



**NORTH LONDON  
PARTNERS**  
in health and care


June 2017

**Working together for  
better health and care:  
our sustainability and  
transformation plan**



# Contents

|   |           |
|---|-----------|
| Foreword.....   | 3         |
| Executive summary .....                               | 4         |
| Our vision: A place where no-one is left behind.....  | 6         |
| Our Strategic Framework.....                          | 8         |
| Programme governance to deliver the plan .....        | 9         |
| <b>The Plan .....</b>                                 | <b>12</b> |
| Implementing our plans.....                           | 12        |
| Social Care .....                                     | 12        |
| Prevention.....                                       | 14        |
| Health and care closer to home .....                  | 18        |
| Urgent and emergency care .....                       | 22        |
| Planned care .....                                    | 26        |
| Mental health.....                                    | 31        |
| Cancer .....  | 37        |
| Maternity .....                                       | 39        |
| Specialised commissioning .....                       | 43        |
| New commissioning and delivery models .....           | 45        |
| Consolidation of specialties.....                     | 46        |
| Workforce .....                                       | 47        |
| Estates.....  | 52        |
| Digital.....  | 55        |
| <b>Addressing the financial gap .....</b>             | <b>57</b> |
| <b>Communications and Engagement .....</b>            | <b>66</b> |
| <b>Equalities analysis and impact assessment.....</b> | <b>70</b> |
| <b>Conclusion and next steps .....</b>                | <b>77</b> |





## Foreword

Welcome to our plan for health and care in North London.

Health and social care services in North London have become 'partners in health and care' to improve the access and quality of services, and to make the system more efficient. As partners, we serve a population of more than 1.5 million people from the London boroughs of Barnet, Camden, Enfield, Haringey and Islington.

This is our plan for changing the way the health and social care services in North London work, to bring them together to provide the entire local population with access to the best possible health, care and wellbeing services, and to make North London a place where no-one is left behind.

We have a proud history of providing high quality health and care services. We have an important role to play in delivering the **NHS Five Year Forward View** and other national health and social care policy. We need to ensure our services can adapt to meet future needs and are financially sustainable against a backdrop of increasing demand. In particular, we need to support services work better together, both in hospital and the community, to keep people well and independent and to help them recover when they are unwell.

On 31 March, NHS released the **Five Year Forward View Next Steps**. This update provides us with an opportunity to relook at our local plan and to make some adjustments so that our focus remains aligned to the national priorities while delivering at local level.

Our current system is unsustainable. The health and social care needs of our local people are changing and the way we are currently organised means that waiting times for some services, as well as the health outcomes vary. As our population ages, we now need to consider how people will receive care and what that care may look like. We believe there is the scope to provide more services closer to people's homes. Working alongside local authorities, we can design and deliver the right care in the right setting so that everyone can live and age with dignity. We need to do more to recognise the mental health as well as the physical health needs of our population. We want the standard of care and people's experience of health and social services to be of the highest quality.

Our financial situation remains challenging as the demand for health and social care continues to grow year on year, exceeding any increase in funding.

We have worked hard to identify challenging but achievable opportunities to deliver efficiencies in the way in which we deliver health and care. This plan sets out the impact we believe we can make. However, the plan does not yet balance the finances, either next year or by 2020/21. There are significant pressures on budgets particularly in 2017/18. We will continue to look for opportunities for further efficiencies, including one-off measures that can improve the financial position in the short run pending full implementation of the transformational changes that we plan to deliver over the next few years.

We know that this is probably not be enough to bring our plan into financial balance. To support our need to achieve financial balance, we will continue to work with NHS England and NHS Improvement as part of the Capped Expenditure Process to help us to produce a set of affordable NHS plans 2017/18, which potentially includes difficult choices. This aims to help us deliver the best possible clinical outcomes for local people within the limited funding available.

Bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services, is challenging. The environment in which we work is constantly changing and we must be ready to respond when it does. Our plan will continue to evolve. There may be new opportunities we can embrace, or decisions to be made about the viability of some of the things we currently do. We will work closely with local people, communities and our staff when deciding what further changes are needed and in how we implement these changes. At the heart of every decision is our commitment to deliver the health and care the people of North London expect and deserve.



## Executive summary

It has been over a year since we came together as a partnership of 21 health and social care organisations in North London. During this time, we have invested time, energy and resources into building strong relationships with each other and developing a shared vision for a health and care system that can deliver high quality services to our community where and when they need, while becoming more sustainable.

We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. We agree on the nature and scale of the challenge described in our **Case for Change** (published September 2016).

Creating a healthier population is at the heart of our plan. Our vision is for our community to be happier, healthier and to live longer in good health. To do this we must embrace the opportunities that working together can deliver. We must look to emerging technologies and finding new and better ways of working that can eliminate duplication and waste and we must develop and support a motivated, highly skilled and professional workforce to serve North London.

As partners we have a shared vision, a collective agenda and the commitment to transform the health and care services of North London.

Every day the media report on the pressure experienced by the health and social care system. We know that to meet the demands of our population now and into the future we must do things differently. We have already invested time and resources into finding new ways of working. Our community has told us they want a more joined up and integrated health and care system, they want care closer to where they live and work, delivered by professional and compassionate health and care workforce. Some of our boroughs, such as Islington and Haringey, already have a strong history of working together and we know there are some similarities in the health and care profile of the North London populations. We want to use this collective knowledge to deliver better health and care services to the North London community and to ensure we have a system that is efficient, effective and sustainable.

To build a better health and care system we must also look at the social determinants of health and wellbeing. There are high levels of poverty, mental ill health and employment insecurity. In general, life expectancy is increasing, but for many people, the last 20 years of their life is lived in poor health. As a result, older people often require a lot of support from health and care services.

Working together presents an opportunity for our health and care services to focus on the people we commission and provide services for. We want to share the collective responsibility for meeting the mental and physical health and care needs of the North London community and to help make our community more resilient.

Our greatest aim is to help people to be, stay or regain good health and wellbeing. To do this we must take a preventative approach, build strong community services and improve health and care outcomes for people. Working together in this way will allow us to look across the system at how services are provided and identify opportunities to add value, improve outcomes and eliminate duplication and reduce costs.

Our vision is for North London to be a place where our people experience the best possible health and wellbeing. North London is a place where no-one is left behind.

To achieve our vision, this plan must result in real and demonstrable improved health and care outcomes for the people. Our community will experience the benefits of improved health and wellbeing, better services delivered within the available resources for our health and care system.

We currently project a financial deficit across the NHS organisations in North London of £234m in 2016/17. If we do nothing, by 2020/21 we project this financial deficit in health will rise to £811m plus a funding gap across North London councils on social care and public health of a further £247m. Our plans reduce this financial deficit across the NHS organisations to £75m by 2020/21 but we clearly need to continue to work to identify further opportunities for efficiencies to ensure that we have financially sustainable services.

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this

We will therefore continue to work to identify additional efficiencies that will help to reduce this residual gap and this includes working with NHS England and NHS Improvement as part of the Capped Expenditure Process to help the NHS produce a set of affordable plans for 2017/18.

We have in place a governance structure to enable NHS and local government organisations to work together in a new way to deliver our plan. It is crucial that whole system is aligned and committed to the delivery of this Sustainability and Transformation Plan (STP) and we have ensured the two year health contracts that are in place for 2017/18 - 2018/19 are consistent with the plan's strategic framework (outlined below).

Much work and effort has taken place to provide more detail about our proposals. We have begun to engage with those who use health and care services and we invite the public to work with us to test our thinking and validate that our plans truly reflect their needs.

We are committed to being innovative in our approach; to focusing on improving the health and wellbeing of our community and delivering the best care not only in London, but nationally. Local people deserve to be supported to live happier, healthier and longer lives, and we are fully committed to making this vision a reality.



# Our vision: A place where no-one is left behind

We want to transform North London into a place where no-one is left behind. We are united in our commitment to transforming care to deliver the best possible health outcomes for our local population. This will be done by shifting our model of care so that more people are cared for in 'out of hospital' settings, and through prevention, more proactive care, and new models of care delivery, we can reduce the reliance on secondary care and improve the way people access and receive care.

To deliver on our bold vision, we have designed a programme of transformation with four fundamental elements:

- **Prevention:** We know that many of the health challenges facing our population arise from preventable conditions. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population;
- **Service transformation:** We know that there are emerging technologies and new and better ways to deliver services. To meet the changing needs of our population we will transform the way that we deliver services;
- **Productivity:** We know that there is duplication and waste that can be eliminated by working together. We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** We know that there may be untapped resources that can be put to work to improve our capacity. We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Developing our vision in North London has taken time. We have harnessed high quality clinical and practitioner leadership at every stage of the process. The vision for North London initially drew on existing local engagement work which was underway before the STP process started – putting the needs and expectations of the public at the heart of the plan. Leaders across the system agreed the vision in September 2016. This process, alongside more local engagement events, has ensured that our vision is collectively owned across the health and care partnership. We will continue to engage with our population and develop the plan with them throughout the process.

By establishing North London 'Partners in health and care' we will work together to deliver our Sustainability and Transformation Plan (STP) and realise our vision for North London. Our core principles to support our ambition are:

## Our core principles

- We will put the health and wellbeing of our population at the heart of our plan;
- We will work in a new way as a whole system; sharing risk, resources and reward. Health and social care will be integrated as a critical enabler to the delivery of seamless, joined-up care;
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research-based delivery models that move innovation in laboratories to frontline delivery as quickly as possible;
- We will make the best the standard for everyone, by reducing variation across North London;
- In terms of health, we will give children the best start in life and work with people to help them

remain independent and manage their own health and wellbeing;

- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible;
- We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate;
- To do all of this we will do things radically differently through optimising the use of technology;
- This will be delivered by a unified, high quality workforce for North London.

We are continuing to include staff and residents in the development of our plan. We will continue to engage with people and groups throughout the process so that our conversation with our local community continues to develop and mature alongside our proposals. Each organisation in the partnership is committed to delivering the right service, at the right time, in the right place.

Further detail about how we plan to engage with our patients and residents can be found in the [Communications and Engagement](#) section of this document.



# Our Strategic Framework

To deliver on our vision and achieve an increase in health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency, we have designed our five year programme of transformation with four elements:

- Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in North London is preventable. We will increase our efforts on prevention and early intervention to improve both the physical and mental health and wellbeing of our whole population. This will reduce health inequalities, and help reduce the demand for more expensive health and care services in the longer term. Best of all, we can improve the quality of life of our residents and build a more resilient community;
- Service transformation:** To meet the changing needs of our population and to respond to what people have told us they want from health and care services, we will transform the way that we deliver services. This involves taking a “population health” approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Working in partnership with local authorities, together we can provide a better health and care experience for people when they need it, and in a place that more conducive to recovery or longer term care, supported by caring and compassionate professionals;
- Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the **Carter Review** and working together across organisations to identify opportunities to deliver better productivity at scale;
- Enablers:** To increase our ability to provide health and care services for the future we have identified key areas that will support the delivery of transformed care across North London. To do this we must have the necessary architecture in place. This includes digital, workforce, estates, and new commissioning and delivery models.

**Exhibit 1: The North London STP strategic framework**

|                    |  |  |                   |
|--------------------|--|--|-------------------|
| <b>Social Care</b> | <p><b>Service Transformation</b></p> <p><b>Improves population health outcomes; reduces demand; improves the quality of services</b></p> <ul style="list-style-type: none"> <li>Health and Care closer to home</li> <li>Urgent and Emergency Care</li> <li>Children and Young People</li> <li>Specialised Commissioning</li> <li>Planned Care</li> <li>Mental Health</li> <li>Maternity</li> <li>Cancer</li> </ul> | <p><b>Productivity</b></p> <p><b>Reduces non value-adding costs</b></p> <ul style="list-style-type: none"> <li>Commissioner savings</li> <li>Provider savings</li> <li>System-wide productivity</li> </ul> | <b>Prevention</b> |
|                    | <p><b>Enablers</b></p> <p><b>Facilitates the delivery of key workstreams</b></p> <ul style="list-style-type: none"> <li>Digital</li> <li>Workforce</li> <li>Estates</li> <li>New Commissioning and delivery models</li> </ul>  |  |                   |





## Programme governance to deliver the plan

In coming together as a collaborative, we have developed a governance structure, which enables NHS and local government partners to work together in new ways. The objectives of the North London STP governance arrangements are to:

- Support effective collaboration and trust between commissioners, providers, political leaders and the general public to work together to deliver improved health and care outcomes more effectively and reduce health inequalities across the North London system;
- Provide a robust framework for system level decision making, and clarity on where and how decisions are made on the development and implementation of the North London STP;
- Provide greater clarity on system level accountabilities and responsibilities for the North London STP;
- Enable opportunities to innovate, share best practice and maximise sharing of resources across organisations in North London; and
- Enable collaboration between partner organisations to achieve system level financial balance over the remaining 3 years of the Five Year Forward View timeframe and deliver the agreed system control total, while safeguarding the autonomy of organisations.

