that there are also opportunities for further efficiencies in general practice by focusing on the non-medical workforce, skilling up receptionist staff and practice managers to take on some of the administrative duties currently carried out by general practitioners as well as working with voluntary sector partners and volunteers. Enabling staff to provide appropriate care in a less stressful environment could make general practice a more attractive career and may increase recruitment and retention.

Increased multi-disciplinary working is imperative to improving the capacity and quality of care, with GPs acting as specialist generalists able to spend more time addressing low volume/high complexity care and, through closer links with clinicians working in secondary care, provide a more responsive and safer level of care. This will require people to work in different places and in different ways.

Page 70

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

NHS

Our context: primary care estate

The information provided here is taken from the NCL estates strategy; priorities for estates sit within this estates strategy, and the two strategies should be read in conjunction.

Primary care infrastructure is critical to support the NCL ambition for care closer to home. The current NCL primary care estate is characterised by a large number of small properties in fragmented ownership, which impacts the ability to enact change at pace, given the various interests and complex arrangements which need to be managed.

Transformation in primary care estates is critical as it acts as a key enabler to delivering the overall vision for care. Currently only around one third of practice premises are rated excellent or good, therefore a 'do nothing' option is not viable if we wish to deliver good quality care in an appropriate environment.

34 GP premises within Camden
76% are in a good condition
0% require improvement
24% are in poor condition

41 GP premises within Haringey
37% are in a good condition
61% require improvement
2% are in poor condition

33 GP premises within Islington
27% are in a good condition
33% require improvement
40% are in poor condition

The data has been interpreted from the CCG Estates Databases, where completed.

Camden data - April 2018. Haringey data - June 2018. Islington data - 2016. Data currently unavailable for Barnet and Enfield.

Each CCG has different methods of measuring physical condition; the NCL estates plan adapted this to reflect good, requiring improvement and in poor condition.

Fig 1.

NCL GP Business Types and Ownership [1]

Business type	3PD/Private	CHP	GP Owned	NHSPS	Total
Corporation	4				4
GP Branch	5		2	1	8
Not Known	1				1
Partnership	90	9	41	15	155
Single Handed	44	6	19	6	75
No information				1	1
Total	144	15	62	23	244

1. NCL devolution Business Case, November 2017: Version 5 Master database, NHS England London

Primary Care Provision

Across London as a whole, the London Health Commission – Better Health for London 2014 found:

- 36% of GP premises are rated in excellent or good condition, 51% are rated average; the remaining 13% are rated poor, very poor or terrible.
- GP premises rated as average require refurbishment. GP premises rated poor, very poor or terrible require rebuild.
- NCL-wide data is limited; for the three CCGs with available information (fig 1), this suggests that approximately one third of primary care premises are operating in good condition, and the balance requires improvement or is in poor condition.

Fragmented estate

NCL primary care ownership analysis (2016) showed GP services operating out of 244 properties (table). Of these:

- 75 are occupied by a single-handed GP and 155 by a partnership;
- The majority of GP properties are owned by the private sector and leased to GPs;
- The distribution across ownership types is similar for both partnerships and single-handed GPs; and
- Only 15% of GP occupied properties are owned by either NHSPS or CHP.

Source: North London Partners – Draft estates strategy July 2018. **Note:** Data on this slide refers to GP premises. Numbers therefore differ to references to GP practices elsewhere in the strategy. Numbers also vary as a result of differences in timing when data compiled.

Page 71

NORTH LONDON PARTNERS in health and care

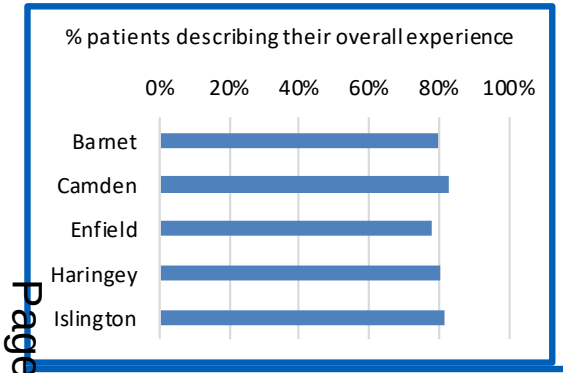
London's sustainability ation partnership

DRAFT

NHS

Our context: patient experience of general practice

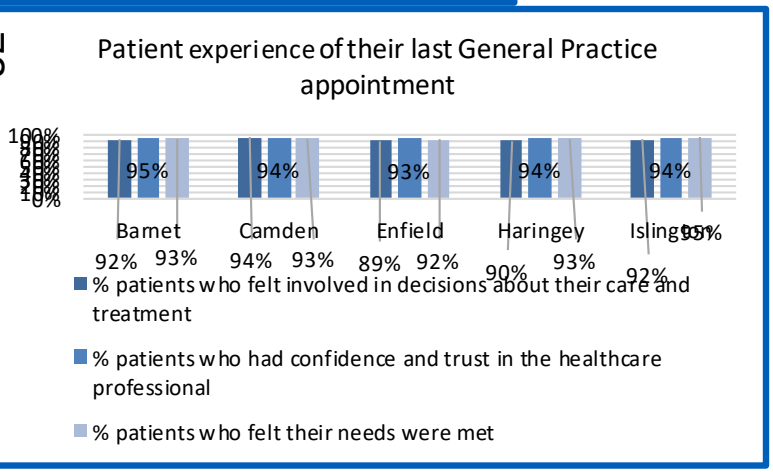
A recent nationwide survey shows the majority of people are **positive about their GP care**; eight out of ten patients rated their overall experience of their GP surgery as good. The survey also found that **confidence and trust in GPs** and healthcare professionals remains extremely high, as does patients feeling involve in decisions about their care and treatment and patients feeling that their needs were met. However, the survey also highlights areas for improvement, such as **telephone access**, and supporting patients to use **online GP** services for booking appointments, ordering repeat prescriptions and viewing their medical records.

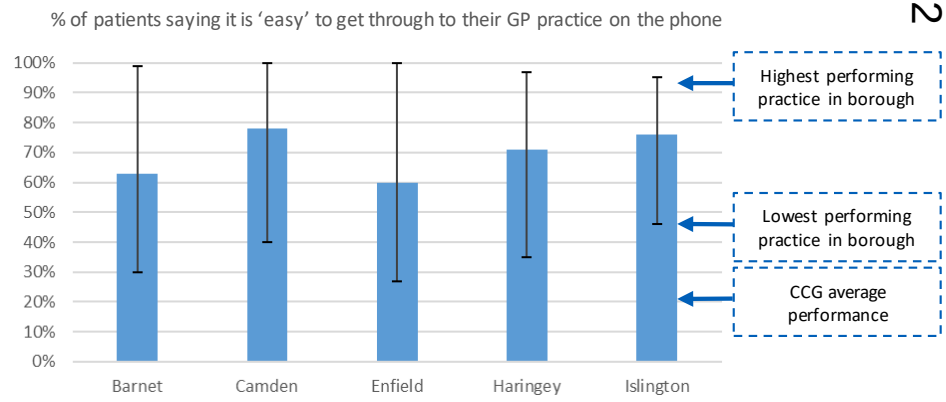


Eight out of ten patients rated their overall experience of their GP surgery as good.
NCL data: 2018 national GP survey

National GP Survey data shows that on average, two thirds of patients find it easy to get through to their GP practice on the phone.

However, when we compare data at an individual practice level, there is lots of variation between practices, which tell us that some practices are performing much better than others against this measure of patient experience. Understanding the reasons behind this variation, and learning from the highest performing practices in each borough will be key to reducing this variation and making patient experience more consistent.





Source: 2018 National GP Survey

Page 72

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London's sustainability ation partnership

NHS

DRAFT

Our context: extended access and patient experience of using online GP services

Increasing patient awareness and uptake of online GP services is a priority area for General Practice. Nationally there is still a long way to go to achieve this. Our results show that we are in line with the national averages for patients using online services, although we know that some of our NCL GP practices are much further ahead than the rest of the country.

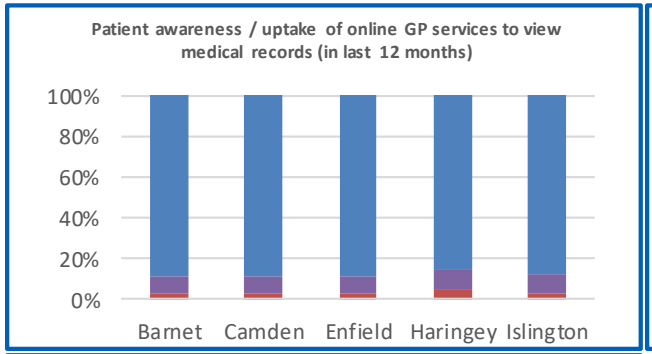
8am – 8pm extended access

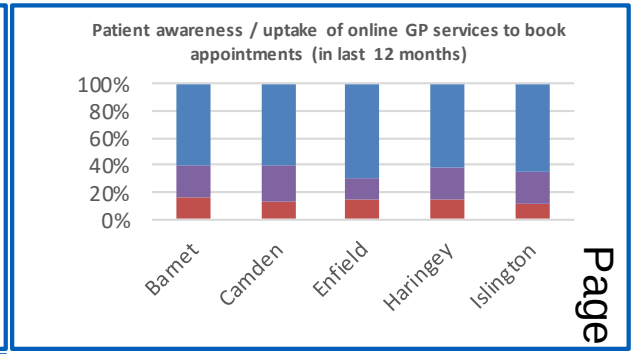
All boroughs in North Central London offer access to primary care appointments between 8am-8pm seven days a week. This has been a significant change in how practices work together and in how patients access services. This is because the extended access hubs work 'at scale' by offering appointments to patients from multiple practices.

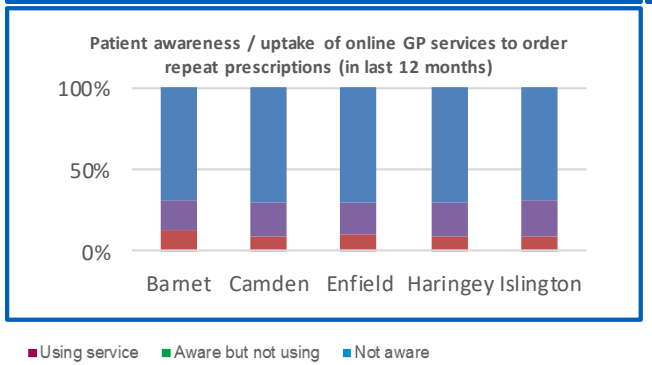
There may be opportunities to promote these extended access services even more widely, so that everyone is aware of them.

In a recent patient survey in one NCL borough, patients said that they found the Saturday 'extended access hub' appoints to be more relaxed, with fewer people waiting and that they felt less rushed and like the GP had more time to listen.

From a recent survey in Enfield, over 40% of patients using this service reported that had the service not been available, they would otherwise have gone to their GP, and over 20% would otherwise have gone to A&E.







The survey tells us that there is a lack of awareness of online services across NCL. Improving this will be key to increasing their uptake amongst patients. There is also a cohort of patients who are aware of online GP services but choose not to use them; more will need to be done to understand the experience of this group.

Sources: 2018 National GP Survey; Healthwatch report: 'Improving access to GP appointments in Haringey' April 2018

Page 73

NORTH LONDON PARTNERS in health and care

Central London's sustainability and transformation partnership

DRAFT

NHS

Our vision for general practice

Page 74

We want to do more for ourselves

We recognise the NHS is under pressure, but we can help by playing a bigger role in looking after our own health and wellbeing

What would this look like?

