North Central London
Sustainability and
Transformation Plan

North Central London Sustainability and Transformation plan

Progress report – September 2016

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

Contents

1 Executive summary

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

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

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

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

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

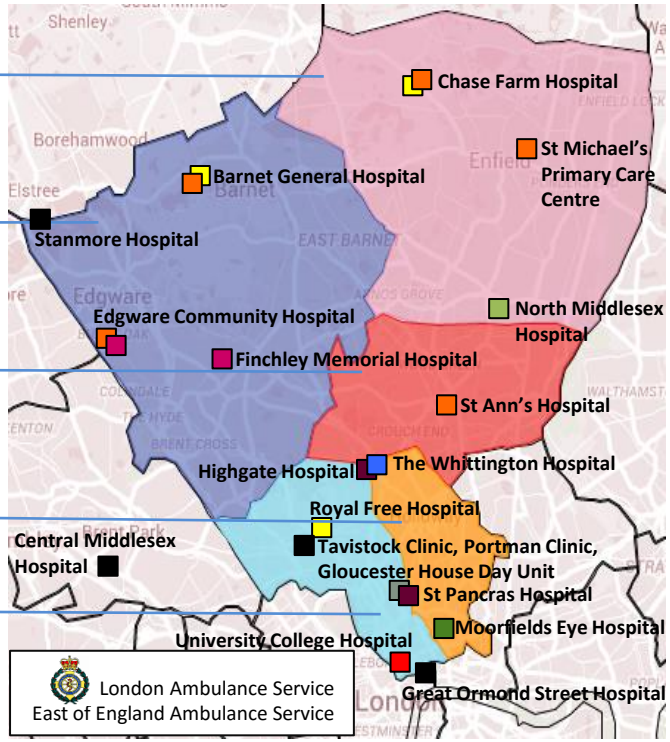
Enfield CCG / Enfield Council
~320k GP registered pop, ~324k resident pop
48 GP practices
CCG Allocation: £362m (-£14.9m 15/16 OT)
LA ASC, CSC, PH spend: £184m

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

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

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

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



Total health spend **£2.5b**

Total care spend **c.£0.8b**

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

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

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

Note: all OT figures are normalised positions

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

NCL CCGs activity stats

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

Total GP registered population 1.5m

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

2 We are building on our local strengths

Who we are

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

Our history

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

Building on our strengths

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

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

What next

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

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

3 Case for change: health and wellbeing

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

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

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

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

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

Lifestyle choices put local people at risk of poor health and early death
Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk, but have not yet developed a long term health condition. The biggest killers in NCL are circulatory diseases and cancer; these diseases are also the biggest contributors to the differences in life expectancy across NCL.

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

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

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

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

3 Case for change: care and quality

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

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

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

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

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

There are differences in the way planned care is delivered. This may be because of levels of patient need, or differences in clinical practice. The number of people seen as outpatients is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