A detailed governance handbook including the terms of reference for all of the governance groups is available [here](#). A summary of the programme governance is provided below.

The delivery of the plan is overseen by the North London Programme Delivery Board. This is an executive steering group made up of a cross section of representatives from across North London. This group is specifically responsible for providing accountability for the implementation of the workstream plans. Membership includes the Senior Responsible Officers (SRO) of each workstream and SRO leads for CCGs, Providers and Local Authorities. Two subgroups provide advice to the Programme Delivery Board: the Health and Care Cabinet (formerly the Clinical Cabinet) and the Finance and Activity Modelling Group.

The Health and Care Cabinet meets monthly to provide clinical and professional steer, input and challenge to each of the workstreams as they develop. Membership consists of the five CCG Chairs, the eight Medical Directors, clinical leads from across the workstreams, three nursing representatives from across the footprint, Pharmacy and Allied Health Professions representatives, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children's Services respectively.

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

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

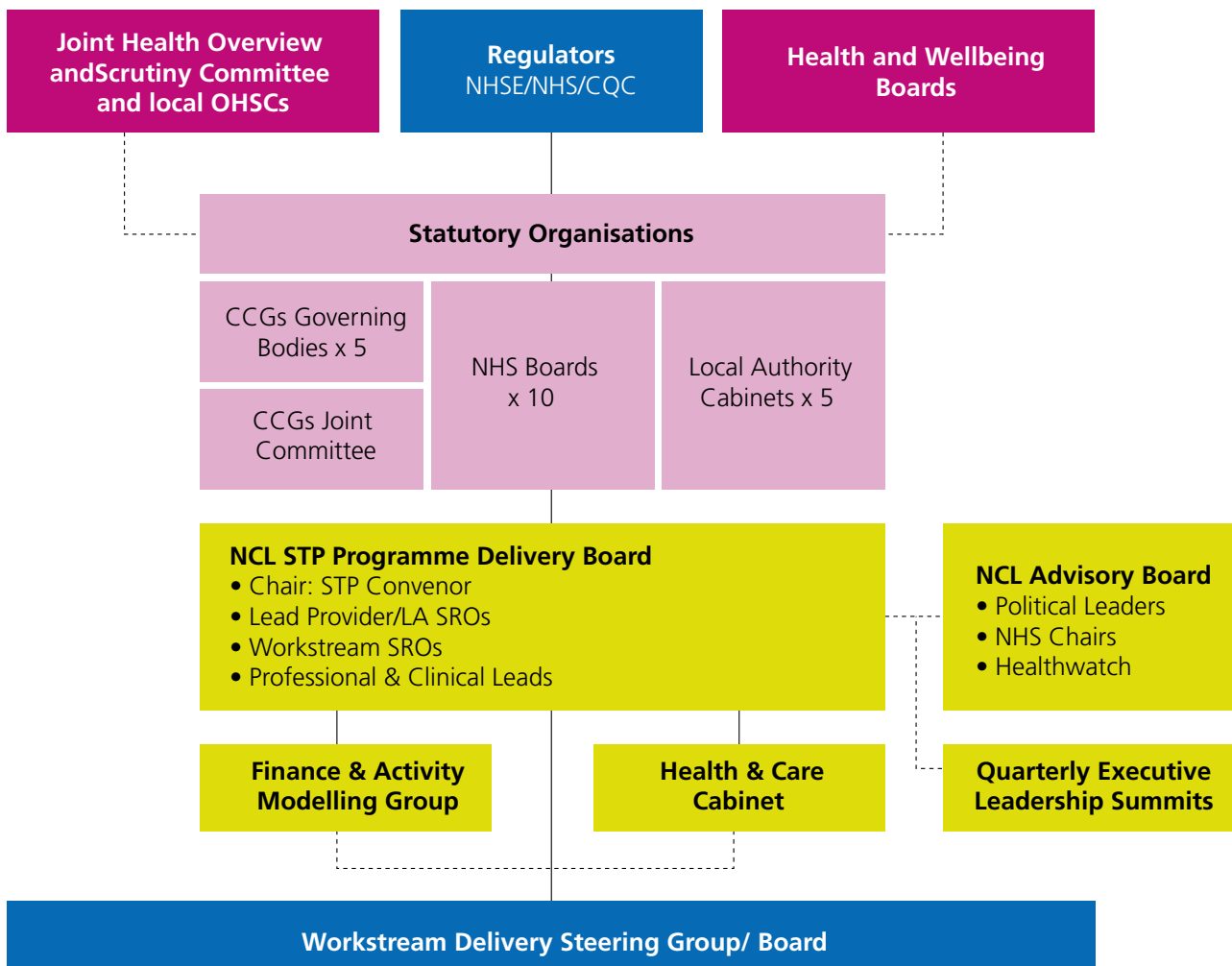
A new STP Advisory Board was established established in June 2017. This group will have an advisory role, enable a collective partnership approach, and act as the 'sounding board' for the implementation of the STP plans. The membership of this group includes Local Authority leaders, NHS Chairs, and Healthwatch. This will go some way to address the democratic deficit and representation of views of the local population, and ensure a better connection with the independent members of NHS boards/governing bodies, local authority leadership, patients, and residents. This group will meet quarterly and a decision whether or not to appoint an Independent Chair will be discussed in due course.

In addition to the above governance groups, CEOs and other relevant executive directors and stakeholder representatives will meet quarterly for executive leadership events to enable continued engagement and momentum, regular communication, and to assist with resolving any programme delivery issues identified by the programme delivery board.

There has been the appointment of a single Accountable Officer for the five CCGs across North London. This will ensure a more collaborative commissioning approach across North London. The Governing Bodies of the five CCGs agree to establish a Joint Committee for some elements of commissioning in North London including:

- All acute services core contracts and other out of sector cude commissioning
- All learning disabilities contracting associated with the Transforming Care programme
- All integrated urgent care (through the Urgent & Emergency Care Boards including NHS 111/ GP Out-of-Hours services)

### Exhibit 2: Agreed programme governance structure



## **Programme resourcing**

The implementation of the STP is regarded as business as usual, so the majority of the capacity required to implement the plan will be found from within existing management and clinical capacity within the health & care organisations in North London. In addition we have established a Project Management Office (PMO) which facilitates and coordinates the meetings of the main governance groups, liaises with each of the workstreams to monitor and track delivery plans, as well as delivering communications and engagement support to the programme.

Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality.

## **Health and wellbeing boards**

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, CCGs have engaged with HWBs as we developed the plan and will continue to do so as it is implemented.

## **Overview and scrutiny committees**

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health and care services in their local area. Local authorities themselves are scrutinised on the delivery of health and social care services for which they are directly responsible and accountable, but commissioners and providers of NHS services must also consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

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

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place for North London. The JHOSC undertook a review of the draft STP during November and December 2016. The JHOSC heard verbal and written evidence from local residents and a range of other stakeholders at specially convened meetings. This review has generated a report from the JHOSC setting out a number of key principles and recommendations across eight themes, which aim to support and inform the further development and delivery of the STP going forward. The JHOSC also reviewed governance and communications & engagement proposals in March 2017. We continue to work constructively with the JHOSC as the proposals are developed so we can plan ahead for any potential public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

To meet the changing needs of our population we must transform the way that we deliver services and shift the nature of care from reactive to proactive. We will embed prevention in everything we do. This starts with giving children the best start in life and helping people stay healthy and well throughout their lives. We will develop our care closer to home model, and we will create a holistic approach to mental health services. We will improve urgent and emergency care, optimise the planned care pathway, consolidate specialties where appropriate and transform cancer services to improve the treatment and care experience for patients and their families.

## Implementing our plans

This work began as an NHS directive. However, we are all committed to ensuring integrated health and social care is what we provide our population. Now health and social care are working together to join up the system. Our collaboration means more joined up health and social care services, this integration is a key success factor in the realisation of our plan.

A robust delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements, communication and engagement plans and the key risks to successful delivery.

The delivery plans are live documents and will continue to be reviewed and revised as the programme develops. Each workstream has developed a detailed delivery plan which will provide a reference point for the relevant governance structures and the central PMO to keep planned delivery on track, and to support the effective management of interdependencies between workstreams.

## Social Care

Social care plays a crucial role in our plan and is reflected throughout this document. Sufficient, high quality and sustainable social care delivered directly by local authorities (e.g. via social workers) or commissioned through external providers (e.g. in the residential, nursing and home care markets) can deliver excellent outcomes for residents in North London and reduce the burden on health and care services.

However, adult social care faces similar funding challenges to the NHS, as the ageing population with more long term conditions begin to draw on adult social services in the same way they do the NHS. Put together with recruitment and retention issues and a social care provider market under significant pressure, it is important that we invest time and effort in social care and the NHS in equal measure.

Recent measures announced by the Government have begun to ease the financial pressure, but a significant financial gap remains. In the 2017 Spring Budget, the Chancellor of the Exchequer announced an additional £2bn investment into adult social care from 2017/18 to 2019/20. This is on top of the £2.4bn announced as part of an improved Better Care Fund in the 2015 Spending Review and separately, powers for Councils to raise additional revenue for adult social care through applying a precept of up to 6% over the next three years. The additional £2bn investment equates to £28m for North London Councils in 2017/18 and £55.5m by the end of 2019/20. This is to be spent specifically on adult social care for the purposes of meeting adult social care needs, reducing pressures on the

NHS, including supporting more people to be discharged from hospital when they are ready, and stabilising the social care provider market. North London Councils will be working closely with NHS organisations to implement these measures during 2017/18, using guidance in the new Better Care Fund Policy Framework and Planning Requirements 2017-19. More detail on the financial position of local authorities on adult social care is reflected in the 'Addressing the financial gap' chapter.

Since the publication of the draft plan in October 2016 NHS organisations and local authorities in North London have continued to work together to ensure the STP addresses the challenges across health and social care. As such, many workstream delivery plans now seek to deliver benefits and outcomes from both a health and social care perspective. Directors of Children's Services (DCS) and Directors of Adults Services (DASS) across all five North London Councils have been contributing to the development of the delivery plans where there is an opportunity to work as a system across health and social care.

We have also undertaken some further analysis across North London to understand the nature and scale of the local social economy and pinpoint areas where the NHS and local authorities need to work together closely to deliver better health and care. These areas are summarised below.

### **Hospital admission avoidance and discharge**

Councils' ability to arrange social care packages for adults in North London is a major contributing factor to delays in hospital discharge, albeit it is not the biggest cause. Latest data from NHS Digital shows that 55% of delays are caused by the NHS, 42% by social care and the remainder attributable to both parts of the system. Each Council in North London has a different approach to arranging packages of care and ensuring timely discharge from hospital, therefore there are variations in the length of wait to be discharged from hospital depending on where you live in North London. There are similar variations in the way each Council supports people to avoid unnecessary admission to hospital.

We will be working closely with NHS colleagues as part of the Urgent and Emergency Care workstream to ensure variation is minimised across North London.

### **The social care 'market'**

Under the Care Act 2014, upper tier local authorities have a responsibility to manage and shape their local social care market to ensure the needs of users and carers are met. A significant proportion of social care packages are purchased from an external marketplace of large and small, profit-making and not-for-profit organisations some of which operate nationally and/or locally. Analysis shows that the 42% of delays transfers of care attributable to social care, the majority of these relate to difficulties in sourcing a suitable package of care in a residential or nursing home or in the person's own home with homecare. Analysis of 2016 data from NHS Digital suggests a growing trend in delays attributable to the sourcing of suitable home care vs bedded care, suggesting pressure on homecare market capacity. Local authorities in North London also pay different prices for residential, nursing and home care, even when purchasing the same package of care from the same provider.