I want to be listened to and heard

- I won't have to rely as much on my GP to interpret information for me
- I'll be able to access the information and advice I need to make more decisions for myself
- I'll understand which services to use and when
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me[7]

Services will work better for me

- My health records will be up to date and services that help me will be able to access them
- I will tell my story once
- The professionals involved with my care talk to each other; we all work together as a team

I'll have easier access to the support I need to stay well

- I won't have to go to hospital so much
- Investigations such as blood tests and ECGs can be done in alternative places to the hospital

I'll be able to do more online

- I can book and cancel appointments online, when it suits me; I won't have to visit the GP, miss appointments I don't need or wait for the post to get my test results
- I can order repeat prescriptions online; I don't need to make a special trip to my surgery to place the order
- I can see my health and care records and can decide who to share them with. I can correct any mistakes in the information.

Our healthcare services know people want timely access to services and they want their mental health needs to be considered alongside their physical health.

- More health and care will be available **in the community, or out of hospital**, ensuring that people **receive care in the most appropriate setting** at a local level and with local accountability. It is recognised that for some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed.
- At the heart of the care closer to home model is a '**place-based**' population health system of care delivery which draws together **social, community, primary** and **specialist** services underpinned by a systematic focus on **prevention** and **supported self-care**.
- There are many excellent services in north central London; the health and care closer to home model will focus on scaling these services up, **reducing unwarranted variation** and **establishing the Care and Health Integrated Network** model, the default approach to delivering care and to place-based commissioning of services, ensuring services are focused on the care of people within a defined geography and population, focused around a cluster of GP practices and their registered patient list (the name of which will vary by borough).
- Health and care partners, including social care and the voluntary, sector will play a key role in the design, development and delivery of the future model.
- We will work towards addressing the **sustainability** and **quality** of **general practice**, including **workforce** and workload issues.

Page 75

Source: National Voices – person-centred coordinated care; Better Conversation: Better Health

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London's sustainability ation partnership

DRAFT

Our vision: resilient, sustainable and thriving general practice

"There is arguably no more important job than that of the family doctor […] if general practice fails, the whole NHS fails" Simon Stevens, Chief Executive, NHS England, 2016

Our ambition:

The current strengths of general practice are not lost, recognising the value in different GP roles (partners, salaried and sessional)
The workforce feels valued and NCL invests in newly qualified healthcare professionals (training, education, quality improvement); NCL is seen as an attractive place to work
Reduced variation in levels of funding between boroughs in NCL
Reduced pressure on general practice, through collaboration to develop at scale solutions to drive efficiencies and productivity, e.g. education and training, GP retention, back office functions, delivery of outcomes, population health management
A systematic and data-driven approach to practice resilience, with reduced need for CCG intervention

Our priorities:

- Develop and work with organisations within the system who have the capability to support general practice to be sustainable, thriving and resilient
- Build capacity and capability within the general practice workforce, ensuring people are seen by the right professional, the first time
- Work with partners in recognition of the changes in general practice workforce to test new models of care and demonstrate the impact of any new roles, e.g. portfolio careers, pharmacists, occupational therapists, physios in general practice
- Explore more alignment of terms and conditions for general practice staff (retention and unwarranted variation)
- Work towards rebalancing the investment in general practice, recognising the historical variation in funding within NCL. Once the GMS/ PMS equalization is achieved, use the funding to ensure enhanced general practice is delivered equitably to all residents in NCL
- Encourage the development of general practice at scale provision, including at network, neighbourhood and borough level collaboration, ensuring, and tackling and reducing the administrative burden on GPs through collaborative working arrangements, delivering services in the most efficient way
- For at scale general practice providers working in partnership with their CCGs using a data-driven approach (local intelligence and NHSE data) to develop an alert system to mitigate resilience risks to practices ahead of time. Practices will know how to access this support and will receive timely support to maintain patient care

What will be different for patients and professionals:

- Additional skills and capacity in general practice: patients' care is of a good quality and their needs are met in a timely fashion
- Increased and more consistent security of service provision as a result of longer contracts, resulting in more stable primary care teams
- Development of new employment models; the workforce will change; a greater role for specialist nurses, pharmacists, physicians' associated, health care assistants, mental health workers and other healthcare professionals
- A valued and motivated workforce with training and development for a variety of roles including specialists and portfolio careers
- Staff enjoy their work and achieve a good work life balance; NCL is the destination of choice for healthcare professionals in training
- Staff enabled and supported to work at the maximum capabilities and competencies, so increasing productivity and efficiency and avoiding duplication or waste
- Collaborative and integrated working will deliver economies of scale and increased sustainability
- GPs will feel supported by strong management teams, so enabled to provide strong clinical leadership at both practice and network levels (if desired)

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London's sustainability ation partnership

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NHS

Our vision: high quality, equitable and safe, person-centred care

Our ambition:

For all NCL practices to be in the top 25% of best performing practices nationally on agreed markers (clinical and process), reducing unnecessary variation in general practice so patients know what to expect from their GP, wherever they choose to access services
GP practices supporting people to address the social determinants of health, with the aim of everyone with a long term condition to have the opportunity for an annual care planning conversation

Our priorities:

- Invest in quality improvement support teams (QISTs), focusing on delivering high quality primary medical care services and improved outcomes and experiences for the population; ensuring general practice understand local work and priorities
- Work collaboratively towards commissioning more services through outcomes-based contracts, so that investment can be targeted towards those who need it the most
- Regularly review evidence and good practice, supporting initiatives with the potential for the biggest positive impact for patients, e.g. care coordinators for people with long term conditions
  General practice will enable an holistic, strengths-based and more systematic approach to the care of patients through collaborative working within the community, ensuring people are supported to set goals and identifying what's important to them
- Support patients and carers to be actively involved in their own care, working in partnership with their health, care and community providers. Through visible and accessible, active care navigation, people will be able to access local services in their community, increasing their involvement in self care, prevention and health promotion programmes; GP staff will be able to receive feedback from navigators
- Strengthen the patient and carer voice in developing of local person-centred service models
- Continue to work closely with partners including local authority, public health, community, voluntary sector providers and other public sector organisations, to ensure a more effective prevention and healthy living offer

What will be different for patients and professionals:

- Improved outcomes, experience and patient satisfaction
- Consistent high-quality care across general practice; safer, less (unwarranted) variability and better quality, consistent care delivered by highly trained GPs, nurses and other professionals, with appropriate continuity of care
- Care will be centred around each person so they won't need to have multiple appointments about different long term conditions
- Patients will have the knowledge, skills and confidence to enable them to work in partnership with their health care professional

- Working towards all practices achieving good or excellent CQC ratings
- Easy access to shared good practice (e.g. policies, procedures, protocols)
- Technology used to support long-term conditions management and safe hospital discharge
- Collaboration through partnership working with patients who are informed and engaged, will result in improved utilisation of GP services so ensuring health care professionals experience less demand and an improved work life balance

Page 77

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

NHS

Our vision: proactive, accessible and coordinated care

Proactive care - supporting and improving the health & wellbeing of the population, self-care, health literacy, and keeping people independent and healthy
Accessible care - providing a personalised, responsive, timely and accessible service
Coordinated care - providing a patient-centred seamless experience of care and GP-patient continuity*

Our ambition:

Aligned with national and regional policy on providing proactive, accessible and coordinated care, recognising the importance of getting the basics right:
A step change in the roll out and uptake of digital technology in general practice (for patients and professionals)
Identify safe healthcare professional staffing levels in general practice, and work towards achieving these over the life of this strategy
Keep services local in premises that are fit for purpose for the delivery of primary care services

Our priorities:

- Focus on timely access to general practice, making sure that everyone can access their GP surgery during the core hours (currently 8am-6.30pm), recognising that people may prefer different means of access (in person, telephone, online). Face to face appointments should be offered to those who need them, making sure there is an opportunity for a senior clinician to assess the need, where appropriate, similar to the approach used to triage out of hours demand. We will monitor the utilisation of appointments (core and extended hours)
  Focus on continuity of care for people with complex care needs, people who are especially vulnerable, in a care home, or are in need of end of life care
- Encourage practices to work together and share resources, to deliver a full range of services to patients in their local community, e.g. working flexibly across hubs/ neighbouring practices e.g. encrypted communication apps for communication within an integrated team
- Ensure that all services provided within the core and enhanced contracts are available to the population, whether at a patient's own practice, or nearby, supporting practices to respond flexibly to patient demand

What will be different for patients and professionals:

- Improved (and less variable) access to general practice services
- Continuity of care for those patients that need it most
- Better management and care of long-term diseases; when they are frail and elderly, and at the end of life – integrated services supported by shared access to clinical records
- More access to and use of digital technology, with more responsive care, delivered in a range of ways, e.g. online, email and telephone not just face-to-face –
- Improved ability to book appointments
- Unregistered patients supported to register and access services
- People with more complex health and care needs will benefit from face to face appointments in a planned approach

- Reduced duplication through improved sharing of data, and improved productivity, e.g. registries that ensure patients have fewer crises due to better planned care, receptionists not having to chase appointments, test results being communicated
- Use of new technology, e.g. symptom checkers, e-consultations, will lead to reduced demand relating to unscheduled care, freeing up time for planned care appointments, prioritising patients with the greatest needs
- Through closer working relationships with the wider MDT, GPs and their teams will feel supported in delivering care, so will feel more able to manage increasing complexity; professionals other than GPs will be able to provide continuity of care for patients

Page 78

* Source: Strategic Commissioning Framework for Primary Care, 2015

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London's sustainability ation partnership

DRAFT

NHS

Our vision: integrated services that respond to the needs of the patient and the population

Our ambition:

Integrated working between GP practices and other community-based providers, supporting new roles into the wider GP team
High impact prevention interventions systematically embedded into everyday practice, in order to prevent ill health and promote wellbeing, with a focus on smoking, blood pressure, overweight, physical inactivity, and alcohol
GP practices to support people to address the social determinants of health, with the aim of everyone with a long term condition to have the opportunity for an annual care planning conversation

Our immediate priorities:

- Support the development of care and health integrated networks, through which teams of professionals can provide innovative, proactive and person-centred care
- Work with system partners, including other health, local authority and voluntary, third sector and charity providers to develop more coordinated and integrated models of care, focusing on patient needs around a shared vision, taking a proactive approach to delivering this care with our partners; community/ integrated services should be able to access those people who do not engage with regular services (e.g. housebound because of mental not physical health)
- Work with partners to support the development of an NCL strategy for care homes, to ensure equity of care to those with the greatest need
- QISTs will coordinate the management of people on population health management registries centrally, using data to identify priorities, driving improvements in outcomes and reductions in unwarranted variation across the system
- Use digital technology to improve information sharing to support 24/7 access to care, electronic advice, navigation and other clinical messaging systems between primary and secondary care clinicians e.g. access to EMIS primary care record for intermediate care teams
- Provide general practice with the tools to support patients to navigate their way through care, enabling easier access to appropriate care, with access to health (in addition to general practice) , social care, lay and voluntary organisations, coordinating and improving signpostin to social prescribing schemes, making sure this service is visible and accessible

What will be different for patients and professionals:

- Patients will be able to access more care locally from a range of service providers/ partners
- General practice will remain the gate keeper to care, but patients will be able to access a broader range of clinical, social and voluntary sector services through their GP
- Enhanced patient experience with as smooth and uncomplicated as possible a 'journey' through the health and care system
- patients who would benefit from support are identified early and thos

- Access to a broader range of clinical skills will enable a multi-disciplinary approach to caring for patients, releasing specialist medical resources
- Access to patient information broadened through a common clinical IT platform will enable seamless, integrated service provision
- Integration minimises the risk of duplication
- GPs and other health and care professionals will feel like valued members of a team working in partnership

CASE STUDY: Peter is 12 years old and in Year 7 of secondary school. He has had asthma and eczema since early childhood. He lives in Enfield, with his mother, who has mental health problems and a mild learning disability. She does not work. His asthma has previously been well controlled, but he has missed a lot of school during the last year. He has gained weight and is missing sports lessons because of the asthma.
Peter will have access to a nurse specialist in the community. At school he will be seen by an asthma nurse. This is more convenient, improves Peter's ability to self-manage and involves less time in hospital.
Peter and children like him will: **require fewer A&E attendances** and admissions; become involved in care, and **able** to manage; be **supported** by people who know him and his family; **miss less school**; have **improved fitness** and **confidence**

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Our enablers for delivering our vision

Page 80

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

NHS

Our enablers: workforce

Delivery of the NCL STP workforce agenda is centred on four priorities: 1) **Resourcing**, including **Retention**; 2) **Primary Care Transformation**; 3) **New Care Models**; 4) **Learning, Development** and **Transforming our Workforce**.