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

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

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

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

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

3 Case for change: finance

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

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

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

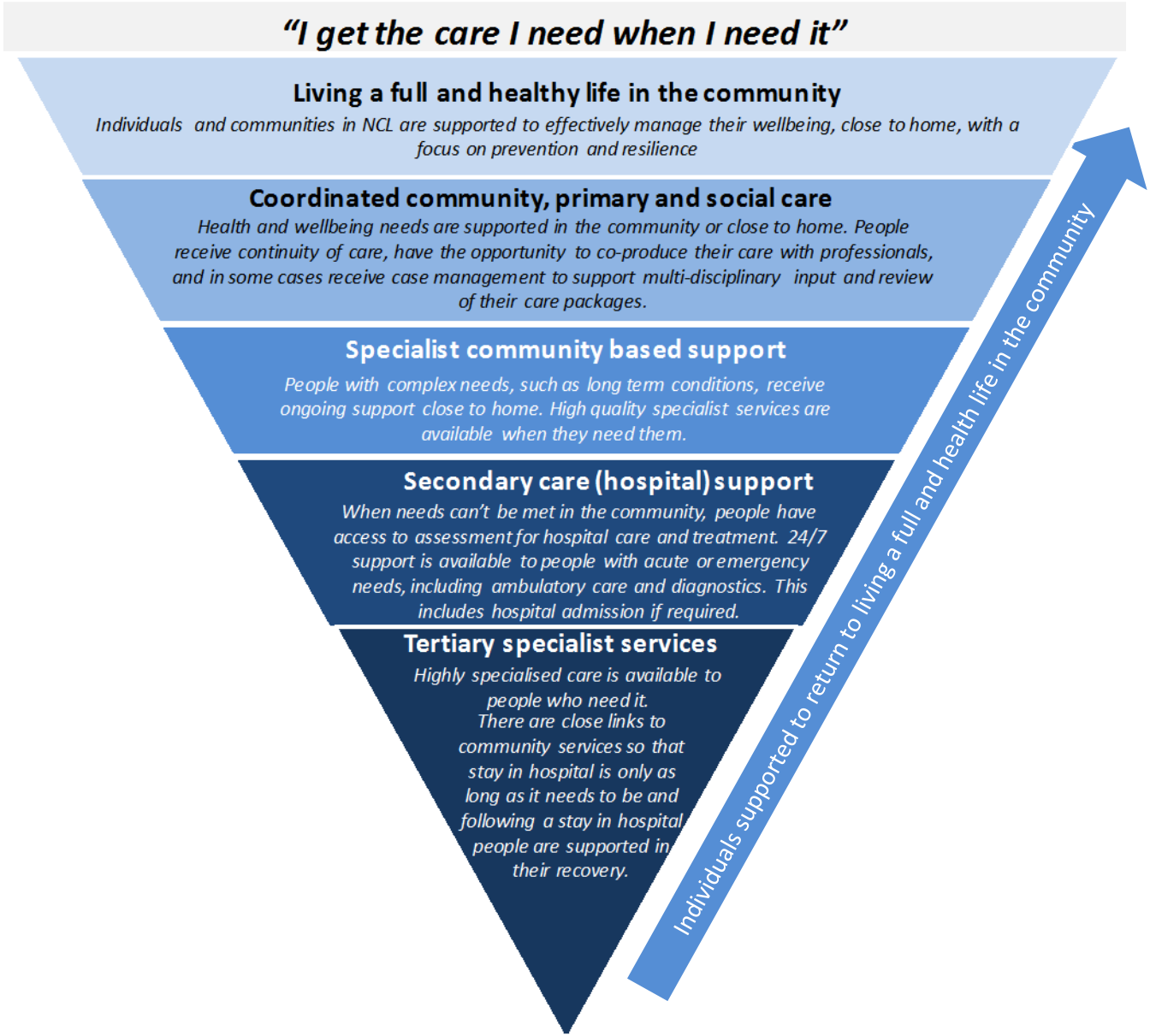
This means we will:

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

Our core principles are:

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

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



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

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

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

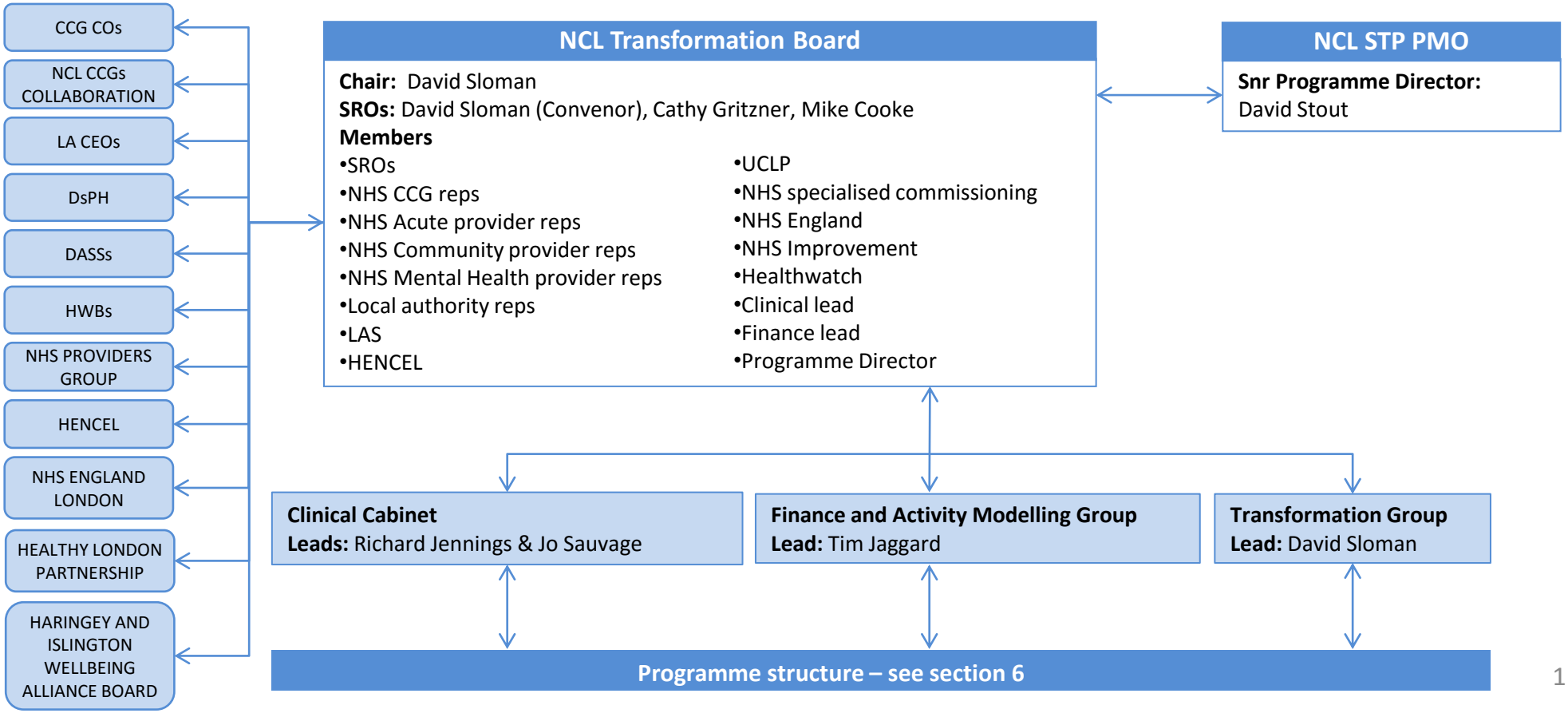
Finance directors from all organisations have been working well together to identify the projected NCL health and care position in 20/21 should we do nothing. We are working closely with NHS England to address the challenge around specialised commissioning, which is particularly relevant in our footprint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

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

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

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

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



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

Development of programme structure

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

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

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

6 Health and Wellbeing – Population health including prevention workstream

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

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

6 Health and Wellbeing – Primary care transformation workstream

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

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

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

6 Health and Wellbeing – Mental health workstream

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

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

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

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

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

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

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

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

6 Care and Quality – scope of workstreams and deliverables

Optimising the elective pathway

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

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

Consolidation of specialties

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

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

6 Productivity - Organisational-level productivity

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

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

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

6 Productivity - System productivity workstream

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

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

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

6 Enablers - Health and care workforce workstream

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

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

6 Enablers - Health and care estates workstream

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

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

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

6 Enablers– scope of workstreams and deliverables

Digital and information

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

New care models and new delivery models

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

6 Enablers - Commissioning models

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

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

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

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

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

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

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

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

Engagement to date

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

Communications & engagement objectives

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

Delivering the objectives

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

9 Conclusion and next steps

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

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

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

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