High quality, sustainable capacity in these markets are critical to achieving the aims of the STP, both in order to prevent admission to hospital and help with timely discharge, but also in ensuring care can be delivered closer to home and in the community. North London local authorities will be working together to shape and manage the market, working closely with NHS colleagues to ensure shared ambitions are achieved.

## The social care workforce

The social care workforce ranges from social workers directly employed by Councils to care workers employed in the independent sector and family carers who provide care on a paid for or voluntary basis. A study by Skills for Care in 2016 showed that 78% of employed carers in North London worked in the independent sector. Employment terms and conditions can be challenging, with care workers being paid near the National Minimum Wage or London Living Wage (depending on the terms and conditions of the Council in North London) with variances in their contractual terms. Whilst many new starters (73%) in the independent care sector have previous experience of working in adult social care in North London (suggesting we retain our workforce well), the average turnover rate in the region is 21% with some boroughs seeing as many new starters as those leaving the sector. The care sector in North London also employs a large number of non-British nationals (42%), with some boroughs seeing more non-British national employed vs British nationals. Uncertainty on the future of non-British workforce creates additional pressure and anxiety in the marketplace, which is a challenge shared in other public services including the NHS.

North London Councils will be working together with NHS colleagues under the STP workforce workstream to develop capacity and skills in the care workforce.

## Prevention

Much of the burden of ill health, poor quality of life, and health inequalities in North London is preventable. Between 2012 and 2014, an estimated 20% (4,628) of deaths in our community were from preventable causes. By focusing on helping people to stay well we will improve health and wellbeing outcomes for our whole population, reduce health inequalities, and help manage demand for health and care services in both the immediate and longer term.

We will embed evidence-based prevention and early intervention across the whole health and care system. This will include council services, social care and the voluntary and community sector. We will build upon the individual strengths that each part of the public sector in North London can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and other organisations such as the London Fire Brigade in preventing falls.

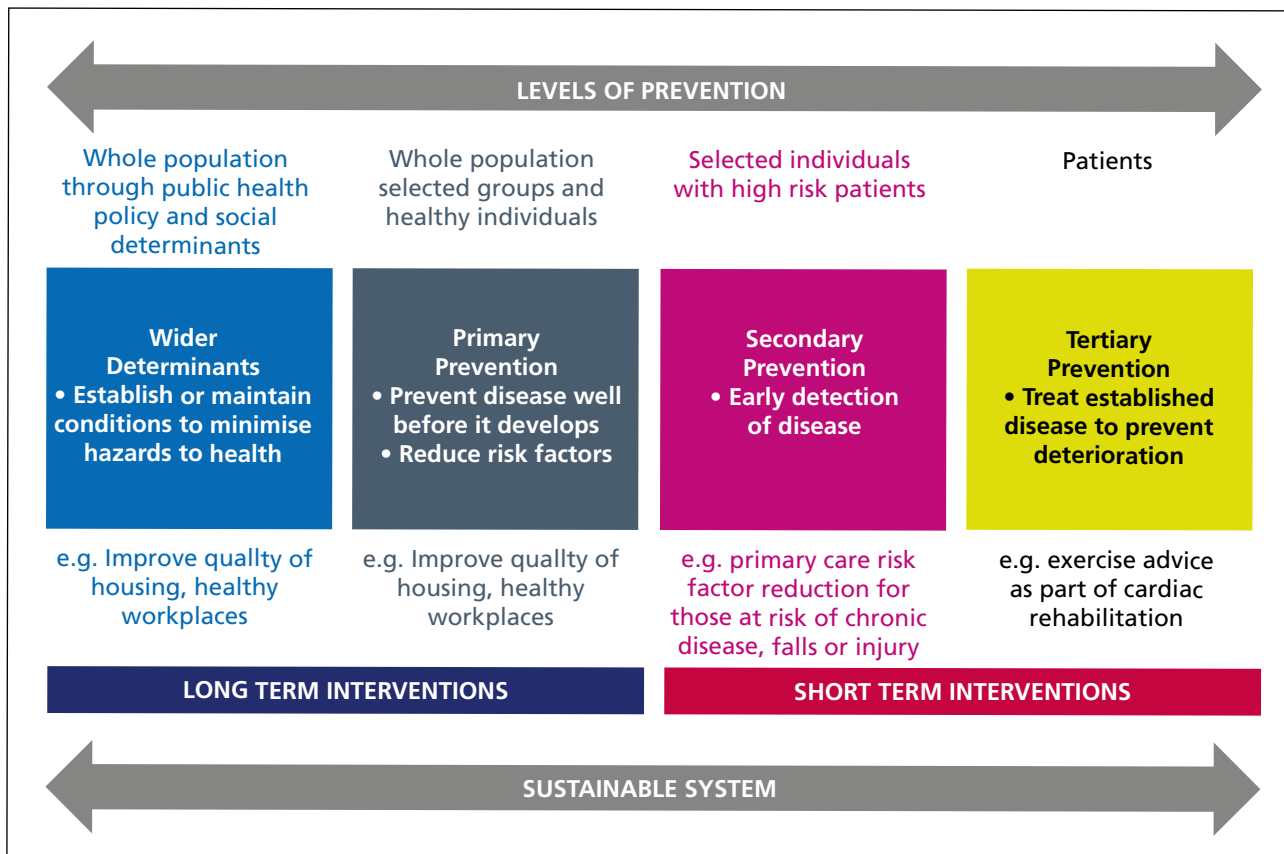
Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many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

We also recognise the important contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill

health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

Our prevention plan focuses on interventions and system change across the whole spectrum of prevention (exhibit 3), where there is strong evidence of effectiveness. We have identified opportunities where we could quickly build upon successful local initiatives across North London to achieve economies of scale.

**Exhibit 3: Approach to prevention**



We will concentrate our efforts on three priority areas with different initiatives:

| Workstream               | Initiative                        | Description  | Deliverable  |
|--------------------------|-----------------------------------|--|--|
| Workforce for prevention | Making Every Contact Count (MECC) | Residents will be appropriately directed to services that might be of benefit to them, including lifestyle interventions and those addressing the social determinants of health e.g. debt, employment, housing. The 'brief advice' and signposting given as part of the MECC programmes will increase the numbers of referrals into preventative services.   | Increase the number of staff across the health and care system and the wider public sector participating in online MECC training.                  |
|                          |                                   | Residents with mental health issues, including dementia, will be identified more quickly and guided towards the right support service to address their needs.  | Increase the number of frontline health and care staff participating in face-to-face MECC training.  |
|                          | Mental Health First Aid (MHFA)    |  | Increase the number of non-medical frontline staff (NHS and LA) trained in MHFA.   |
|                          | Dementia awareness                |  | Increase the number of NHS and social care staff trained in basic dementia awareness.<br><br>Commence training for dementia friendly GP practices. |
| Healthy environments     | Haringey devolution pilot         | Pioneer new approaches to tackling problem gambling, alcohol misuse and smoking to secure the sustainability of the NHS, and reduce demand on social care by creating a supportive environment where it is easier to make healthy choices.<br><br>Prevent people with mental health difficulties from becoming long-term unemployed and claiming ESA benefits by providing effective early help and job retention support.   | Rapid application of learning across North London.   |
|                          | Child Obesity                     | Reduce levels of childhood obesity, reduce the negative impacts on children's physical and mental health over the short and longer term through ensuring that the settings where children spend their time are recognised as healthy, and promote healthy eating and physical activity.<br><br>Reduce the health and wellbeing gap by targeting settings in our most deprived communities and those with a high proportion of children from some BAME groups who are more likely to be overweight / obese. | Increase the number of early years' settings and schools in North London accredited as healthy schools or early years settings.                    |
|                          | Workplace Wellbeing               | Build on existing momentum and commitment to promote a culture that improves health and wellbeing of employees, by working with the North London Health Education England lead, North London healthy workplace leads and Healthy London Partnerships to promote a culture that improves health and wellbeing of employees and leads to healthy and productive workplaces.  | All North London NHS and local government organisations sign up to and attain at least achievement standard of the Healthy Workplace Charter.      |



|                   |                                    |  |  |
|-------------------|------------------------------------|--|--|
| Healthier choices | Obesity                            | Develop and up-scale the delivery of weight management programmes which include integrated physical and wellbeing activities. Specifically reduce the health and wellbeing gap by targeting those living with a mental illness and a physical condition and those from Black and South Asian minority ethnic groups living in the most deprived areas.   | Increase the percentage of overweight/obese residents accessing support.<br>Increase the number of overweight and obese residents losing $\geq 3\%$ of their body weight |
|                   | Smoking                            | Radically up-scale the delivery of smoking cessation activities across North London, and in all parts of the system, as well as increasing the options available to residents who want to quit smoking. This includes: the use of digital (smartphone) apps being developed at a pan London level; increasing community support through the use of the voluntary and community sector; and providing more specialist addiction support for those with highly addictive behaviours.<br><br>To reduce the detrimental health impacts on foetuses and young children, there will also be additional support for pregnant women to quit smoking, including the expansion of CO monitoring.<br><br>To specifically close the health and wellbeing gap, we will target disadvantaged groups for intervention, including people with serious mental health problems, learning disabilities, specific BAME groups, and those from the most deprived communities. | Reduce smoking prevalence<br>Increase the number of 4-week smoking quitters per year.<br>Reduce smoking related hospital admissions                                      |
|                   | Alcohol                            | Increase in the capacity and reach of alcohol liaison teams, alcohol outreach teams, as well as an increase in alcohol screening rates across North London, to identify and proactively manage via and intensive support programme a complex cohort of high risk and dependent drinkers so that their health needs are stabilised. This will reduce the number of people in crisis and help to avoid repeat hospital admissions and call-outs for blue light services. To reduce the health and wellbeing gap, interventions will be targeting high risk and dependent drinkers who are disproportionately from the most deprived communities.   | Reduce alcohol-related hospital admissions<br>Increase in alcohol screening rates  |
|                   | Falls                              | Falls-related hospital admissions will be reduced through the use of a multifactorial intervention combining regular exercise (including strength and balance), modifications to people's homes and regular review of medications, delivered in collaboration across the local public sector organisations and with the voluntary and community sector. This will include collaboration with London Fire Brigade (in Camden and Islington initially) as part of their 'Safe and Well' initiative, as well as identifying people who have had minor falls for early intervention.   | Reduce falls-related hospital admissions   |
|                   | Sexual health - contraception      | There will be an increase in the offer and uptake of long acting reversible contraceptives to achieve national average expenditure. Residents will have increased choice and convenience of access of contraceptive methods, including via primary care, maternity, abortion, and early pregnancy loss services. There will also be training and skills development for health professionals and awareness raising and outreach in the community.  | Increase the offer and uptake of long acting reversible contraceptives to achieve national average expenditure.<br>Reduce unwanted pregnancies                           |
|                   | Sexual health – late HIV diagnoses | There will be an increase in the offer and uptake of HIV testing to diagnose people with HIV earlier across the system. New regional on-line services will also help increase access to HIV testing, as will outreach and promotion with higher risk and more vulnerable groups.   | Reduce late HIV diagnoses.   |

We will know we have been successful when:

- Every member of the public sector workforce in North London is a champion for prevention and taking proactive steps to close the health and wellbeing gap;
- Our residents, families and communities are supported to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing;
- There are fewer hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths;
- We close the health inequalities gap, through disproportionately greater improvements in health for people with mental health problems and learning disabilities, specific BAME groups, and those in the most deprived communities;
- We start to reverse the trend in childhood obesity, by proactively working across different settings to promote healthier eating and more physical activity among children and young people, as well as using our regulatory powers;
- Those working in North London become healthier, through increased levels of active travel, supporting positive mental health wellbeing, supporting employees to quit smoking and to eat more healthily, leading to reduced absences and increased productivity.

#### **In 2017/18 we will:**

- Ensure that a prevention focus is effectively embedded in all the other clinical workstreams in the plan.
- Seek to identify investment funding to take forward early implementation of the prevention priorities set out in the plan.

## **Health and care closer to home**

Working closely with all system partners, including hospitals, GPs, Community and Social Care, as well as with Patients/Residents and the voluntary sector, we will deliver the right care at the right time to the whole population.