In recognition of the importance and urgency of primary care workforce, specifically general practice in this context, the NCL Local Workforce Action Board (LWAB) in January 2017, agreed to the establishment of the NCL Primary Care Work Stream. A project plan (NCL Primary Care Workforce Programme) was developed, identifying key milestones relating to the NCL STP Delivery High-level Milestone Plan. The project plan for the NCL Primary Care Workforce Programme (2017-2019) set out key priorities within the context of traditional general practice, aiming to address how primary care workforce can be revitalised through inclusion of a wider range of specialisms as well as complementary skills.

The strategy for General Practice is to be considered alongside the *Primary Care workforce Action Plan* and complemented by the development of a *Review of employment models,* to be used as a suite of documents to enable workforce transformation, to keep step with our strategic aims.

The governance arrangements in place across NCL (described in the North London Partners Workforce Governance) support delivery of an aligned approach between the strategic priorities for General Practice, with the workforce priorities of the Local Workforce Action Board. Local priorities feed into this and inform and drive the development, design and delivery of workforce initiatives via the Community Education Provider Networks (CEPNs).

The CEPNs will be key in creating alignment between the local networks of GPs delivering care to a given population (along with the broader primary care team), and large scale general practice providers, supporting general practice at scale; they will provide infrastructure for educational initiatives, including implementing quality improvement methodology, and other educational initiatives determined by local need. The role and the visibility of the CEPNs in delivering education and training for general practitioners at all stages, as well as multi-professional education and training sensitive to local need, will be strengthened.

RETAIN

The experience and skills of older GPs are much needed by the system, and evidence suggests that helping GPs avoid burnout and providing opportunities for new challenges helps prevent premature departure from general practice.

However it is retention of all GPs that is essential; different opportunities will need to be developed in response to the current status quo and the evolving landscape within the context of transformed models of care. Retention initiatives will benefit from alignment with national initiatives and must be informed and driven by local context and bottom-up engagement.

Priorities:

- Co- produce new employment models, enabling all staff to work more flexibly across organisational interfaces
    - Prioritise portability and pass-porting across primary and secondary care
    - Prioritise a review of terms and conditions to enable the above
    - Explore opportunities to enable access secondary care education, building integration through shared learning
- Improve opportunities for flexible working and promote portfolio career options for GPs and other staff along with visible opportunities for career progression (CEPN retention programmes, Innovative GP and First Five programmes)
- Encourage good employment practice e.g. national / SW England good practice approach to terms and conditions for practice nurses
- Strengthen the role and the visibility of CEPNs and continue to develop appropriate training opportunities for GPs, and other clinical and non- clinical staff groups, in order to grow total workforce capacity and skill mix. This should include opportunities for practice managers and administrative staff, to grow capability and capacity
- Develop a systematic programme-managed approach to retention, through the establishment of a retention support programme, recruiting NQGPs and GP 'veterans', working with the at scale primary care providers to develop sustainable ways of providing support for future multi-professional cohorts
- To develop this career escalator approach for all professional and staff groups, to enable movement around the system, as well as structured opportunities for personal development informed by local need
- Promote fellowship schemes, where the 'intelligent' and collaborative use of remuneration by partner organisations have been used to sponsor educational initiatives for GPs and other professionals, through working across organisational interfaces, to be practical exemplars of integration
- Consider how a bespoke menu of opportunity (including holistic measures) may be required to support different professional groups to remain within the area
- Establish peer support for older GPs including scoping what this might look like (with CEPNs)

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NHS

Our enablers: workforce

RECRUIT

Considering the high requirement demographic and attrition rates, recruitment is critical.

Priorities:

- Focus on the GP workforce
  - Through GP Trainee Recruitment aim to help improve and increase recruitment, retention and distribution of GP trainees within NCL
  - Consider how the model of GP training or the academic programme may be enhanced in order to maximise numbers and optimise training, for example GP Trainer networks
  - Work with partners to ensure that the links and alignment for this are systematically managed, so that people who start to work here, stay and progress
  - Consider opportunities for returning practitioners, as well as overseas recruitment initiatives
- Focus on creating opportunities to attract others to professions in general practice e.g. work experience, business and administrative / health care apprenticeships, and opportunities for existing health professionals to work in general practice e.g. pre-registration nursing students, medical, pharmacy or paramedic students.
- Focus on the GP Nurse workforce
  - Continue with recruitment programmes to attract GP Nurses
  - Increase the number of nurse pre-registration placements in general practice.
  - Increase access to clinical academic careers and advanced clinical practice programmes, including nurses working in advanced practice roles in GP
  - Develop healthcare support worker (HCSW), apprenticeship and nursing associate career pathways
- Make NCL an attractive place to work, including for new international GP recruits.
- Ensure that all educational rotations include exposure or placement in primary care & General Practice
- Local ownership and leadership of at scale providers

WIDEN OUR SKILL MIX

Transformation in the way we deliver care will require new ways of working, so the workforce supporting this care will need to diversify. Utilising the skills of other health and care practitioners will enable us to reduce the workload on GPs and will ensure our patients receive the best care. It will also reduce duplication and ensure that care is given by the person with the best skills for the job.

Widening our skill mix will encompass initiatives to provide additional training for existing staff within the scope of their existing role, or diversification to extend the remit of their role. Our workforce capacity can be increased by introducing more entry level posts, but with opportunities laid out for career progression, as well as novel roles such as medical assistant roles, nursing or physician associates.

Priorities:

- Commit as a system to identify the necessary resources to support testing of new employment models and to collaborate across traditional organisational interfaces to support the training of new roles with a diverse skill set. Examples include GP Fellowship roles.
- Support GPNs to work at the top of their license, develop and maintain skills, and continue to create development opportunities to support development of skills in leadership and career mentoring.
- Support and augment the development of new roles to work in general practice, e.g. nursing associates pilot, medical assistants, physician associates
- Increase the recruitment of other professional to support the work in general practice e.g. allied health professionals; or practice-based pharmacists, with enhanced skills such as minor illness training
- Support and augment the development of existing initiatives, which enable collaborative learning across disciplines e.g. supporting paired learning at under graduate and post graduate level for GPs and pharmacists
- Ensure that this strategy, reporting into the Integrated Education Provider board, informs a whole system approach to training and development of a more integrated workforce, skilled to support enhanced patient care in general practice
- Ensure that the local CEPNs can systematically lead in the delivery of these initiatives to meet local and system-wide priorities, working with at-scale providers to define their role in workforce and leadership development
- Facilitate more joined up working between commissioners of education and training with commissioners of services
- Enhance the alignment between the GP work stream and other clinical work streams to maximise the benefit to general practice from design opportunities in other pathways. For example, integrating the opportunities from urgent and emergency care pathway redesign using community pharmacy, to support GP surgery staff and integrate nurses and pharmacists with the extensive community pharmacy network, generating a workforce solution that is skill mix and location flexible and ensures a more sustainable solution.

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NHS

Our enablers: workforce

Focus on both the **existing and new workforce; retain, recruit and develop a new skill mix.** Map current workforce initiatives and develop a strategic workforce action plan, setting out skills, capacity and clinical/ caring roles, to feed into the development of future training

WE WILL:

- We recognise that a lot of work has been undertaken already to:
  - Make general practice workforce a key priority within the workforce workstream for North London Partners
  - Develop the governance and accountability to ensure a link between the Community Education Provider Networks (as local design and delivery vehicles for workforce planning and development) and the Local Workforce Action Board, so that all the opportunities derived from an integrated approach to workforce, can be explore and implemented for the greatest benefit of our staff (including health and social care) and patients
  - Identify early priorities for general practice workforce planning and development, produce a *Primary Care Workforce Action Plan* to be complemented by the development of a *Review of employment models*, to address what needs to be done and options for how

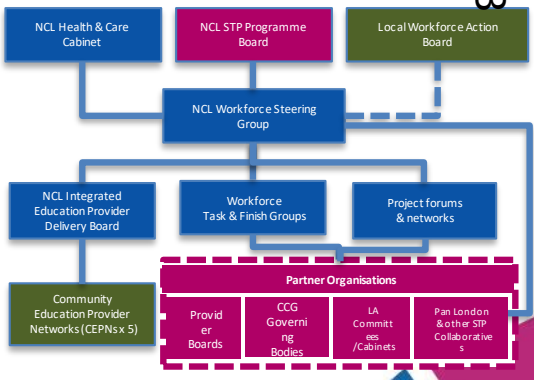
  We have undertaken a mapping exercise of some aspects of current workforce planning and development initiatives, and will establish a more systematic and strategically aligned programme-managed approach to the ongoing design and delivery of the *Primary Care Workforce Action* plan
- Co-produce and develop a better understanding of how the workforce will need to change, describing the skills, capacity and clinical /caring role required to feed into the development of future local training initiatives for general practice and primary care, using existing roles, which are not is short in supply more effectively, e.g. physiotherapists and pharmacists
- Work with practices to helps teams become better informed on how to manage recruitment and retention difficulties.
- Provide workforce development opportunities, including OD, leadership and QI training
- Strengthen the links between GP provider alliances, other provider partners and the CEPNs, to better support the delivery of education, which is responsive to local general practice need (in the context of the development of new organisational alliances and system integration)
- Strengthen links between general practice and wider roles e.g. navigators, to better achieve integration
- Work with partner organisations to create aligned HR processes so that our workforce is able to move across organisational interfaces with a universally recognised passport of employability
- We will create universal access to a kite-marked standard offer for mandatory training recognised by all partner organisations
- Continue to work closely with Health Education England and Higher Education Institutions to consider how educational commissi ons/ training modules for general practice and others might be modified in content and methodology of delivery, aligned with local need
- Take every step to ensure we consider the wellbeing of general practice staff and consider how proactive borough-based approaches might be adopted to provide local support for the general practice workforce

CASE STUDY: Clinical Pharmacists in General Practice

Gloucestershire CCG have invested in full-time prescribing pharmacists to work in GP practices, prescribing medication, resolving medication queries and seeing patients for medication reviews in clinic.

This represents a significant amount of work taken away from GPs (estimated 30 minutes per GP per day). In addition, pharmacists provide training and support to their colleagues and take the lead on improvement work such as develo… new services for frail elderly patients.

NHS Gloucestershire Clinical Commissioning Group



Page 83

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

DRAFT

NHS

Our enablers: digital

Our NCL technology partnership offers ways to use data from separate providers: Health Information Exchange (HIE) and Population Health Management (PHM). The solutions are linked -both have the same data sources for all five health & care economies: primary care, acute care, mental health, community & social care.

Health and care information exchange

HIE is an established technology offering a longitudinal patient and resident record. It works by connecting multiple systems and building data into appropriately controlled sections, creating an integrated record.

Population health management (PHM)

As well as treating people when they become unwell, we will do more to prevent ill health developing and support health improvement both in our daily encounters with residents as we deliver care and by planning services that respond to their longer-term needs. We will take a data-driven approach to achieve our aspiration of proactively managing health and wellbeing in partnership with our local communities at all levels of the system (one-to-one, practice, Network, borough and across boroughs), to connect people at risk to services (health and non-health) and interventions.

The plan and timetable for rolling out HIE and PHM are being developed with stakeholder involvement.

Online consultations

Implementing Online Consultations, including video consultations, is part of a wider programme of primary care transformation in line with and funded as part of the GP Forward View. As well as improving patient access and the patient experience, we see technology as supporting greater practice efficiency, providing the ability to better manage workloads and address demand, reducing the pressure on general practice.

We will test options for offering online consultations with a range of practices in NCL, with the aim of offering this to all residents of NCL after a pilot period.

The use of Electronic Health records in general practice is ubiquitous. This represents a rich data source that historically has only been accessible at a practice level. We will support the uptake of new technology, which will enable the sharing of coded data across health and care providers and with local residents, so supporting the delivery of proactive, person-centred, coordinated care and ensuring people can better manage their own health and care needs.

Data linkage with regional programmes e.g. One London, will ensure joining up records across the capital, so people can walk into healthcare providers and each will have access to the same real-time record.

Locally, we will focus on delivering the NCL **Health Information Exchange, Electronic Disease Registries (supporting PHM) online consultations** and NHS **patient apps.** Health and care professionals will need to access and share information, and alert, task and notify other relevant professionals across care settings.

Digital approaches will ensure that data is used to support new models of care, proactive preventative care and improvements in access e.g. risk stratification tools to identify patients at risk of hospital admission, so helping to reduce unwarranted variation and ensuring residents receive early interventions that prevent or delay development of health deterioration.

Patient apps, linked to the NHS app to create a **Person Held Record** (PHR), through a centralised citizen identification offer, will enable people to carry out transactions e.g. book hospital and GP appointments, track and share their health and care activities and communicate with their care team.

Data sharing agreements will be put in place for any new instances of information sharing, which are not a part of direct care.

We will support a strategic approach to improved electronic advice, navigation and other clinical messaging systems between primary and secondary care clinicians, e.g. access to EMIS primary care record for intermediate care teams.

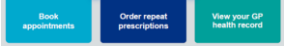
We will ensure that services are well-publicised.

Patients will be activated and engaged with their care record.

CASE STUDY: Cheshire – Bringing together health and social care data

The Cheshire Care Record (CCR) is a collaboration between more than 80 organisations – ranging from acute providers to CCGs, serving 736,000 local residents. The CCR is an overview of your health and social care information in one digital record. Whether you are visiting your GP, attending hospital, or being seen in your own home by a community nurse or social worker, all the health and social care professionals involved in your care will have access to the information they need, to make the best decisions about your diagnosis, treatment and care plan.

Cheshire Care Record



Resilient, sustainable and thriving general practice - High quality, equitable and person-centred safe - Proactive, accessible and coordinated - Integrated services that respond to the needs of the patient and the population

NORTH LONDON PARTNERS in health and care

London's sustainability ation partnership

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NHS

Our enablers: estates

In line with the NHS Five Year Forward View, we are committed to improving and developing estates to support GPs to work collaboratively, movement of health and care closer to home and the pooling of auxiliary resources. Improving the estate will better support a thriving and resilient workforce.

Focusing on primary care estate will ensure a wider variety of services can be based within the local community and will support primary care in being able to meet the projected population growth and associated increase in demand. The NCL estates strategy includes more detail, including resourcing.

Delivery of the NCL estates strategy relies on health and care partners– including Local Authorities, CCGs, Trusts, and property companies, collaborating and prioritising through the North London Partners Estates Board, whilst not superseding individual organisational autonomy. The estates plan includes multiple CCG schemes designed to **match population growth, deliver primary care at scale and bring care closer to home** (including eight live estates ETTF schemes) alongside large scale estates **transformation and refurbishment** in the acute provider estate.

We will target **estates** support in line with need; agree and prepare a capital priority list to be ready to respond to the availability of capital, and ensuring there is sufficient estate to meet the needs of the population.

As part of NCL estates and locality planning work, we will ensure that any new primary care premises developments are designed with the future of integrated general practice in mind (e.g. RCGP Roundhouse).

Primary Care Hub Network and service expansion

- Development of primary care estate to function as a network, pooling resources across community nursing, mental health, clinical pharmacy and diagnostic facilities
- Facilities will be designed to match projected population growth

Examples include:

1. Finsbury Leisure Centre Redevelopment– improvement of the existing leisure and nursery facilities and an additional health centre and 120+ residential units to support the growing population
2. Hampstead Group expansion – a potential scheme, pending funding, to support: extra capacity; care closer to home; social care and prevention; and; integration of ambulatory care through collaboration with the Royal Free London, operating as a primary care hub
3. Tottenham Hale and Hawes & Curtis Green Lanes– primary care expansion to support housing and population growth

Care and Health Integrated Networks

- Implementation of the Networks to facilitate new models of care
- Bringing together virtual multidisciplinary teams will require flexible, high quality estate throughout the community

Integrated working to move care closer to home

- Redesigning estates to enable diversion of some urgent care services from acute providers to primary care hubs. E.g. Archway Primary care hub and the Whittington
- Primary care estate redevelopment to include affordable housing. E.g. Meridian Water development

The priorities for developing the North London Partners estates strategy:

1. Developing **a place-based approach** to allow us to optimise use of our estate in each locality to support service delivery, drawing on One Public Estate principles
2. To **respond to** care requirements and changes in **demand** by putting in place a fit for purpose estate: Plan for population growth and ongoing demographic change with a view to shifting the balance across primary, acute and community services to deliver the highest quality care closer to home, further enabling us to tackle health inequalities in NCL
3. To increase the **operational efficiency** of the estate: improving utilisation, tackling backlog maintenance and optimising running costs
4. To enhance **delivery capability**: supporting wider changes in health care delivery, alongside workforce and digital enablers, including supporting opportunities to create Homes for NHS Staff
5. To enable the delivery of a portfolio of estates **transformation projects** supporting the implementation of the vision for care and further development of social and affordable housing.

Source: North London Partners – Draft estates strategy

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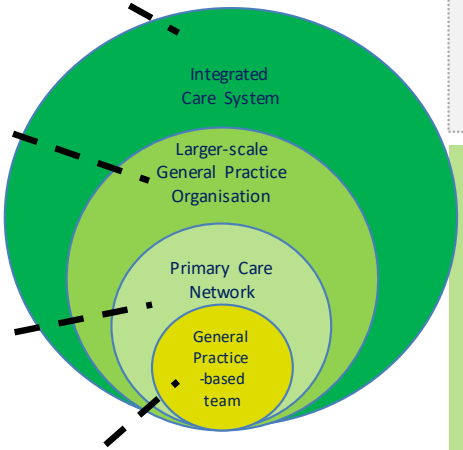
Our enablers: working at scale

General practice as the foundation of a wider Integrated Care System – working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget

Usually at borough level and often a single organisation e.g. federation or multi-site organisation – this is the platform to provide the scale and to develop and train a broad workforce, create shared operational systems and QI approaches including use of locally owned data, support the delivery of collective back office functions to reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership and the 'voice' for general practice in the local health economy

Serving populations of 30-50,000, bringing together groups of practices and other community providers around a natural geography. Support multidisciplinary working to deliver joined up, local and holistic care for patients. Key scale to integrate community based services around patients' needs to provide care for people with enduring, complex health and care needs, who require close collaboration between service providers and long-term care condition

Small enough for the benefits of continuity of care and personalised services. Big enough to safely cover rotas and ensure a balanced skill mix. Providing care to patients with ongoing illnesses and flare-ups of established conditions, undifferentiated or medically unexplained symptoms or health anxieties, who may benefit from an episode of continuity pending diagnosis and effective treatment, or long-term continuity of care with single clinician or a clinical team for an enduing condition



Large-scale General Practice Organisations*

These organisations consist of multiple practices working via formal collaborative arrangements across a large, geographically coherent population. This enables them to develop and train a broad workforce, and to create shared operational systems and quality improvement approaches, including use of locally-owned data. It also creates opportunities to support the delivery of collective back office functions that reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership through which a strong voice for general practice can be heard across boundaries.

These organisations are not intended to replace practice, or diminish practice autonomy, but should support a number of vital functions that can best be achieved at this larger scale.

Collaborating to strengthen general practice

- A strong general practice voice in the provider landscape
- Strengthened practice resilience
- Effective system partnerships
- On-going quality improvement
- Economies of scale
- Workforce development
- New population-based approaches to care
- Innovative approaches to care provision
- Adopting new technology

There are a range of at scale general practice providers in north central London, at different stages of development, with varying levels of infrastructure and holding different contracts, including six GP federations. We will support at scale providers as they develop, in line with a business development matrix.

Source: London Strategic Commissioning Framework: Next Steps, 2018 **Note:** levels of service provision may be locally defined

Resilient, sustainable and thriving general practice - **High quality, equitable and person-centred safe** - **Proactive, accessible and coordinated** - **Integrated services that respond to the needs of the patient and the population**

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Our enablers: quality improvement

Quality Improvement (QI)…

…describes a commitment to continuously improving the quality of healthcare, focusing on the preferences and needs of the people who use services. It encompasses a set of values (which include a commitment to self-reflection, shared learning, the use of theory, partnership working, leadership and an understanding of context); and a set of methods (which include measurement, understanding variation, cyclical change, benchmarking and a set of tools and techniques).

The goal of QI is the "triple aim" of:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

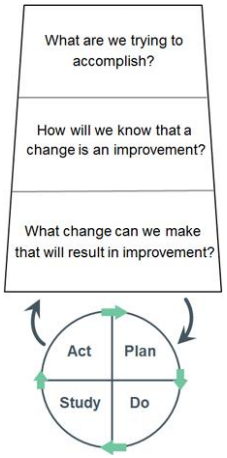
With the establishment of **Quality Improvement Support Teams** (QISTs) in each borough, we have committed to using QI as our approach to reduce unwarranted variation in patient care. QISTs **are borough-based** teams of QI experts, sitting within primary care but working across the system. They offer support to identify and tackle unwarranted variation and build QI capability, embedding QI approaches within general practice. QISTs will hold population health management registries, and will coordinate the management of people on these registries, working with partners to use data to drive improved outcomes for the whole system.

The **QI Programme** exists to support QISTs and enable a greater uptake of QI in primary care. We will:

- Bring QIST leads and other QI stakeholders together to develop a consistent approach to identifying and scoping opportunities to reduce unwarranted variation across NCL
- Raise the profile of our QI approach by making resources, support and learning opportunities accessible to NCL staff through the NLP QI Network; a forum for collaboration across organisational and geographical boundaries
- Use QI methodology to support the delivery of Health and Care Closer to Home priorities

QI Network Event

The North London Partners QI Network brings partners from all health and care providers in the region to come together to learn from each other and share best practice. Each event offers a forum to network across traditional boundaries and create opportunities to work together on improving care.



Case Study

Mrs G is a 69 year old woman who has heart failure, diabetes and arthritis. She has recently suffered a heart attack. She has limited mobility, walking with a roller frame indoors and using a scooter outdoors. She generally manages well with activities of daily living. Her son helps with some meals. Mrs G has a pendant alarm. The **frailty service's** GP rapid screening identifies Mrs G as moderately frail. She agrees to telephone screening and is also seen at home by a physiotherapist.

The service identified Mrs G as at increased risk of falls and social isolation. She had no hand rails, no access to outside space, and a broken intercom. Mrs was referred to social services, and her local Council were contacted to repair the intercom. As a result, Mrs G is less likely to fall and has maintained her independence – gaining access to the community and being able to socialise.