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. 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, with the aim of reducing demand on the system over time. Social care and the voluntary sector will play a key role in the design, development and expansion of the future model.

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

North London has good services, the health and care closer to home model will focus on scaling these services up, reducing variation and making the care closer to home integrated network model the default approach to care and place based commissioning of services. We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for

some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed. The model will make sure services are focused on the care of people within neighbourhoods.

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

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

- **Developing 'Care Closer to Home Integrated Networks'** (CHINs<sup>1</sup>): These may be virtual or physical, and will potentially cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients;
- **Quality Improvement Support Teams** (QIST) will also operate from CHINs, to reduce unwarranted variation by providing hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients which will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes;
- **Extended Access:** Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Telephone triage, virtual consultations and online booking systems will be available for all patients;
- **Social Prescribing:** In line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by nine-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across North London; scaling up weight management programmes with integrated physical and wellbeing activities; reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception. The care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.

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1 CHINs is a working title only – name to be co-designed with patients and residents

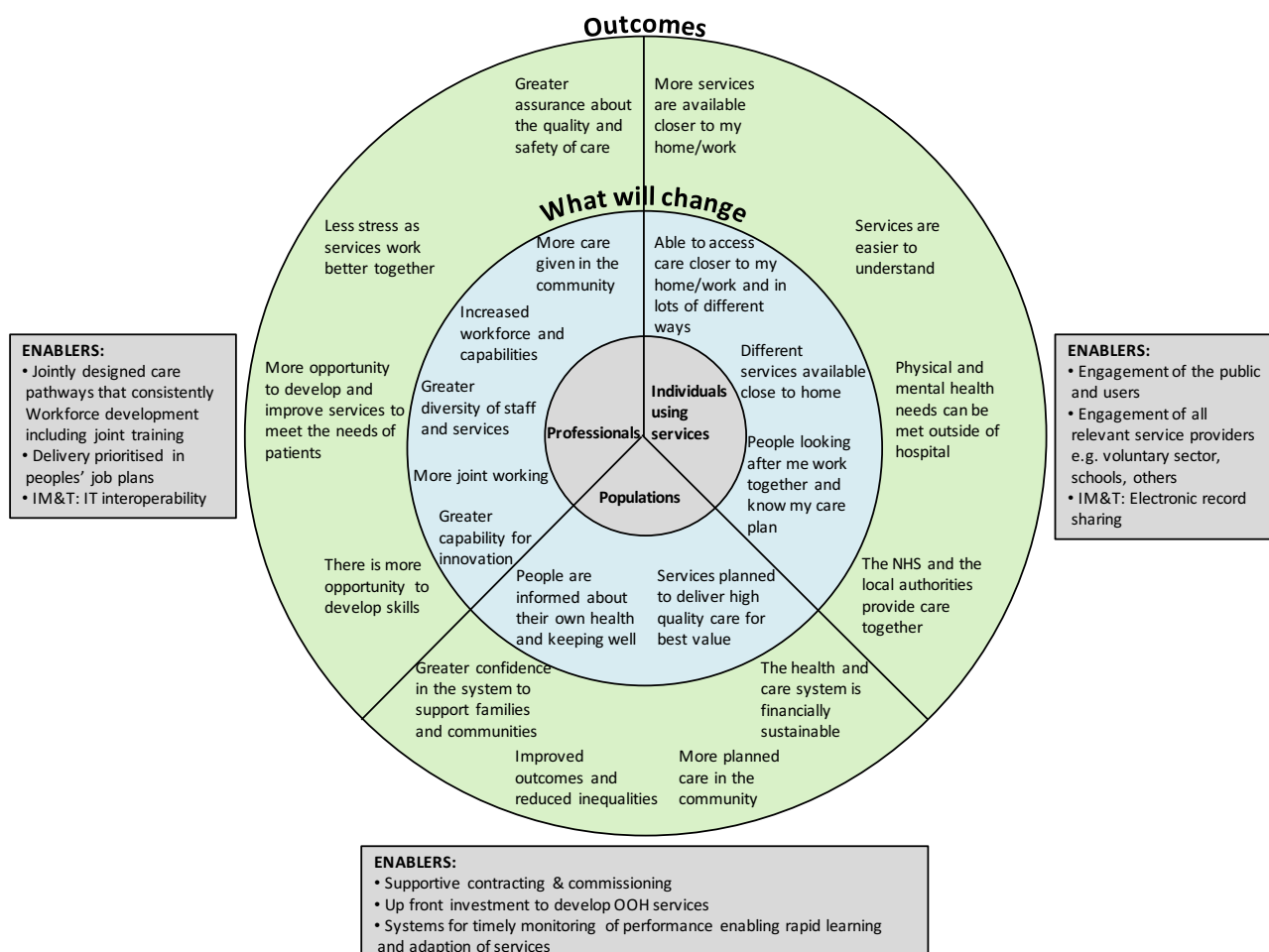
The impacts of three main strands of this workstream are detailed below:

| Initiative   | Description   | Deliverable   |
|--|---|---|
| <b>Improved access</b>                                 | Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Patients will be able to access a GP through a variety of different methods such as telephone and e-consultations as well as book appointments and access their records online.  | <ul style="list-style-type: none"> <li>• Improved patient satisfaction with access to primary care</li> <li>• Reduced number of patients with a primary care appropriate problem seen in A&amp;E or Urgent Care</li> <li>• A health and care system that is more resilient</li> </ul>   |
| <b>Quality Improvement Support Teams</b>               | Improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes.  | <ul style="list-style-type: none"> <li>• Reduction in unwarranted clinical variation</li> <li>• Reduction in activity and cost of secondary care services</li> <li>• Preventing people from dying prematurely</li> <li>• Enhancing quality of life for people with long-term conditions</li> <li>• Reduction in inequalities in health</li> <li>• Ensuring people have a positive experience of care</li> </ul> |
| <b>Care closer to Home Integrated Networks (CHINs)</b> | CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focused on the strengths of residents, families and communities | <ul style="list-style-type: none"> <li>• Reduction in clinical variation</li> <li>• Reduction in activity and cost of secondary care services</li> <li>• Preventing people from dying prematurely</li> <li>• Enhancing quality of life for people with long-term conditions</li> <li>• Reduction in inequalities in health</li> <li>• Ensuring people have a positive experience of care</li> </ul>             |

Improving outcomes will be the crucial measure of success of the care closer to home model. The benefits of our health and care closer to home model include:

- Improved patient satisfaction with access to primary care
- Reduced unwarranted clinical variation
- Prevention of people from dying prematurely
- Reduced inequalities in health
- Enhanced quality of life for people with long-term conditions
- More people have a positive experience of care and support to self-care
- Shared learning across CHINs and QISTs and ability to roll out best practice, new technology and new ways of working more quickly across North London

## Exhibit 4: Delivery of the Better Health for London outcomes through the health and care closer to home model



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

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

The Integrated Personal Commissioning site will:

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

## In 2017/18 we will:

- Offer improved access to Primary Care across the whole of North London: Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- Implement the first wave of 'Care Closer to Home Integrated Networks' (CHINs) in each of the boroughs and invest in the corresponding Quality Improvement Support Teams. We aim to achieve comprehensive coverage of these networks during 2018/19

## Urgent and emergency care<sup>2</sup>

We are all aware of the pressures faced in A&E departments throughout the country. Every year we hear about breaches of waiting times and ever-increasing the winter pressures. We know the system is overburdened and cannot meet expectations for performance and patient experience.

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations.

The Health and Social Care services within our five boroughs will be working collectively to solve problems that affect a person's care. We will explore new ways of delivering our services to provide the best quality services for the resources we have available. This will span from the moment somebody identifies that they have an urgent or emergency need through to when they return home.

The focus on urgent and emergency care services will reduce confusion about which service people should access, will reduce the number of unplanned admissions to hospital and will support people to return home from hospital as soon as possible. This will improve people's experience of the care they receive when unwell or in crisis and make sure that people have their care on a planned basis wherever possible.

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

In the future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the falls response part of the community based admission avoidance team. Mary will then be visited at home by the falls team on the same day, who will design a package of care to support Mary to stay at home. The falls team will be able to make a rapid appointment with her GP or a hospital specialist if they think that Mary would benefit from a medical opinion. Mary will then get the treatment and support that she needs, quickly, to help support her.

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<sup>2</sup> This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system

To do this we need to work with local people to understand the urgent and emergency care services that they need and would choose to access. We will work with local people in designing our services to better understand the way they want to use services for an urgent or emergency need.

**Our top priorities are:**

- To create a consistent and reliable Urgent and Emergency Care service by 2021 that is accessible to the public and easy to navigate, inspires confidence, promotes consistent standards in clinical practice and leads to a reduction in variation of patient outcomes
- To review current Urgent and Emergency Care services and compare them against the defined national and London-wide standards
- To implement a high quality Integrated Urgent Care model which complies with IUC ‘top 8’ requirements set nationally
- To develop high quality, responsive 7 day community services, enabling more care to be provided closer to a person’s home
- To develop an enhanced community based, admission avoidance model to support care being provided closer to a person’s home and to reduce the number of avoidable hospital admissions
- To develop high quality ambulatory care services across North London, supporting people to receive acute care on an outpatient/ day case basis and thereby reducing the number of avoidable hospital admissions

The projects that we will be starting with first will focus on:

| Workstream  | Description  | Initiatives  | Impact  |
|---|--|--|---|
| <b>Enhanced Community Based Admission Avoidance &amp; Ambulatory Emergency Care</b> | Developing high quality, responsive community-based services that work 7 days a week, and support someone to have their care closer to home and therefore not requiring admission to hospital or the need to attend an emergency department. | This focuses on: <ul style="list-style-type: none"> <li>• joining up of all community-based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access ;</li> <li>• developing services in acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment; and</li> <li>• developing admission avoidance models to support ambulatory / short stay community based care for paediatrics.</li> </ul> | Key benefits to be achieved include reductions in admissions and readmissions and improved patient experience |

| Workstream                   | Description  | Initiatives  | Impact  |
|------------------------------|--|--|---|
| <b>Acute Frailty Pathway</b> | Developing the care we provide for frail older people who become unwell to support them to be assessed and treated quickly, so they can remain in their home for as long as possible | <p>This focuses on:</p> <ol style="list-style-type: none"> <li>1. enabling rapid, early, risk-based assessments of elderly people by senior geriatricians and the provision of diagnostic support, therapy, mental health teams, access to care in the community 7 days a week and access to rehabilitation teams through a single point of access;</li> <li>2. enabling rapid treatment of frail older people by standardising services, processes and pathways across North London to ensure that only those requiring admission are admitted to hospital;</li> <li>3. enabling rapid discharge of medically optimised frailty patients.</li> </ol>  | Key benefits to be achieved include reducing variation, improving patient outcomes and improving patient flow   |
| <b>Last Phase of Life</b>    | Improving the quality of peoples' care within the last phase of their life, to support them to die in their place of choice  | <p>This focuses on:</p> <ol style="list-style-type: none"> <li>1. improving the care of care home patients in the last 12 months of life by embedding practice facilitators / case finders in the relevant local community palliative care service to identify, support and record care planning information for care and nursing home residents in their last year of life;</li> <li>2. Specialist Palliative Care (SPC) services working together to reorganise services around two hubs (north and south) to provide SPC advice 7/7 a week, enable Single Points of Access and to reduce inequity of provision;</li> <li>3. Telemedicine - remote Band 7 nurses will support 3-5 Band 5 nurses who visit patients and provide care in community and 'eSHIFT' technology will provide remote access to electronic patient records, enabling Band 5 nurses to communicate key clinical findings centrally, and be given expert advice on next steps.</li> </ol> | Key benefits to be achieved include reducing A&E admissions and non-elective activity, improving end of life care, improving patient experience, and improving the knowledge and care of the social care workforce. |



| Workstream                    | Description   | Initiatives  | Impact  |
|-------------------------------|---|--|---|
| <b>Integrated Urgent Care</b> | Improving and standardising access to Urgent Care across North London to avoid the need to attend an emergency department | This focuses on implementing a high quality Integrated Urgent Care model which brings together current urgent care services such as 111, GP out of hours, Pharmacy, Urgent Care Centres and Minor Injury Units to create a single, unified approach to urgent care in line with the London UEC designation standards   | Key benefits to be achieved include a reduction in A&E activity and an increase access to a locality GP/ Primary Care clinician   |
| <b>Simplified Discharge</b>   | Addressing the multiple different reasons that mean somebody's discharge from hospital back to their home is delayed      | This involves: <ol style="list-style-type: none"> <li>1. establishing a Trusted Assessor Model wherein health and social care professionals complete a single assessment of patients' needs, which can be shared, reducing duplication;</li> <li>2. developing 7 day community services to support discharge processes through the development of single access points, including a North London discharge referral form;</li> <li>3. improving patient flow through the hospital, ensuring the right care can be delivered at the right place at the right time through the implementation of the 'SAFER' patient flow rules;</li> <li>4. supporting shorter hospital stays by ensuring that, where appropriate, an assessment of on-going care and community support needs takes place in an environment familiar to an individual, either at home or using 'step down' beds;</li> <li>5. stroke - transformation of service delivery to implement a consistent approach to the management and delivery of stroke pathways across North London.</li> </ol> | Key expected benefits include reduction in delayed transfers of care, improved patient flow, reduction in readmissions, reduction in excess bed days and improved patient experience results. |

#### In 2017/18 we will:

- Join up all community based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access
- Develop services in all acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment on a same day basis with no overnight stay
- Develop admission avoidance models to support ambulatory/ short stay/ community based care for Paediatrics

- Implement simplified discharge for stroke patients
- Begin design work to improve and standardise access to Urgent Care across North London to avoid the need to attend an emergency department

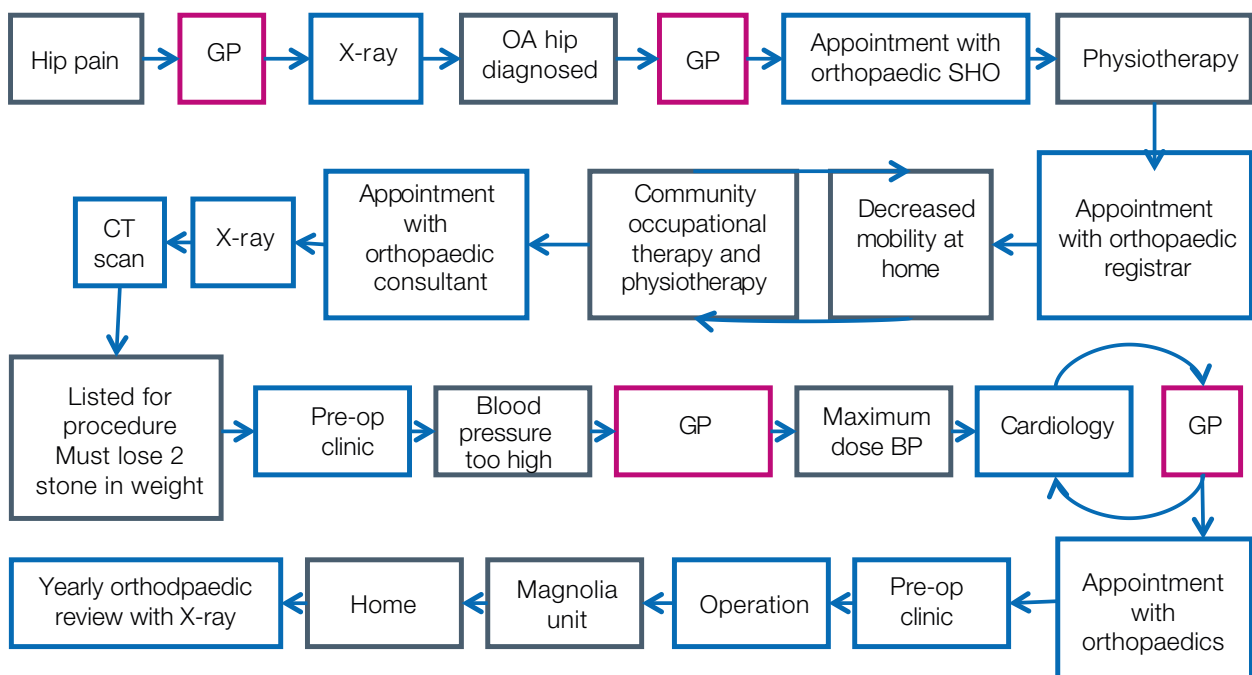
## Planned care

Building on the opportunities identified through RightCare<sup>3</sup>, we will deliver the best value planned care services across North London to reduce unwarranted variation in planned care across providers in North London. This will include;

- Reducing variation in the length of stay in hospital
- Reducing variation in the number of outpatient appointments received by patients with similar needs.
- Optimising pathways to ensure patient safety, quality and outcomes, and efficient care delivery.
- Standardising Procedures of Limited Clinical Effectiveness (PoLCE), consultant to consultant (C2C) referrals and referral threshold policy across North London to ensure parity of care regardless of patient's postcode.

Below is an example of a journey from a patient who was suffering from hip pain. Due to handoffs, inefficiencies and suboptimal advice and information transfers, this patient's pathway continued for more than three years.

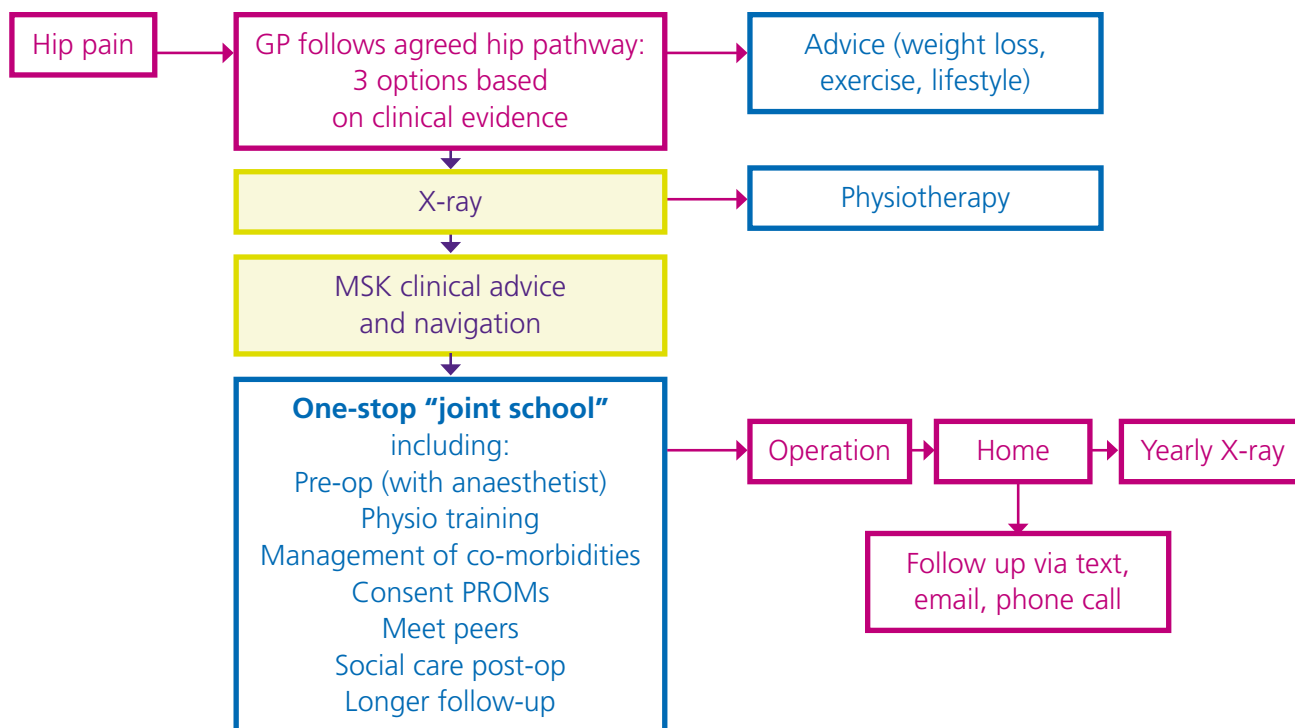
**Exhibit 5: Example of previous patient journey**



Moving forward the planned care workstream will seek to create a system where patient journeys are as efficient, safe and well managed as possible. As a result the new pathway will look more like the below and last a much shorter amount of time.

<sup>3</sup> RightCare Atlas of Variation in Healthcare, September 2015

## Exhibit 6: Example of revised patient journey



As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience. In order to deliver this the workstream will adopt the following principles:

- Standardised approach to pathway delivery across CCGs and hospitals
- Senior clinical triage and advice with access to multidisciplinary triage where appropriate
- Majority of outpatients managed within a community or primary care based service
- Community services supervised by senior clinicians
- Diagnostics ordered once and only when clinically necessary – reduce over ordering
- One stop service/co-location to improve patient experience
- Follow-up once, and only when necessary
- Patient centred, safe services
- Payment mechanism based on whole system management and clinical outcomes
- Quality of GP referrals and clinical thresholds improved – protocol driven
- Educational support for primary care through training and development led by senior clinicians
- Provision of health and advice telephone lines for clinicians
- Integrated IT/information portal
- Use of technology to deliver virtual services
- Standardised approach to Procedures of Limited Clinical Effectiveness (POLCEs)
- Standardised approach to consultant to consultant referrals

Drawing on local and global examples of best practice and building on the evidence, we will redesign pathways with local clinicians and patients, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics. A key enabler to the work will be the provision of enhanced advice, based on competency to make sure everyone within the system, including patients, have the right access in order to manage their conditions.

We will leverage the following opportunities for improvement to planned care pathways:

- clinical advice and navigation: ensuring competency based advice and navigation for patients so they are managed in the most optimal way for their condition
- standardised POLCE and consultant to consultant policies: ensuring parity of care and reduction in

handoffs and unnecessary procedures

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

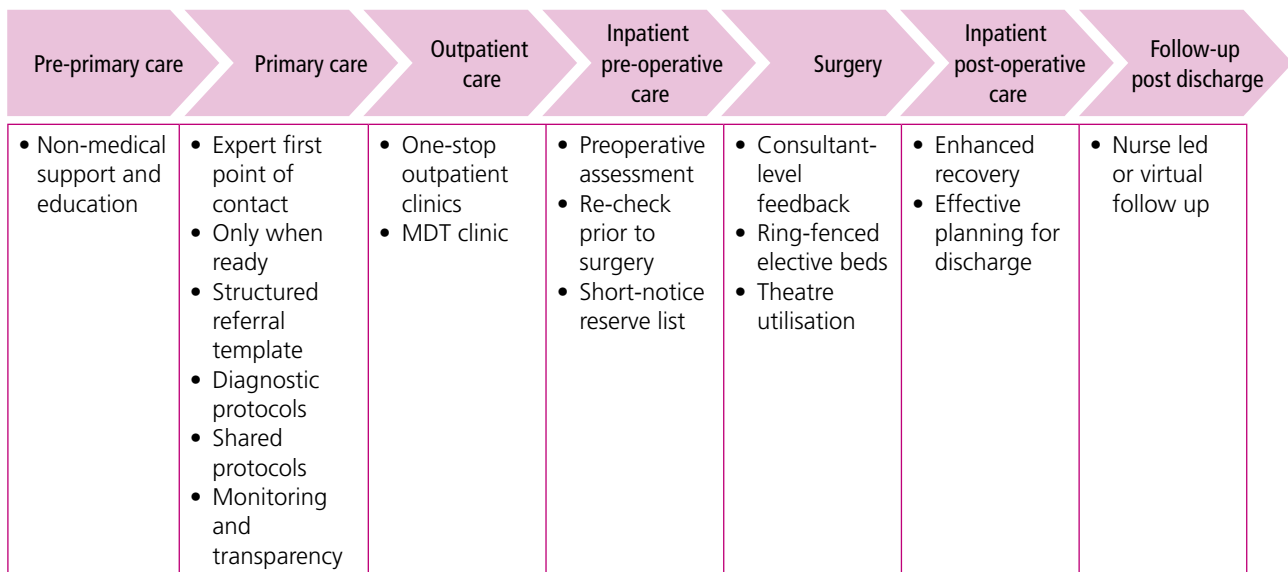
Below is an outline of the eight areas of focus and the resulting benefits for the system:

| Workstream                                     | Initiatives                       | Description   | Impact  |
|--|-----------------------------------|---|---|
| <b>Group 1 'High volume'</b>                   | MSK                               | High volume referrer where extensive work is already being undertaken across North London                               | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> <li>• Improved utilisation of inpatient services</li> </ul> |
|  | Dermatology                       |   |   |
| <b>Group 2 'Integrated CAN'</b>                | Clinical Advice and Navigation    | Single point of access for advice and navigation and referral management  | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> </ul>   |
| <b>Group 3 'Work in train'</b>                 | Neurology                         | Service that already has work being done within North London that could be adopted using 'follow the fastest' principle | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> <li>• Improved utilisation of inpatient services</li> </ul> |
|  | Urology                           |   |   |
|  | Ophthalmology                     |   |   |
| <b>Group 4 'Fastest First'</b>                 | Gynaecology                       | Service that already has work being done within North London that could be adopted using 'follow the fastest' principle | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> </ul>   |
|  | Gastroenterology                  |   |   |
|  | Colorectal Surgery                | High volume service, identified as priority through stocktake and/or Right Care data                                    | <ul style="list-style-type: none"> <li>• Improved utilisation of inpatient services</li> </ul>  |
| <b>Group 5 'Avoiding the postcode lottery'</b> | PolCE                             | Standardisation of thresholds and policy across North London to ensure parity of care provision.                        | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> </ul>  |
|  | Consultant to consultant referral |   |   |
| <b>Group 6</b>                                 | Diagnostics                       | Standardisation of diagnostics thresholds and ordering across North London  | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Improved utilisation of diagnostics</li> </ul>   |

| Workstream                     | Initiatives  | Description   | Impact  |
|--------------------------------|--|---|---|
| <b>Group 7<br/>'Phase 2'</b>   | Vascular Surgery                                     | High volume service, identified as priority through stocktake and/or Right Care data                                    | <ul style="list-style-type: none"> <li>• Integrated pathways and services</li> <li>• Reduction in variation in length of stay</li> <li>• Standardisation of service and pathways across North London</li> <li>• New financial models based on whole system design</li> <li>• Improved patient experience</li> </ul> |
|                                | Breast Surgery                                       |   |   |
|                                | Hepatobiliary & pancreatic surgery, Upper GI surgery |   |   |
|                                | General Surgery                                      |   |   |
|                                | ENT  | Service that already has work being done within North London that could be adopted using 'follow the fastest' principle |   |
| <b>Group 8 'Local schemes'</b> | Local Schemes  | Local CCG specific schemes that do display any initial benefit to North London level work                               | <ul style="list-style-type: none"> <li>• New local models based on the need of borough or area specific population</li> </ul>   |

To deliver on the above, a series of interventions will be put in place at each stage of the planned care pathway. These are illustrated and detailed below.

### Exhibit 7: Interventions that support optimised planned care pathways



Implementation of these high level interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the

first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicians at the initial appointment. Structured referral templates are currently used by some providers and commissioners in North London to good effect, but would be used more widely as part of the optimised planned care pathway.

- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatments as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue regarding the quality of referrals and continuously improve their own referral practices.
- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physiotherapists and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied:** patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced planned care beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for planned care patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

## In 2017/18 we will:

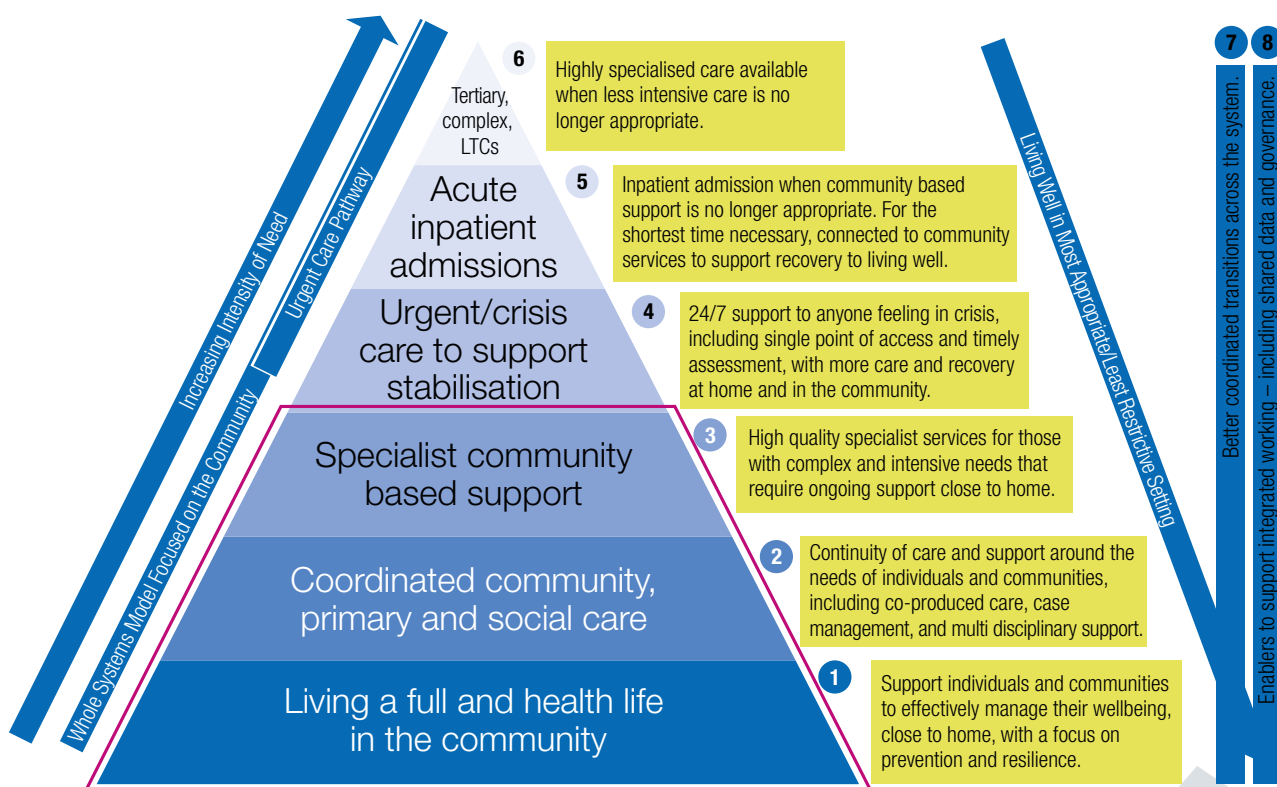
- Work with local clinicians and patients, responding to local needs and opportunities to redesign pathways in:
  - > MSK and Dermatology
  - > Urology, Neurology and Ophthalmology
  - > Gynaecology, Gastroenterology and Colorectal Surgery
- Design a single point of access for advice and navigation and referral management
- Standardise thresholds and policy across North London to ensure parity of care provision through a review of Policies of Limited Clinical Effectiveness and Consultant to Consultant referrals
- Standardise diagnostics thresholds and ordering across North London

## Mental health

Our ambition is that unless someone requires highly specialised care, they will be able to receive the care they need with North London, and not require an out of area placement. By investing in community based care, we aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds.

We will develop a 'stepped' model of care supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs. The provision of appropriate social care is a key success factor for people with long-standing mental ill health and this will be central to the success of the stepped model.

**Exhibit 8: The mental health 'stepped' model of care**



We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. We want to improve overall mental health outcomes across North London and reduce

inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will work towards achieving the key mental health access standards:

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

Through this work we aim to bring all of North London up to the same level of care quality. No matter where in North London you live, you can expect to receive the same high quality care. This includes:

- increase mental health basic awareness, reduce stigma and increase mental health self-awareness
- support at risk population to stay well
- provide more accessible mental health support delivered at locality level
- increased alternatives to admission and support for discharge to enable more people to live well in the community, with better crisis support
- eliminate the need for out of area placement for female service users who require psychiatric intensive care via the female PICU initiative
- give more women access to specialist perinatal mental health services
- make sure more children have access to mental health support and unless highly specialised care is required, eliminate out of area placements for children requiring inpatient support
- more people in A&E and on physical health inpatient wards to have their mental health needs supported
- support more people to spend more time at home, rather than in hospital
- For North London to become more dementia friendly

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

Broadly the programme covers mental health support for all age groups and the current identified initiatives include:

- Community resilience
- Primary care mental health
- Acute pathway – including Health Based Place of Safety, S136, alternatives to admission
- Female psychiatric intensive care unit (PICU)
- Child and adolescent mental health services (CAMHS) and Perinatal mental health
- Mental health liaison
- Dementia

Over time other areas may be identified which have the potential to deliver savings. Currently out of scope are specialist commissioned mental health services (excluding Tier 4 CAMHS) although this may be reviewed over time.



In the development of this model of care we are committed to coproducing with those who have lived experience. We have established an 'experts by experience' group, the EbyE Board, with representation from across our 5 boroughs. The group formed in December 2016, and going forward will be involved in all of our areas of work, and support us in further engagement and coproduction across North London.

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

| Workstream                                   | Description   | Impact   |
|--|---|--|
| <p><b>Improving Community Resilience</b></p> | <p>Both for the general population, and those at risk of developing mental ill health or of becoming more severe.</p> <p>For the general population this includes a health promotion campaign aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma.</p> <p>For the at-risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support<sup>4</sup>; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies<sup>5</sup>. This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscence therapy and engaging with local shops to raise awareness.</p> | <ul style="list-style-type: none"> <li>• 3% reduction sick days</li> <li>• 165 new jobs via IPS scheme</li> <li>• Reduction in suicide rate</li> <li>• Improved well-being for the general and at-risk population</li> </ul> |

<sup>4</sup> Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within North London)

<sup>5</sup> Five Year Forward View - Reduce suicide by 10%

| Workstream   | Description   | Impact   |
|--|---|--|
| <b>Increasing access to primary care mental health services</b>    | <p>Ensuring more accessible and extensive mental health support is delivered locally within primary care services. This will be developed as part of the Care and Health Integrated Networks ; enabling physical health and mental health needs to be treated and supported together<sup>6</sup>. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services<sup>7</sup>, with more care to be offered through Care and Health Integrated Networks rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need<sup>8</sup> with a focus on supporting people with long term conditions. In 2017/18 the Primary Care Based Mental Health service is being rolled out to all Islington CCG practices. This service provides assessment and support within primary care, as well as training for GPs, so that more people can have their mental health supported in primary care rather than secondary care.</p> | <ul style="list-style-type: none"> <li>• 30% reduction in secondary care MH referrals</li> <li>• Delivery of national IAPT targets</li> </ul>  |
| <b>Improving the acute mental health pathway</b>                   | <p>Building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to hospital admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to provide more effective discharge, enabling people to live well in the community. In the southern part of North London a plan is being developed to close the A&amp;E HBPoSs, and move to a purpose built suite at Highgate Centre for Mental Health, this is expected to open in 18/19. In the north section of North London there is the potential to develop a complex rehab ward.</p>   | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved stakeholder satisfaction</li> <li>• Reduced LoS</li> <li>• Avoidance of need for additional inpatient beds.</li> <li>• Bed occupancy maintained at 95%</li> <li>• HBPoS provision to meet North London needs</li> </ul> |
| <b>Developing a female Psychiatric Intensive Care Unit (PICU):</b> | <p>It is important to facilitate local provision of inpatient services to female patients requiring psychiatric intensive care. There is currently none available in North London. Patients will be able to remain close to their communities, with a more streamlined and effective pathway with the focus on recovery. A potential site within North London has been identified, and work is underway to develop the plan further.</p>  | <ul style="list-style-type: none"> <li>• Eliminate out of area placements</li> <li>• Improved quality of provision and patient experience</li> <li>• Reduced LoS</li> <li>• Financial savings.</li> </ul>  |

6 FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within North London)

7 Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within North London)