Page 87

Page 87

Source: Royal College of GPs *Quality Improvement Guide for General Practice,* Institute for Healthcare Improvement

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Our enablers: the care and health integrated network model

A care and health integrated (virtual) network/ neighbourhood: a network of partners from across health (primary, community, acute and specialist) and the local authority based around a population of between 30-80,000 people (NB this is a slightly different range to the London Primary Care Network of 30-50,000).
Professionals proactively work together around a register of patients or local people (not all patients on the register). Partners take collective responsibility for managing patient outcomes (at network level) and work collectively to delivery of annual targets. Contracts will be aligned.
A network is **NOT** a:

- physical hub for one-stop care for all long term conditions
- new service integrating all services around the whole registered patient list
- locality where all services work to new geographical boundaries but continue existing ways of working

Case study: Tom is a ten year old boy who lives with his family in Barnet, where he is registered with the family doctor. His doctor has looked after a number of generations of his family and has known Tom since he was a baby.

Tom has a learning difficulty, which means he requires additional support at school. He also has diabetes. With Tom beginning to enter his teenage years, there have been some changes to his medical condition and to his behaviour. His GP initially referred him to a local hospital trust. This trust reviewed Tom but then referred him onward for specialist support at the South London and the Maudsley Child and Adolescent Mental Health (CAMHS) service. Tom's behavioural challenges make it difficult for his family to travel with him on public transport and this means his grandad has to drive him through central London for an appointment every three months. This is really difficult for Tom and for his grandad, as it is a long journey and parking at the hospital is expensive. If the clinic is not running on time, Tom's grandad has to go out to top up the parking metre. The whole process is very stressful and is putting a strain on the family relationships and does not seem to be improving Tom's care.

Tom's GP decided to take a more coordinated and proactive approach to Tom's care. Instead of waiting for Tom's annual review, and instead of Tom having to travel to many different clinics, the GP contacted each of the health professionals involved, and arranged a coordinated meeting for Tom. all of the key people involved in Tom's health and social care and his school, including Tom and his grandad, were able to be at, or dial into the meeting. With all of the health and care professionals able to speak to each other, the GP was able to coordinate a new approach to Tom's care which meant that he no longer needed to go to so many appointments or travel so frequently to south London. The changes in Tom's care have meant that his condition is more stable and his family feel they know where to go if they need support.

Resilient, sustainable and thriving general practice - High quality, equitable and person-centred safe - Proactive, accessible and coordinated - Integrated services that respond to the needs of the patient and the population

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Our enablers: financial resources (2)

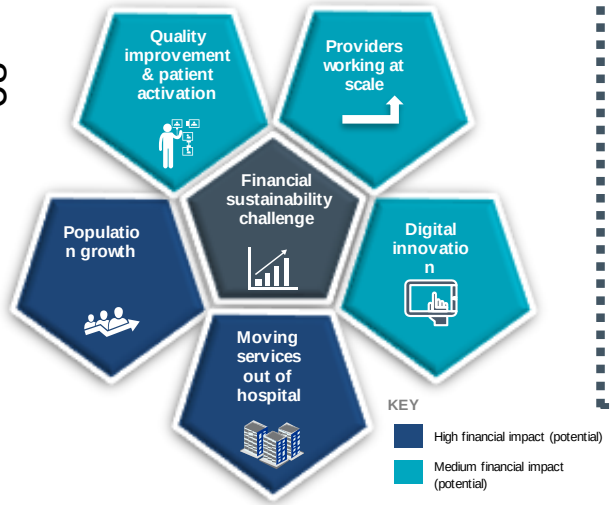
Recurrent

Core GP funding

The funding for core GP services is allocated by NHS England, although the operational management of this has been delegated to NCL's Clinical Commissioning Groups. This funding will increase in line with our population growth and list size as per national allocations. In 2018/19 the allocated budget for NCL is £211m.

Locally commissioned services (LCS)

In 2018/19, CCGs are planning to spend £6.9m on locally commissioned services. There is currently wide variation across the C CGs as to which locally commissioned services are offered to our patients, what tariffs are in place and how we support our practices to work together. We will work towards re ducing this variation by aligning how we commission our local services across the five boroughs and through the development of NCL wide service specifications. We will work wit h our practices to ensure that changes are made in a sustainable way – for example by moving towards longer term contract commitments.



Transformation funding

National GP Forward View and Transformation Funding

The National GP Forward View (GPFV) provided additional, non-recurrent investment for primary care; over the last two years NCL CCGs have been able to invest this and other national funding to support the transformation of primary care. It is expected that GPFV funding will continue to 2021, however future funding allocations are not yet known. In 2018/19 this has resulted in £14m of investment for primary care, of which £1.9m was local CCG funding into extended access services.

Local CCG investment

NCL CCGs are committed to continuing to invest locally in primary care services. In order to deliver further efficiencies and quality improvement, we have signalled a priority of quality improvement support teams and care and health integrated networks; in 18/19 CCGs have already invested over £1.8m of local funding into our care and health integrated networks (networks) and quality improvement support teams (QISTs).

Our enablers: financial resources (1)

Financial sustainability

As noted earlier, the population is increasing, and expectations are rising along with the costs of meeting them. Alongside these increases, the level of health funding has grown more slowly over the last eight years than in any comparable period since the NHS was founded in 1948. Demands on local resources are growing faster than those available.

In NCL there is an increasing financial challenge, with the 'do nothing' gap for north central London expected to be £811m deficit by 2020/21. CCGs are therefore under increasing pressure to identify efficiencies across the system whilst maintaining a high quality of services for patients; we know we need ambitious and transformational programmes to address the shortfall. These financial pressures and the ongoing requirement to make significant year on year savings are not unique to NCL, but it is our priority and responsibility to ensure that the resources we already have are used wisely.

There is a combination of recurrent and non-recurrent funding into general practice, and we are also operating at a time when future allocations for primary care funding are not yet confirmed, which has implications for longer term planning. We will commit to ensuring that the primary care budget is well-spent, and will work towards our overall ambition of reducing variation in investment in primary care between boroughs.

Within this wider economic context, safeguarding the financial sustainability of our practices is essential to ensuring we can offer high quality services to our patients. The direction of travel described in this strategy is intended to contribute to our financial sustainability. For instance increasing our use of digital technology, delivering services at scale, aligning our locally commissioned services and using a wider skill mix will help us to continue to meet the rising demand within the resources that are available to us.

Our ambition: To reduce the variation in investment in primary care between boroughs in NCL

2018/19 Primary Care Finance Summary	NCL wide	NHS Barnet CCG	NHS Camden CCG	NHS Enfield CCG	NHS Haringey CCG	NHS Islington CCG	Total NCL
RESOURCES	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Delegated Primary Care	0	51,271	37,355	42,559	42,598	37,165	210,948
LCS Investments	0	744	2,650	1,187	310	2,019	6,910
Sub-total (recurrent funding)	**0**	**52,015**	**40,005**	**43,746**	**42,908**	**39,184**	**217,858**
GP Forward View (Extended Access)*	0	1,741	1,390	3,240	1,245	1,495	9,109
GP Forward View (Other and Transformation funding)	140	1,576	1,128	1,331	1,439	1,231	6,845
National Diabetes Transformation Funding	0	197	98	197	197	98	786
Sub-total (non-recurrent funding)	**140**	**3,514**	**2,615**	**4,767**	**2,880**	**2,824**	**16,740**
Total Resource	**140**	**55,529**	**42,620**	**48,513**	**45,788**	**42,008**	**£234,598**

2018/19 Primary Care Finance summary
*This figure includes £1.9m of local CCG funding towards extended access services.

At scale A group of general practices working together to deliver services e.g. GP Federation or super practice

Business Intelligence The systems behind or the practice of using data and other information in order to understand more about users of service, activity, trends, and performance.

CCG Clinical Commissioning Groups; healthcare commissioning organisations, led by GPs and represent a group of GP practices in a certain area.

Care & Health Integration Network / Neighbourhood A network of partners providing care for an agreed population, usually between 30-80,000 people

CEPN Community education provider

Co-design Patients and service users working directly with health professionals – both clinical and managerial – to develop services or solutions to problems experienced by the health system. In a true sense of co-design, each person's voice and perspective is valued equally in what they bring to understanding the problems and their potential solutions.

CQC Care Quality Commission

CVD Cardiovascular disease; a condition of the heart

ETTF Estates and technology transformation fund

GP General practitioner

GP Federation A type of healthcare provider - A joint enterprise between local GP practices (usually within a borough), organized usually to provide services at scale, or in addition to services provided by individual practices

GPFV General Practice Forward View (national policy document)

IGPR International GP recruitment – a national programme to recruit doctors from other countries to work in the NHS

LMC	Local Medical Committee
LTCs	Long Term Conditions
Neighbourhood / Care & Health Integrated Networks	A network of partners providing care for an agreed population, usually between 30-80,000 people
North Central London	The London Boroughs of Barnet, Camden, Enfield, Haringey and Islington (the area covered by North London Partners)
Population Health Management	An approach to health aiming to improve the health of an entire population, addressing a broad range of factors impacting health on a population-level, e.g. environment, social structure, resource etc. An important theme in population health is the importance of social determinants of health.
Quality Improvement Support Teams (QISTs)	Borough-based teams of quality improvement experts, sitting within primary care but working across the system. They offer support to identify and tackle unwarranted variation and build quality improvement capability, embedding quality improvement approaches within general practice.
QOF	Quality and outcomes framework
Record sharing	Ensuring that clinicians can access patient records wherever a patient is seen to reduce risk and duplication.
SCF	Strategic Commissioning Framework - The strategic regional policy document for primary care in London
STP	Sustainability and Transformation Partnerships – a collaboration of health and local authority partners in an area to agree system-wide priorities, plan collectively how to improve residents' day-to-day health, and design and run services in a more coordinated way. In NCL this is five CCGs, five Local Authorities, eleven Providers (including 4 acute Trusts), c220 GP practices and 497 active social care sites, including 273 registered care homes (47 of which provide nursing)
Social prescribing	A way for patients to be referred to local, non-clinical community services e.g. walking clubs or self-help to support their health and wellbeing. People might be referred by a GP, nurse, link worker, care navigator or other health professional.

https://www.bma.org.uk/collective-voice/influence/key-negotiations/nhs-funding/investment-in-general-practice-in-england

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00743-1/fulltext Lancet findings show that overall GP workload in England rose by 16% in the 7 years up to 2014, with more frequent and longer GP consultations. Rates of GP consultations rose by 12·36% per 10,000 person-years, compared with 0·9% for practice nurses. Moderate rises in rates of GP face-to-face consultations (5·2%) were overshadowed by an almost 100% increase in the rate of GP telephone consultations. The mean duration of GP face-to-face consultations rose by about half a minute, from 8·65 min (95% CI 8·64–8·65) in 2007–08 to 9·22 min (9·22–9·23) in 2013–14. This rising tide of workload is probably an underestimate; an additional 40% of GP time is spent on tasks not measured in this study, e.g. arrangement of referrals or admissions, renewal of prescriptions, administrative and clinical meetings, and teaching. Gibson, J, Checkland, K, Coleman, A et al. Eighth National GP Worklife survey Manchester: University of Manchester. http://www.population-health.manchester.ac.uk/healtheconomics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf; 2015. ((accessed March 7, 2016).)

https://www.nuffieldtrust.org.uk/files/2018-02/nt-divided-we-fall-gp-web.pdf

Google Scholar See all References Moreover, although the dataset does not provide data about the number of GPs (which could account for the increase in consultations), the investigators point out that other data show there has been a 1% decline in full-time equivalent GPs over this time period.

England N. House of Care model – background; updated 2015. Available from: https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/house-of-care/house-care-mod/

Ten things you need to know about long term conditions, DoH; 2008 [updated 4/24/2008]: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_084294]

Mathers N, Roberts S, Hodkinson I, Karet B. Care Planning. Improving the Lives of People with Long Term Conditions. London; 2011 2011.

Programme YoC. "Thanks for the petunias". A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions. Newcastle; 2011 5/2011.

Better conversation: Better Health http://www.betterconversation.co.uk/images/Action_Booklet.pdf

https://adobeindd.com/view/publications/f1caab26-4963-464e-ba33-6ff71d991a9a/1/publication-web-resources/pdf/VID-169_-_Empowering_the_Person_Timeline_May_2018_v3.pdf

https://www.nottingham.ac.uk/pharmacy/research/divisions/pharmacy-practice-and-policy/research/cpigp.aspx

https://www.nottingham.ac.uk/pharmacy/documents/generalpracticeyearfwdrev/clinical-pharmacists-in-general-practice-pilot-scheme-full-report.pdf

Allied Health Professionals into Action 2016/17-2020/21 NHS England

GP Five Year Forward View

HLP priorities

Strategic Commissioning Framework for Primary Care

https://www.england.nhs.uk/wp-content/uploads/2018/08/nhs-england-gp-support-pack.pdf

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Agenda Item 10

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
Royal Free Hospital Financial Update	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 30 November 2018

SUMMARY OF REPORT

This paper introduces an update (Appendix A) from the Royal Free Hospital on its financial performance.

Contact Officer:

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RECOMMENDATION

The Committee is asked to consider and comment on the update.

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world class expertise local care

Royal Free London NHS
NHS Foundation Trust

The Royal Free London

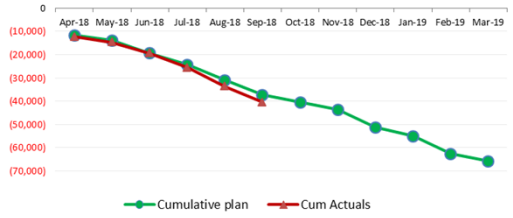
Joint Health Oversight and Scrutiny Committee

Page 97

Page 97

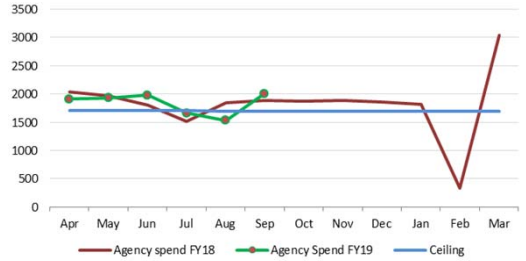
YTD Performance at M6 – Headlines

Performance against Plan



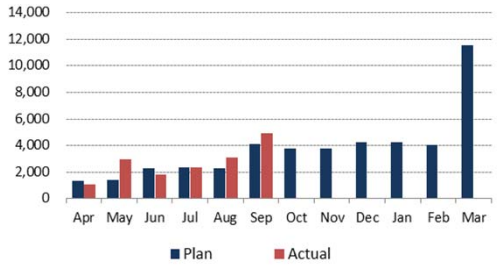
- *YTD performance against plan - £2.7m adverse predominantly due to impact of FIP phasing*

Agency Spend Vs. Last year



Agency spend for the month was £2m. Agency spend is £0.8m above ceiling at end of M6

FIP Performance

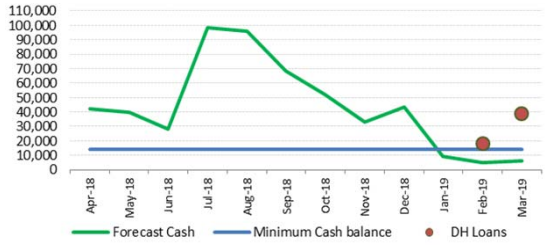


- *YTD FIP delivery of £16.1m*

Better Payment Performance Code

	Total		within 30 days			
	Number	Value £'m	Number	Value £'m	% Number	% Value
NHS	1,608	£29.67	477	£14.51	**30%**	**49%**
Non NHS	88,143	£303.15	71,601	£219.63	**81%**	**72%**
Total	**89,751**	**£332.82**	**72,078**	**£234.14**	**80%**	**70%**

Cash Flow forecast



Capital Expenditure

YTD			Forecast		
Plan	Actual	Variance	Plan	Actual	Variance
£m	£m	£m	£m	£m	£m
47.6	46.3	1.2	82.4	82.4	0.0

Page 98

CFO Message

Delivered an actual deficit of £40.4m at end of M6; £3.1m worse than plan

1 At end of September, the Trust delivered an actual deficit of £40.4m. This was £3.1m worse than plan. Adverse variance predominantly relates to the impact of phasing the FIP income target in equal twelfths in the financial plan whilst delivery is expected in Q4

Key drivers for year to date performance are

- Clinical income upside of £2.6m driven predominantly by non-elective activity
- Phasing of the FIP target in equal 12ths - £3.7m
- Overspends relating to digital investment
- Lower than planned PPU contribution

Delivered £16.1m of FIP at end of September

2 The Trust delivered £16.1m of FIP at end of September. The Trust is currently forecasting to deliver £43.1m of FIP on plans identified for FY19. This is £2.3m below its target for 2018-19.

Recurrent forecast FIP delivery for FY19 including full year effects is currently at £29m. The Trust is committed to identifying £40m of recurrent FIP schemes by the end of this financial year.

Reliance on non-recurrent FIP will have an adverse impact on the underlying financial position.

Emerging risks that will impact delivery of FY19 plan

3 At end of September there are emerging risks that have the potential to impact on the delivery of FY19 plan. Some of the emerging risks are

- Above than planned expenditure relating to digital investment
- Income risks as contracts are performing to a level above what is affordable to CCGs.
- Slippage against FIP plans identified
- Impact of winter pressure in light of no additional funding from the CCG
- Continuing underperformance relating to PPU contribution

Page 99

M6 Overview

	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	£ '000s	£ '000s	£ '000s	£ '000s	£ '000s	£ '000s
NHS Clinical Income	56,968	56,806	(163)	343,353	345,964	2,612
TEDD Income	16,472	17,653	1,181	98,840	93,956	(4,884)
Non NHS Clinical Income	3,167	2,637	(529)	18,543	16,165	(2,377)
Other Operating Income	9,030	8,147	(883)	55,190	50,028	(5,162)
Property Services Income		246	246		1,509	1,509
Total Income	**85,637**	**85,488**	**(148)**	**515,926**	**507,623**	**(8,303)**
Pay	(45,419)	(45,456)	(38)	(273,241)	(270,535)	2,706
Other Pay (Apprentice Levy)	(218)	(200)	18	(1,196)	(1,196)	(0)
Non-Pay Expenditure (Excl. TEDD)	(25,515)	(25,148)	368	(154,685)	(156,902)	(2,218)
Property Services Expenses		(214)	(214)		(1,395)	(1,395)
TEDD Expenditure	(15,857)	(16,538)	(681)	(95,457)	(89,820)	5,637
Total Operating Expenditure	**(87,010)**	**(87,556)**	**(546)**	**(524,579)**	**(519,848)**	**4,731**
SLR	0	(0)	(0)	(0)	(0)	(0)
EBITDA	**(1,373)**	**(2,068)**	**(695)**	**(8,653)**	**(12,225)**	**(3,572)**
Interest, Dividends & Depreciation	(4,942)	(4,711)	231	(28,641)	(28,178)	463
P/L Disposal of Fixed Assets						
Investment In Joint Ventures						
Surplus/Deficit	**(6,315)**	**(6,778)**	**(463)**	**(37,294)**	**(40,403)**	**(3,109)**

Page 100

Financial Improvement Programme

Recurrent FIP delivery

Forecast recurrent delivery

	Recurrent FY19 Target	2018-19 Recurrent schemes	FYE of Recurrent schemes	Total recurrent delivery for 2018-19	Shortfall against recurrent Target
Barnet Hospital	7,450	5,278	260	5,538	(1,912)
Chase Farm Hospital	880	640	331	971	91
Royal Free Hospital	14,078	11,600	2,677	14,277	199
Group Clinical Services	4,200	852	20	872	(3,328)
Corporate	13,391	6,056	274	6,330	(7,061)
Central	0	1,000	0	1,000	1,000
	40,000	**25,427**	**3,562**	**28,989**	**(11,011)**

Recurrent FIP Target for FY19

Full year shortfall against the recurrent FIP target

Recurrent Delivery

- *Trust needs to deliver a recurrent FIP of £40m for 2108-19 to deliver an underlying position of £80m deficit*
- *At M6, the recurrent FIP delivery including full year effects is £28.9m – shortfall of £11m against the recurrent FIP target*
- *There is significant focus on recovering this position and we have £7.4m (FYE) of pipeline schemes to partially close this gap (most of these are in corporate areas)*

Recurrent FIP & non-recurrent measures

	Target	Forecast	Variance against Target	YTD Target	YTD Delivery at M6	YTD Variance against Target
Barnet Hospital	8,462	5,470	(2,992)	2,552	3,162	610
Chase Farm Hospital	1,000	739	(261)	302	240	(62)
Royal Free Hospital	15,991	14,356	(1,634)	4,823	5,909	1,086
Group Clinical Services	4,771	1,826	(2,945)	1,439	457	(982)
Corporate	15,211	19,698	4,487	4,587	5,877	1,290
Central	-	1,000	1,000		500	500
Total	**45,434**	**43,089**	**(2,345)**	**13,703**	**16,146**	**2,443**

Currently forecasting a slippage of £2.3m against FY19 FIP target. This excludes any pipeline schemes

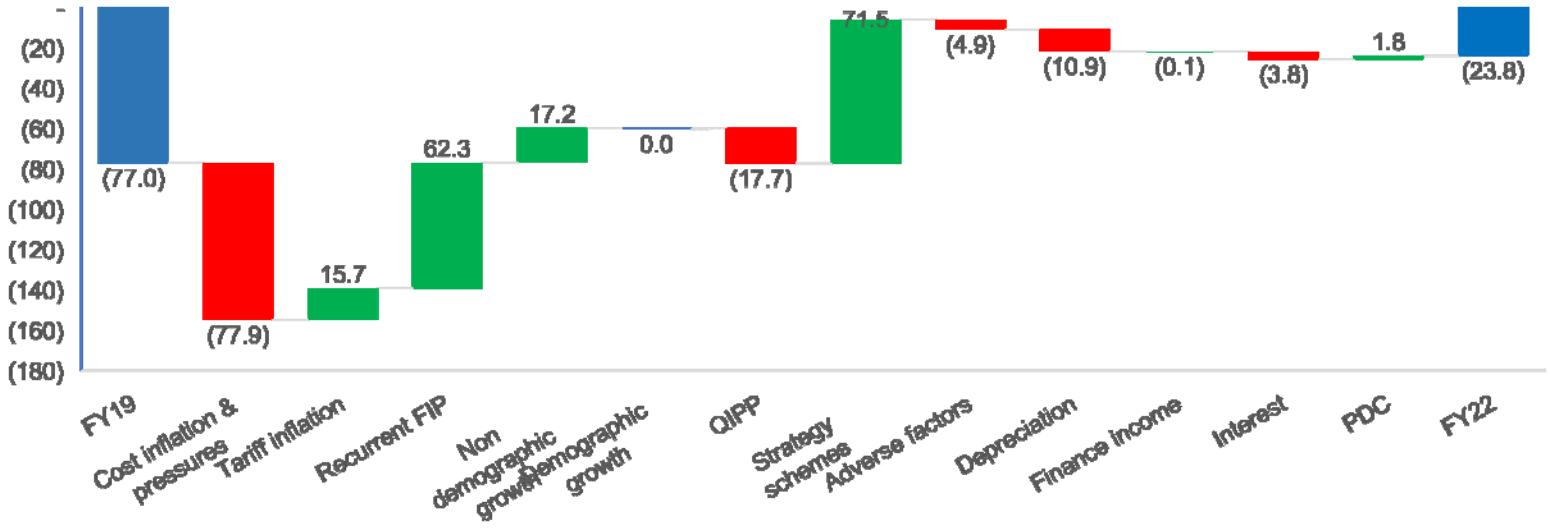
FIP delivered at end of M6

In year performance

- *Target for FY19 is £45.4m*
- *The Trust is forecasting to deliver £43.1m against its FY19 target – shortfall of £2.3m*
- *Forecast delivery includes both recurrent and non-recurrent schemes.*
- *Forecast delivery excludes any benefits from pipeline schemes*
- *We have mitigation plans to meet this total*