8 Five Year Forward View – increased IAPT to reach 25% of need by 2020/21

| Workstream   |                   | Description   | Impact  |
|--|-------------------|---|---|
| <b>Investing in mental health liaison services</b>                                   |                   | By scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments (EDs), we can ensure more people in Emergency Departments and on inpatient wards being treated for their physical health problems will also have their mental health needs assessed and supported. | <ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved A&amp;E performance</li> <li>• Average of 1 day reduction in length of stay</li> <li>• Reduction in readmissions</li> </ul>  |
| <b>Investing in a dementia friendly North London</b>                                 |                   | Looking at prevention and early intervention, supporting people to remain at home longer and supporting carers. This will be delivered in line with national standards around dementia.   | <ul style="list-style-type: none"> <li>• A dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.</li> </ul>   |
| <b>Focusing on perinatal and child and adolescent mental health services (CAMHS)</b> | Shared dataset    | Develop shared dataset to enable comparison and shared learning across North London   | <ul style="list-style-type: none"> <li>• 32% of children with a diagnosable condition being able to access evidence-based services by April 2019</li> <li>• Reduction in LoS and admissions</li> <li>• Elimination of OOA placements</li> <li>• Investment in outreach offer</li> </ul> |
|  | Eating Disorders  | Invest in eating disorders  |   |
|  | Workforce         | Planning for a workforce that meets the mental health and psychological well-being needs of children and young people in North London, including CYP IAPT workforce capability programme  |   |
|  | Transforming Care | Supporting children and young people with challenging behaviour in the community, preventing the need for residential admission   |   |
|  | Perinatal         | Develop a specialist community perinatal mental health team so that more women have access to evidence based specialist perinatal mental health care  |   |
|  | Child House Model | Following best practice to support abused children in North London  |   |
|  | Crisis Pathway    | Develop an North London crisis pathway that includes 24/7 urgent and emergency mental health service for children and young people with care delivered as close to home as possible for children in crisis, this includes local commissioning of Tier 4 CAMHS, and review of S136 provision |   |
|  | Youth Justice     | Work with NHS England to develop co-commissioning model for youth justice   |   |

### **Focusing on perinatal and child and adolescent mental health services (CAMHS):**

We know 50% of all mental illness in adults begins before 14 years of age and 75% by 18<sup>9</sup>. There is significant financial cost associated with perinatal mental ill health along with negative social/emotional impacts on a child's life, health and wellbeing<sup>10</sup>, Focusing on children and young peoples' mental health and wellbeing and perinatal mental health as key priorities we can improve the long term mental health outcomes for our population. The eight priority areas identified above form

<sup>9</sup> Cavendish Square Group

<sup>10</sup> Centre for Mental Health and London School of Economics

the joint aspect of the North London Children and Young People (CYP) Transformation Plans. The principles of THRIVE<sup>11</sup> will be used as an overarching approach with the aim of at least 32% of children with a diagnosable condition being able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

There are a number of interdependencies across the North London mental health workstream and the other elements of our programme of work. Other areas of work such as workforce are crucial in identifying the future workforce we need in order to deliver these initiatives, which includes new roles and developing new skills.

The Estates workstream is another important enabler of a number of our initiatives. This includes the redevelopment of the Barnet, Enfield and Haringey Mental Health Trust, St Ann's site and the Camden and Islington Foundation Trust St Pancras site in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site.

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

- Transform the current inadequate acute mental health inpatient environments on both sites
- Provide more therapeutic and recovery focussed surroundings for patients and staff
- Improve clinical efficiency and greater integration of physical and mental health care
- Release estates across the trusts, to enable development of community-based integrated physical and mental health facilities
- Develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence
- Provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

The delivery of these initiatives, and the realisation of the proposed benefits, is critically dependent on increased investment. For 2017/18 to date we have identified investment of an additional £1.3m and have succeeded in accessing a further £2.5m from national transformation funding.

Priorities for mental health are being taken forward in line with available funding at this stage and with a focus on the ability to test new models of provision and strengthen the evidence base for effectiveness. The STP remains committed to expanding the pace of transformation in mental health care as resources, including national transformation funding become available.

### **In 2017/18 we will:**

- Roll out primary care mental health services in Islington
- Establish integrated IAPT capacity in Haringey and Islington
- Map and design the acute care pathway
- Establish a specialist community perinatal mental health team
- Bid for local commissioning of Tier 4 CAMHS
- Develop core 24 hour mental health liaison services at UCLH and North Middlesex
- Plan the development of a local female PICU to be put in place in 2018/19
- Seek to identify further investment funding to take forward implementation of other priorities in line with the plan

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<sup>11</sup> THRIVE is a population approach to children and young people's mental health developed by the Tavistock and Portman Foundation Trust and Anna Freud Centre which aims to replace the traditional tiered model with one which tailors the response of services to the presenting needs and expressed preferences of young people.

## Cancer

Working in partnership as the UCLH Cancer Collaborative, Commissioners and providers across north central and north east London and west Essex joined together in late 2015 to form the national Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, under the auspices of NHS England's new care models programme.

We aim to save lives and improve patient outcomes and experience for those with cancer in North London and beyond by driving changes in delivery of cancer care across a whole health system that will save hundreds of lives, reduce variation and improve quality of care.

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

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

Our top priorities are to:

- **Improve survival:** through earlier diagnosis, implementation of best practice and improved access to novel diagnostics and therapeutics
- **Improve patient experience:** by reducing pathway delays (sustainable delivery of 62 day standard), supporting care closer to home and developing integrated patient pathways across primary and secondary care, physical and mental health, health and social care
- **Reduce cost:** using new models of care, reducing variation in pathways and closer integration between providers and across the commissioning landscape
- **Generate new income:** by capitalising on our position of natural competitive advantage in translational and clinical cancer research

Faster diagnosis will be delivered at pace and scale through a range of approaches including the use of decision support tools mobilising primary care in the early detection of cancer, driving the straight to test agenda and effective modelling to focus diagnostic capacity most efficiently on areas of need. Quality of care, variation in treatment and outcomes and improved cancer waits will be tackled through implementing agreed whole pathways of care through diagnosis and treatment to living with and beyond cancer and end of life care. Efficiencies can be further consolidated through innovative service delivery models and partnerships to deliver personalised cancer care from diagnosis to living with cancer and beyond.

Our cancer workstream builds on the platform established by the National Cancer Vanguard and encompasses a breadth of priorities, primarily the recommendations from the National Cancer Taskforce. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across North London, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models, implement interventions to increase screening uptake rates, lead innovation in cancer diagnostics and deliver a programme to improve awareness of cancer symptoms in primary care.
- **Pathway improvement:** across the region there is an on-going challenge to ensure that patient' rights under the NHS constitution concerning waiting times for cancer diagnostics and treatments are consistently realised. We are working together as a whole system to understand where the 'pinch points' are that cause delays in pathways, and to be able to 'flex' diagnostic capacity and workforce. We have already enabled reconfiguration of some small volume MDTs to improve diagnostic pathway and workforce efficiency and resilience.
- **Living with and beyond cancer:** working with patients, hospitals and GP practices to support long term self-management, increase care in community settings and improve both understanding and communication of patients' holistic needs between healthcare professionals and with patients.
- **End of life care:** evidence indicates a need for service improvement to ensure that patients are better supported to choose the location for their last days of life. There is also growing evidence indicating a need for better informed clinical and patient decision making concerning the value of therapeutic interventions in the last days of life.
- **New models of care:** we are developing the case for a single provider model for radiotherapy in North London, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and links the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality standard for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer took place in September 2016.
- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we are developing balanced scorecards which can be made available to MDTs, providers and commissioners through a free to access web-based platform. A project on interventions in the last three months of life is about to launch in conjunction with PHE.
- **Cancer Academy:** a new Academy is being launched to provide infrastructure and expertise to develop programmes for patients, primary care, multidisciplinary teams, cancer professionals and staff working in cancer clinical research. The Academy is working closely with partners across London as well as with UCL to collaborate effectively in programme design and delivery.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

We are focused on achieving a step change in key patient outcomes including:

- Deliver Cancer Taskforce aspiration for proportion stage 1 & 2 diagnoses by 2020
- Reduce to the national average or below the proportion of patients diagnosed in an emergency setting
- Achieve and sustain delivery of the 62 day access standard from the 2nd quarter of 2017/18
- Improve patient experience to achieve or exceed national average performance
- Reduce variation in these outcomes across NCEL and close the gap with the best performing regions, aiming for no CCG to be in the lowest quartile for any of these outcomes by the end of 2018/19

- Aiming to improve overall one year survival rate and reduce the current large variation seen across North and East London

### **In 2017/18 we will:**

- Achieve a shift in the stage at which patients receive a cancer diagnosis, through a range of access and awareness improvements.
- Agree new care models in chemotherapy and radiotherapy to reduce variation in quality, improve financial sustainability and support care closer to home
- Work to define and capture the outcomes that matter to patients along their pathway from diagnosis to living with and beyond cancer so that this information can be fed back to patients, clinicians, providers and commissioners
- Undertake analysis that will improve patient experience and informed decision on therapeutic interventions during the last days of life.
- Define and implement best practice cancer pathways and service delivery models.
- Reduce wastage and improve value for money from cancer drugs spend

## **Maternity**

In 2014-15 there were approximately 20,000 babies born to North London residents and 24,000 births delivered by the local Trusts. In North London there are specialist maternity services centred on a single tertiary level neonatal unit, as well as obstetric, midwifery led-units and home births taking place. The population is diverse and growing and experiences significant fluctuations as people using health and care services move in and out of the city. North London has significant areas of deprivation as well as older women, more likely to be overweight or obese and likely to experience medical complications in pregnancy such as gestational diabetes, when compared with the national averages.

Across North London, fewer women access services in midwifery-led settings, within birth centres and at home than would be clinically indicated. While community midwifery antenatal care is offered by all providers, more care can be provided close to home or work. Women are not being offered choice of care setting or receiving continuity of antenatal or postnatal care. There is a lower than national average score for experience during the antenatal, intrapartum and postnatal periods and perinatal mental health support is varied.

In November 2016, North London was successful in a bid to become an early adopter of the National Maternity Transformation Programme. This programme sets out to achieve the ambitions of the Better Births report - the output from the National Maternity Review conducted earlier in 2016.

Based on the Better Births report, the primary objectives for their Maternity Programme are:

- To improve the experience of women accessing maternity services in North London
- To provide increased community-based choice across the pathway of care and greater access to midwifery-led care within birth centres and for home birth
- To improve continuity of maternity care, including continuity of carer
- To improve the safety of maternity care provided to women
- To improve the quality of information offered during pregnancy so that women can be supported to make choices that are most appropriate for their needs
- To develop a single point of access or centralised booking service

The key areas of transformation have been identified and summarised into three main categories:

**Personalisation** – We will redesign maternity provision so that women and their families will be able to choose maternity care in a variety of settings and by the most appropriate clinicians. This will be achieved through the development of innovative models of care, advice and education

which, where possible, will take place outside of the acute hospital setting. This will require staff development, process improvement and the development of appropriate early information around risk to choice and continuity. The gap between the actual and desired place of care will be reduced and births in midwifery-led settings (where appropriate) will be increased. Women will have an engaged professional advocate (usually their midwife) to provide unbiased support and advice. Maternity teams will work closely with the emerging perinatal mental health services to develop improved services for women affected by mental ill health.

**Continuity** - The majority of care will be provided in community hubs by midwives working in partnership with other agencies including:

- Social Services
- Health Visiting
- Family Nurse Partnership
- Housing
- Contraception
- Mental health
- Neonatal outreach with classes offered to all (antenatal, breastfeeding, parenting, pre-conceptual care for next pregnancies)

Autonomous teams of midwives will be supported by named obstetricians with the governance, training, protocols and processes to work in any facility within the North London system. There will be continuity from the initial booking visit through the availability of a centralised booking service offering appointments, information and advice. Maternity information will be shared across North London organisations through the implementation of electronic medical records. Continuity of postnatal care will be improved through revised models of care and care plans.

**Safer Care** – Governance and training will be centralised so the system becomes more responsive and learns from events. Duplication will be reduced with prompt response to abnormal results achieved through equal access to all systems partners (with a woman's permission). We will continue to reduce perinatal deaths through the Still Birth Care Bundle, investigating deaths using a standardised review process, increasing utero transfers to L3 units, reviewing capacity and escalating 'red' outcomes for peer review. Benchmarking and driving improvement plus ensuring the Maternity Services dataset is completed by all providers. Care will be delivered by a multi-profession workforce which is able to work across organisations to support new models of care and improve staff safety levels.

The programme will be delivered through four workstreams, which address different elements of the transformation plan. However, because of the interdependencies between the workstreams, the working groups will need to be cross cutting. For example, the work on improving community care through the establishment of community hubs is dependent on the work to establish systems for collaborative working. The establishment of a single point of access is dependent upon the work on choice.