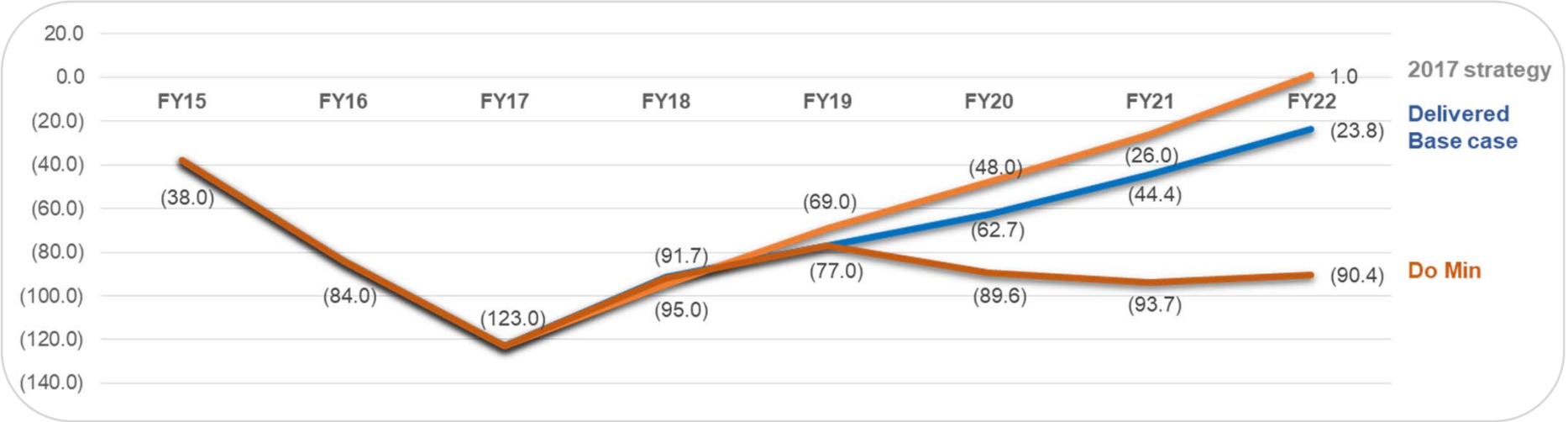
Page 101

Financial Strategy - Executive Summary

	Summary
18/19 – 21/22 Delivered Base case of the Financial Strategy	• Out strategy targets a £53.2m improvement in the underlying deficit, from £77.0m in FY18/19 to £23.8m in FY21/22 • The 'Delivered Base' case represents the scenario where we successfully deliver 2.0% recurrent FIP each year and additionally our 'Strategic Schemes' to the value currently in the plan (£71.5m) as intended. We continue to work to minimise the delivery risk for these strategic schemes. We also believe there is opportunity in some areas where we do not yet have strategic savings  • As well as these savings the strategy includes provision for inflation, cost pressures, changes in MFF rates and all financing costs. We have assumed that for NHS clinical income growth is broadly offset by QIPP schemes. • It assumes we implement a £178.8m capital plan, and fund it through loan financing, charity funding and disposals • We continue to work on capital affordability given the continued require to invest in our estate and asset base but in a position where we have significant cash pressures. • The strategy assumes that we deliver annual recurrent improvements of 4.2% of income or 5.3% of influenceable costs – against our 3.2% historical average of influenceable costs

Page 102

Underlying financial trajectory



Strategy context	• Our strategy aligns to delivering our 14 financial group goals, and, in doing so, the benefits of our group model • For example, it demonstrates how we will eliminate the deficit at Chase Farm, which returns to a surplus by FY21/22 • Our strategy for a £23.8m deficit by FY21/22 balances optimism and deliverability – this conclusion triangulates with the internal and external references points we have at our disposal (our historical financial improvement delivery, known risks in the strategy, Drivers of the Deficit analyses, Model Hospital, the National context, and RCI efficiency) • The £23.8m deficit excludes any Provider Sustainability Fund payments linked to control total delivery
Strategy execution	• We have stated the various sources of assurance the Board can consider in reflecting on the strategy's deliverability • We have commenced planning for FY19/20, and clarified the Governance structures through which the various elements of the plan will be delivered, and accountability maintained • An external review of the robustness and credibility of our strategy and our ability to deliver it has been undertaken by EY

Page 103

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Agenda Item 11

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Work Programme and Action Tracker 2018-19	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 30 November 2018

SUMMARY OF REPORT

This paper provides an outline of the 2018-19 work programme and action tracker of the North Central London Joint Health Overview & Scrutiny Committee.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS

The North Central London Joint Health Overview & Scrutiny Committee is asked to:

a) Note the contents of the report; and
b) Consider the work programme for the remainder of 2018-19

1. Purpose of Report

1.1. This paper provides an outline of the proposed areas of focus for the Committee for 2018-19. This has been informed by topics highlighted by the previous Committee and a review of key health and care strategic documents that impact on North Central London. Throughout the municipal year, as the Committee considers other areas of interest, these will also be added to the work programme, either for discussion in the current municipal year or in subsequent years.

1.2. The Committee's meeting on 18 January 2019 currently has quite a heavy agenda, with six substantive items currently listed. This is because the Best Start in Life and Maternity items were deferred from earlier meetings. The Committee normally aims to consider no more than four items at each meeting, so members may wish to consider deferring two other items until later in the year.

1.3. The report also includes an action tracker for the Committee, Appendix B. This will be populated with actions from each Committee meeting. It is intended to help the Committee effectively track progress against recommendations and requests for further information.

2. Terms of Reference

2.1. In considering topics for 2018-19, the Committee should have regard to its Terms of Reference:

- To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the areas of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

- The joint committee will aim to work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people

3. **Appendices**

Appendix A – 2018/19 Work Programme
Appendix B – Action tracker

REPORT ENDS

30 November 2018 (Enfield)

Item	Purpose	Lead organisation
Adult Elective Orthopaedic Services	Update on the review of the service	NCL Partners
GP Commissioning Strategy	To consider the emerging draft of a refreshed commissioning strategy focusing on general practice, to build on previous collaboration and to raise standards further for people living in north central London.	NCL Partners
Financial Update: Estates	STP Strategic Risks and Issues – update on estates finances.	NCL Partners
Financial Update: Royal Free Hospital	Update on the financial position of the Royal Free Hospital	Royal Free Hospital

18 January 2019 (Haringey)

Item	Purpose	Lead organisation
STP mental health priority theme update	Update report on the progress against the mental health priority theme within the STP, including progress to date, milestones, risks and issues	NCL Partners
STP best start in life priority theme update	Update report on the progress against the best start in life priority theme within the STP, including progress to date, milestones, risks and issues	NCL Partners
Dementia pathways update	Update on dementia services across the five boroughs, following on from a report to the committee in September 2017. The report will provide further information on areas such as: joint working, update on care homes, a shared service specification and service monitoring	NCL Partners

Child and adolescence mental health services	Update on the CAMHS service following report to the Committee in April 2017	NCL Partners
Screening and immunisation	Update following a report to the committee in February 2017	NCL Partners
STP maternity priority theme update	Update report on the progress against the maternity priority theme within the STP, including progress to date, milestones, risks and issues.	NCL Partners

15 March 2019 (Islington)

Item	Purpose	Lead organisation
STP social care priority theme update	Update report on the social care priority theme following a report to the Committee in March 2018	NCL Partners
STP health and care closer to home priority theme update	Update report on the progress against the care closer to home priority theme within the STP, including progress to date, milestones, risks and issues	NCL Partners
Ambulance service performance	Performance update report on response and handover times	London Ambulance Service East of England Ambulance Service
Reducing A&E attendance	NHS, local providers and councils working together to reduce attendance at A&E	NCL Partners

Additional items to be scheduled

Item	Purpose	Lead organisation
Moorfields Eye Hospital consultation	Consultation on moving services from the existing site to St Pancras	Moorfields Eye Hospital

Update on the Estates Strategy	Update on public and councillor involvement in the Estates Strategy.	NCL Partners
Consultant-to-consultant referrals	Update on how this process is working in NC, especially the LUTS clinic and the new arrangements at GOSH. This to include hearing from the commissioners and the patient groups.	NCL Partners
Case for Change: North Middlesex and Royal Free Hospitals joint working	A further report to the Committee on the case for change underlying North Midds and Royal Free joint working	Royal Free and North Middlesex Hospitals
Moorfields Eye Hospital consultation	Consultation on moving services from the existing site to St Pancras	Moorfields Eye Hospital
Integrating health and social care	Progress update on integrating health and care across NCL and impact of national and regional developments, including the London devolution agreement	NCL Partners

Appendix B: Action Tracker

Item and Action	Action by	Progress
5 October 2018		
DEPUTATIONS The Chair asked that the deputee email her with information that could then form the basis of an email to the Great Ormond Street Chief Executive.	Kate Dwyer/Cllr Kelly	In progress
MINUTES Members asked that it be noted that the questions document circulated at the previous meeting on 7 September 2018 be put online.	Vinothan Sangarapillai	Complete
EMBEDDING PREVENTION WITHIN NORTH LONDON PARTNERS STP Members asked for data to be collected on which public health interventions on prevention were most effective, including overweight, smoking, mental health, the super zone, air quality, poor-quality housing, and workplace bullying and harassment. They also asked that attention be given to lessons that could be learned from public health initiatives abroad.	NCL Partners/Borough Directors of Public Health	The Prevention workstream will feed this back to the directors of Public Health and work to ensure evaluative data is collected. This will be shared with Health and Wellbeing boards across North Central London. This will include ensuring lessons are learnt from international best practice.

Page 111

Item and Action	Action by	Progress
RISK MANAGEMENT: WORKFORCE That information be provided to members on the apprenticeship levy and its use.	NCL Partners	We have raised this at the London workforce board and we are working with Health Education England to get a view across NCL on the use of the apprenticeship levy across NCL.
RISK MANAGEMENT: WORKFORCE That feedback from the care home providers workshop be provided.	NCL Partners	A summary report on the work taking place on Adult Social Care has been provided at Annex A.
RISK MANAGEMENT: WORKFORCE That the evidence base relating to the introduction of new ways of working be provided .	NCL Partners	The NCL programme is working with frontline staff and specialist education providers such as universities to design new roles and ways of working. In many cases there is not yet an established evidence base as these roles are new. As part of the work, we will be adding to and developing the evidence base in this area.
RISK MANAGEMENT: WORKFORCE The Committee recommended that the London Living Wage be included as a requirement in all contracts with private providers.	NCL Partners	It is outside of the remit of the programme to be able to make decisions on partner organisations' behalf. The programme will discuss this at the next board meeting and feed this back to member organisations for consideration.
RISK MANAGEMENT: WORKFORCE The Committee recommended that there be a care workers' representative on the Local Workforce Board .	NCL Partners	This has been added to the next Local Workforce Board 's agenda for discussion at the next meeting.

Page 112

Item and Action	Action by	Progress
RISK MANAGEMENT: WORKFORCE That North London Partners be asked to place increased emphasis on the training and support for care workers.	NCL Partners	The programme noted the recommendation and the workforce programme will discuss this as part of their planning for next year.
PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (POLCE) Future reports to the Committee be delivered on time and on the subject requested.	NCL Partners	The programme team will work closely with the committee to ensure reports are timely, relevant and concise.
PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (POLCE) The Committee recommended that PoLCE guidance must be evidence-based and there needs to greater co-ordination between PoLCE work locally, London-wide and nationally.	NCL Partners	The programme noted this and will update the narrative to accurately reflect the clinically led-evidence base of the policy. The programme noted this and will be working with London and National NHS England colleagues to coordinate future work.
PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (POLCE) Information is to be provided on Equality Impact Assessments of PoLCE recommendations.	NCL Partners	Equality impact assessments are being undertaken for all updated policies. The summaries of these will be available on our website.
PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (POLCE) Information is to be provided on the financial implications of PoLCE recommendations.	NCL Partners	Future reports will include a financial impact assessment along with the Equality impact assessments.

Page 113

Item and Action	Action by	Progress
PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (POLCE) The Committee recommended that advice is sought by the relevant health organisations from the Independent Reconfiguration Panel on whether this is a substantial service change that requires formal consultation.	NCL Partners	For any future updates of the policy NCL partners will undertake the following: 1) Clinically led evidence-base review 2) Equality impact assessment 3) Engagement with any affected groups 4) Work with the JHOSC, the NCL Joint Commissioning Committee and the IRP to understand if formal consultation is required
7 September 2018		
JOINT WORKING BETWEEN NORTH MIDDLESEX AND ROYAL FREE HOSPITALS A further report to the Committee on the case for change underlying North Middlesex and Royal Free joint working.	Royal Free/North Middlesex	This has been added to the list of items to be scheduled.
20th July 2018		
DEPUTATIONS Officers to provide members with information on the outcome of the Leaders' letter.	Will Huxter (Director of Strategy, NCL CCGs)	The response to the Leaders' letter is attached at Annex B.
DEPUTATIONS Members asked that information come back to a future meeting on the policy for consultant-to-	NCL CCGs	This has been added to the list of items to be scheduled.

Page 114

Item and Action	Action by	Progress
consultant referrals and if it was working in NCL. They would also like an update from GOSH, and to hear from the commissioners and the patient groups.	Great Ormond Street Hospital	
ESTATES STRATEGY That an update on the estates strategy come to a future meeting.	Simon Goodwin (Chief Finance Officer, NCL CCGs)	This has been added to this list of items to be scheduled at a future meeting.
STP STRATEGIC RISKS: FINANCE That income and balance sheet information be provided for NHS providers in the sub-region.	Simon Goodwin (Chief Finance Officer, NCL CCGs)	This is available through public websites for organisations. The Estates paper on the agenda for this meeting details the income per provider from the disposals.

Page 115

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ASC WORKFORCE STRATEGY –
developed in partnership with the STP

Recruitment and Retention in the NCL Care Sector

Part of the North London Adult Social Care Programme

Oct 18

Page 117

Adult Social Care Programme Background and Aims:

Background

- Established by the 5 Councils in 2017
- Steered by a Programme Board of DASS and senior commissioners

Purpose

- Develop work where it makes sense to collaborate between 5 Councils
- Support the Councils' interface with CCG

Priorities

- Care homes
- Social care workforce

Principles

- Subsidiarity – recognising local democratic accountability
- Evidence based – addressing the needs of local population for the years ahead
- Engagement – working with providers to find solutions

Page 118

Independent Sector Workforce:

This was identified as a priority by the 5 Councils as the independent sector workforce is growing and therefore a driver of the local economy, but also fragile and (nationally) undervalued. It is also sub-regional in that workers and providers cross boroughs regularly and there is the opportunity to work collectively on initiatives across north London that provide job and development opportunities to our residents; and also promote improved quality of care.

The slides below provide

- high level analysis of the workforce
- a summary of the priorities and projects being taken forwards in partnership with adult social care providers
- a summary of the engagement the North London ASC Programme has undertaken

The work forms part of the STP workforce programme reflecting the key interface between health and care and has levered in significant external funding to drive the priorities forwards.

Page 119

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

CASE FOR CHANGE - NCL SOCIAL CARE WORKFORCE SUMMARY – SfC Analysis April 2018 (2016/17 data)

Adult social care jobs in North Central London: 31,000

Projected number of additional adult social care jobs required by 2030*

The adult social care sector in North Central London contributed **£1 billion** to the national economy

9%

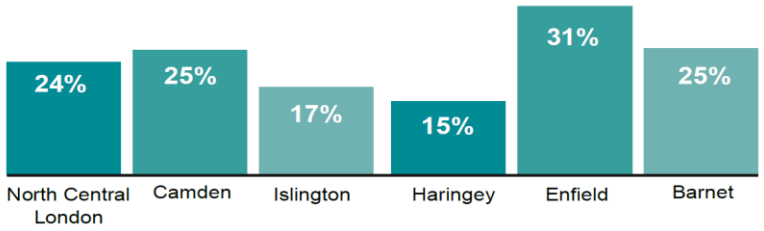
The workforce has increased by **9%** since 2012. This rate of growth has slowed in recent years.

Selected job roles

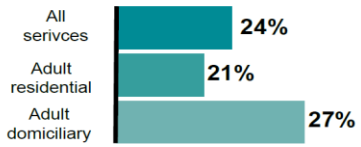
- **19,500** care worker jobs
- **2,900** Managerial roles
- **1,600** senior care worker jobs
- **800** registered nurse jobs
- **500** social worker jobs

Adult independent sector social care jobs in North Central London: 29,000

Workforce turnover in North Central London, by local authority area



Workforce turnover rate by service



Starters, leavers and vacancies

6,200 (24%) workers left their role in the past 12 months

73% starters were recruited from within the social care sector

1,800 vacancies at any one time **(6.6%)**

Summary of key independent sector workforce information

The data below is based on **29,000 jobs** in the independent sector as at 2016/17. Jobs for people using direct payments to employ their own care and support staff, and those working in the NHS are not included.

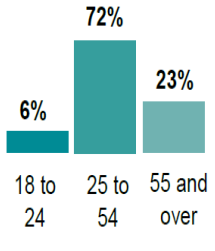
Male **19%**
Female **81%**

Nationality of workers

54% British
17% EU (non-British)
29% Non-EU

Age profile of the workforce

Mean age: **43.9 years**



42% of the workforce have a qualification at **level 2 or above**

Care workers paid an average of **£8.20** an hour

- **6,200 (24%)** Left their role in the past 12 months
- Vacancy rate **6.6%**, 1,800 at any one time

Factors affecting turnover

The information in this section was taken from raw data in the NMDS-SC between March 2016 and March 2017. For a full explanation of the methodology see the accompanying excel analysis.

The **older a worker was**, the less likely they were to leave their role

Workers **new to the sector** were more likely to leave their role

Workers **on zero hours contracts** were more likely to leave their role

Recruitment and retention rates: selected job roles

28.4% of care workers left their role in the last year, while **8.3%** of roles were vacant

12.8% of senior care workers left their role in the last year, while **2.9%** of roles were vacant

23% of registered managers left their role in the last year, while **11%** of roles were vacant

Page 120

1. Programme Summary - Aims, Project Areas & Outcomes

Aims	Project Areas	Outcomes
1. Raise the profile of social care roles and careers	• Establish an ICare Employer Partnership Network • Support employers to identify 20 Ambassadors, across 5 boroughs and deliver 10 career activities in schools, colleges, HEIs, Job Centres & community • Increase number of providers offering work-experience / shadowing and apprenticeship opportunities • Execute a marketing campaign by Mar 2019 to raise profile of opportunities in social care and drive traffic to the PTC portal	• Opportunities in social care are better understood locally – awareness has been raised • Improved recruitment pathways addressing key workforce challenges • Increased employment opportunities to NCL residents • Increased opportunities for social care providers to be represented across the system • Provider representation in STP as BAU
2. Support Providers to grow their workforce to meet growing demand	• Proud to Care portal piloted in early 2019 • Programme of workshops in 2019 in values based recruitment • 15 Providers advertising vacancies on the portal by Mar 2019 • 10 Providers getting applications via the portal by May 2019 • Improved pathways between training providers and employers	
3. Develop workforce skills and support staff to remain in the sector	• Development of initiatives to support portability of workforce • Development schemes for key roles recruit / retain the agreed number of candidates (metrics in each scheme profile) • Social care career pathways are mapped out and supported by targeted training programmes • Increased skills of workforce (EOLC; clinical skills etc)	
4. Support providers to establish a local leadership forum and representation mechanism.	• Projects are co-designed and based around the needs of providers • Providers work together to promote improvement in recruitment and retention	

Page 121

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

PARTNERSHIP

- In Spring 2018 we held two NCL engagement events for home & care home providers & stakeholders to introduce the NL Partners in health and care & the ASC Programme; to engage the market better & hear their key challenges
- Over 100 people attended from across the health and care system including 50+ providers of home care and care homes; ASC; Skills for Care; London ADASS; the STP; Care Provider Alliance; Community Education Provider Network; UCLH; senior council officers and QA leads; GPs and Primary Care leads; Capital Nurse Programme
- This identified some priority areas, which have been developed through co-design processes with ASC providers. All the projects summarised below have been developed in partnership with providers; for example, jointly shaping an apprenticeship offer for registered managers; designing the content required of the Proud to Care Portal
- On 27 September we held a further engagement event with providers focussed on reporting back progress, opportunities to sign up too and new areas to co-design
  - 21 providers attended (30 people) representing 16 Dom Care services and 5 Care Homes
  - 15 staff from across the NLP system

Page 122

BARNET LONDON BOROUGH ENFIELD Council ISLINGTON Haringey LONDON Camden

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Page 123

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22 September 2017

Richard Cornelius, Leader Barnet
Georgia Gould, Leader Camden
Claire Kober, Leader Haringey
Doug Taylor, Leader Enfield
Richard Watts, Leader Islington

Dear Colleagues,

Re: North Central London Sustainability and Transformation Plan

Thank you for the letter you sent to Simon Stevens dated 13 September 2017 regarding the progress of the NCL Sustainability and Transformation Plan (STP), to which I have been asked to reply.

Having only recently taken on the role of NHS England (London) Regional Director, I want to take this opportunity to recognise the support and input that I know you and your teams have provided throughout the development of the Sustainability and Transformation Partnership (STP) process in North Central London.

I understand that in previous correspondence and in person, Anne Rainsberry has discussed with you NHS England's recognition of the tension between the challenges faced, in terms of meeting the absolute need to the more immediate short term financial challenges, while putting in place transformational changes to deliver sustained improvements in health for all local people.

I think it would be hugely beneficial for us to all meet in person to discuss in greater depth the important and complex financial challenges raised in your letter. I hope that we can take a collaborative approach and work to regain the sense that we are equal partners in the process of improving health and social care outcomes across the five boroughs in North Central London.

While I'm aware of the challenges facing each and every one of the 44 STPs in the country I remain optimistic about London's ability to meet these challenges. There is a clear ambition; a great track-record of delivering transformational change and we are home to some of the best clinicians and medical facilities in the world. However, one of the areas I believe we need to focus on in the coming months is working with our Local Authority peers, to fully utilise their expertise.

I believe closer, collaborative working is on its way. We recognise that we don't just need to get the parties around the table; we need to provide them with proactive support to make the changes that are needed based on best evidence.

That is why the NHS in London is investing in an Improvement Collaborative, run jointly by the NHS and by ADASS. A comprehensive range of activities is planned over coming months to bring experts in hospital flow, data, analytics and operational research together with patients, citizens, clinicians, staff and specialists in quality improvement.

I hope that this is only the start of more joint ventures that will bring about real change for everyone living and working in the capital. I am eager to hear your ideas for how we can continue to improve these relationships.

I will ask my office to liaise with your offices to identify a mutually convenient time for a meeting in the near future.

Yours sincerely,

Professor Jane Cummings
Regional Director (London)
Chief Nursing Officer, NHS England