Those elements of work on safer care, which don't fall specifically into one of the four workstreams, will be picked up within a Quality and Safety Subgroup of the Local Maternity Services Board.

Furthermore, given the considerable body of research suggesting that foetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, the Partnership will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy.

In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improving the diet of women of reproductive age has the potential to reduce the health needs of both women and children in the longer term.



Below is an outline of our plans in more detail:

| Workstream   | Initiative   | Description/Deliverable  | Impact  |
|--|--|--|---|
| <b>Ensuring equality of choice for all North London women regarding place and type of care</b> | Identify current birth settings and which are chosen at present  | Detailed mapping of current offer for birth, antenatal and postnatal care by each Trust has been completed.  | <ul style="list-style-type: none"> <li>• Improvement in patient satisfaction in relation to choice and information offered.</li> <li>• Increased score within CQC survey relating to choice questions. More women say they are offered choice of place of antenatal, birth and postnatal care.</li> <li>• Improved and streamlined systems for clinical staff.</li> </ul> |
|  | Determine factors impacting choice of birth setting  | Engage service users to understand the factors that impact choice.   |   |
|  | Identify current antenatal and postnatal settings and which are chosen   | Map key blockers to ensuring choice is offered and perceived as such by women.<br>Map the current processes and how staff and women perceive them. |   |
|  | Determine factors impacting choice of antenatal and postnatal settings   | Engage women to understand what choice means to them.  |   |
|  | Standardise the process for offering choice of care setting at referral  | Engage staff to understand how these systems could improve.  |   |
|  | Ensure women have equal access to a range of antenatal, birth and postnatal settings whichever Trust they choose | Review information available and standardise.  |   |
|  |  | Consider a North London wide website for information.<br>Produce standardised decision making tools, linking to single point of access work.       |   |
| Review guidelines, milestones and workforce to ensure able to implement new models of care.    |  |  |   |

| Workstream                                      | Initiative   | Description/Deliverable  | Impact   |
|---|--|--|--|
| <b>Improving community services</b>             | Mapping of existing community services                   | Detailed mapping of current service locations and activity has been completed. Further mapping to identify other co-located services to follow.  | <ul style="list-style-type: none"> <li>• More care available closer to home or work for women outside an acute setting.</li> <li>• Clear pathways of care across geographical boundaries.</li> <li>• Improved continuity of carer for women.</li> <li>• Improved satisfaction for staff in being able to provide continuity.</li> <li>• Improved postnatal care, demonstrated through improved CQC survey scores and London continuity audits.</li> <li>• Reduced blood spot screening Sis.</li> </ul> |
|   | Identification of maternity activity at community sites  |  |  |
|   | Mapping of existing processes underpinning services      | Detailed mapping of antenatal and postnatal pathways including for out of area women and those from in area who birth outside to be completed.   |  |
|   | Development of North London wide community model of care | A new vision for community services, including models of care and pathways to be developed in conjunction with stakeholders.   |  |
|   | Development of North London wide antenatal pathway       | Develop a plan for the configuration of hubs and other locations, including staffing, IT etc.  |  |
|   | Development of North London wide postnatal pathway       | Develop policies, a training plan and materials.   |  |
|   | Implementation of community hubs                         |  |  |
|   | Reconfiguration and training of North London workforce   |  |  |
|   | Communication of change                                  |  |  |
| <b>Implementation of single point of access</b> | Determine existing access models                         | Mapping to identify current booking patterns is complete.  | <ul style="list-style-type: none"> <li>• Increased level of informed choice about type and location of care at beginning of pregnancy.</li> <li>• Increased rates of early booking to meet screening target at 10+0 weeks.</li> <li>• Reduced levels of DNAs, reduced levels of multiple appointments and bookings.</li> <li>• Streamlined systems within maternity services.</li> </ul>   |
|   | Determine preferred future model                         | In-depth review of referral processes to be undertaken.  |  |
|   | Ensure staff equipped to transition to new model         | Work with women and families to map factors, which shape choices made at booking.  |  |
|   | Refine literature offered to women                       | Develop vision for new model by examining what is available elsewhere and engaging with stakeholders to determine the most appropriate for North London.<br><br>Review and refine current information in conjunction with choice and community work streams. |  |

| Workstream  | Initiative  | Description/Deliverable  | Impact  |
|---|---|--|---|
| <b>Implementation of collaborative working approach</b> | Implementation of shared processes and procedures | Working closely with work stream 2 this work stream is about enabling the establishment of community hubs and the ability for staff to work across the system. | <ul style="list-style-type: none"> <li>• A mobile workforce that can be flexed across the system.</li> <li>• Improved demand management at times of increased activity.</li> <li>• More efficient use of maternity services across North London.</li> <li>• Improved continuity of care for women with the greatest medical and social need.</li> </ul> |
|   | Implementation of shared communication approach   | Governance and indemnity systems and processes will be reviewed and changes required enabling staff to work across the system.                                 |   |
|   | Implementation of a mobile workforce              | Pathways and models of care into and out of acute care to the community will need to be mapped.  |   |
|   | Enabling shared access to patient data / IT       | Along with current training systems and materials so that a new models of education and training can be developed (As per work stream 2).                      |   |

**In 2017/18 we will:**

- Standardise the process for offering women a choice of care setting at referral in North London
- Ensure women have equal access to the different birth settings and antenatal care/postnatal care settings at whichever North London Trust they book with
- Improve Community Services through a review of current pathways and provision that will lead to the design of community hubs
- Work with relevant partners to design a single point of access for maternity services

**Children and Young People**

Children and young people are a significant proportion of the total population of North London (approximately 25% to 30%). The health and wellbeing of our children and young people today will determine the health and wellbeing of all future generations. Our service transformation therefore must include a specific focus on our younger population.

Our simple aim is to ensure children and young people are as happy, safe and healthy as possible and have access to opportunities that allow them to achieve their full potential.

We are committed to reducing health inequalities with a focus on prevention and early intervention. We believe that we need to work across health, education and social care in North London to do this, particularly maximising the potential of nurseries and schools to improve health and wellbeing of our children and young people.

We know that poverty, deprivation and inadequate housing are the greatest determinants of poor health and wellbeing outcomes in children and young people and we face significant demographic challenges. We also know that issues such as domestic violence can impact negatively on the mental

health and wellbeing of children. Our case for change demonstrated that 30% of local children grow up in child poverty, with 6% living in households where no one works. Four of our five boroughs are in the top 10% of areas in England for the number of homeless households with a priority need, and all five are in the top 10% or number of households in temporary accommodation.

In response to these challenges, we have established a North London-wide Children and Young People's Network which will champion children and young people's service development and drive up quality and efficiency. Our priority areas are:

**Paediatric elective and emergency surgery** - Children & Young people should have equal access to surgery based on clinical need. Surgery should be undertaken as close to home as possible by staff with the requisite training and skills. There is opportunity to commission and deliver surgery differently across the footprint to achieve high quality care whilst at the same time realising economic benefits.

**School readiness by five** - Supporting children to have the very best start in life is very important to their future health and life opportunities. However, we know a third of our children in North London do not reach a good level of development in preparation for school. We will explore how to work together to have the biggest impact on this area, in particular by improving oral health of children (tooth extraction is the biggest cause of hospital admission nationally in school aged children five to nine years of age) and by improving children and young people's speech, language and communication.

**Long term conditions** - Asthma is the most common long term condition in the UK and, on average, affects three pupils in every school classroom. We will draw on the London paediatric asthma standards to ensure children and young people are routinely followed up by their GP practice after an asthma related A&E attendance or admission; to ensure every registered asthmatic has a written asthma management plan and an annual health review, which will include correct inhaler technique and medication review; and to extend the Asthma Friendly Schools Initiative successfully piloted in Islington.

**Reducing emergency attendances and admissions** - The network will play a pivotal role in supporting the delivery of reduced paediatric A&E attendances and emergency hospital admissions by 20% by March 2021. This will mean new models of care will be tested and developed across the footprint.

In addition to the areas above, the network will promote an all age, life course approach across all other workstreams within this plan.

To tackle obesity and the number of children who are overweight, we will promote active travel, sport and play for children in schools, encouraging schools to deliver the Take 10, Active 15, Walk a daily mile initiatives that have been successfully adopted in other parts of the country. By 2020/21, our aim is that four out of five early years' settings and schools in North London will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

Working with the Mental Health workstream of this plan, we will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families.

We will capitalise on the universal services of MIND, Place2Be and established voluntary sector initiatives like **Hope Tottenham** that are already working directly with families and young people.

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

We will work collaboratively with the mental health workstream to deliver the Child and Adolescent Mental Health Services (CAMHS) and perinatal initiatives as detailed above. We will explore ways to develop the Partnership and link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy and to reduce the health needs of children in the longer term.

#### **In 2017/18 we will:**

- Engage with the other workstreams in the partnership to support the delivery of their plans to improve the lives of children
- Develop a more detailed delivery plan for work that falls outside of the remit of the other workstreams ready to implement in 2018/19

### **Specialised commissioning**

The London Specialist Planning Board has set out the scope of its work, and established four workstreams on clinical pathways, in Renal, Cardiovascular, Cancer and Paediatrics. We are actively participating in the groups which held their first meetings at the end of January: it is too early to know how these workstreams will impact on North London which has already undertaken significant reconfiguration in three of these. We also understand that NHS England is driving a number of initiatives through commissioning, to control expenditure on high cost drugs and devices. We will incorporate information on these, together with further refinement of additional priorities and North London-driven activity in due course.

### **New commissioning and delivery models**

As part of the development process of this plan, and in response to the changing healthcare landscape in North London, the five CCGs have agreed to establish new ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. The establishment of a more formalised degree of cooperation between the five CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such the Royal Free Group model which aims to bring together a network of hospital providers
- increasing financial risk
- stretched capability and capacity

We have agreed to establish a joint committee across the five CCGs to enable joint governance of some key commissioning decisions; the development of a common commissioning strategy and financial strategy; and the establishment of some shared CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and

outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next two years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

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

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described above, to ensure that health commissioning in North London delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements were agreed by governing bodies in November 2016 and a single Accountable Officer is now in place. The remaining new post holders will start early in 2017/18.

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

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

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

We recognise that the health & care landscape in London is particularly complicated, so we do not expect to implement any significant changes in the short term but will keep our approach under review.

## **Consolidation of specialties**

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

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in North London. We have successfully done this across:

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

We recognise that there are other service areas which are currently or may become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. We agree that improving quality should always be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes.

This work is at an early stage. No decisions have been made. Over the next year we will review whether these or any other services would benefit from consolidation or networking. Consideration of any requirements for consolidation of services will be undertaken within each of our clinical workstreams as they develop more detailed delivery plans. The Health and Care Cabinet will retain oversight of this work to maintain a whole system perspective.

## **Enablers**

As well as making the changes outlined above in prevention and service transformation, we need to ensure the infrastructure and resources we have are redesigned and aligned to deliver these transformed services - these workstreams are known as enablers. To achieve this, we will work as a sector to share and transform the vehicles that underpin delivery.

## **Workforce**

Our vision is to support North London health and social care organisations to be excellent employers, committed to supporting the wellbeing of staff whilst also preparing them to deliver the new care models in a range of settings. We will work with North London organisations across all health and care settings to support their collaborative efforts to achieve this whilst ensuring that everything we do contributes to the following aims:

1. Improve patient experience and outcomes through improved staff experience and engagement
2. Define and adopt new ways of working, including working across health and care settings
3. Maximise workforce efficiency and productivity
4. Create a reputation where North London is recognised as a great place to work aiding recruitment and retention
5. Promote and provide an excellent learning environment
6. Develop, implement and embed a systematic approach to leadership development.

To support these aims we are committed to co-creating, communicating and collaboratively delivering plans to address capacity, quality, cost and capability of our workforce. As leaders, we will encourage a culture of networking, collaborating and educational asset sharing, as we believe that strong relationships between our staff are the best way of achieving change. The 'Breaking Down the Barriers' programme (a collaboration between Health Education England, UCL Partners and a number of our Trusts that aims to improve mental and physical health through education and training) is a positive example of an initiative which will be taken forward through developing such a culture.

We will achieve efficiencies in employment by:

- connecting employment services and processes collectively across the footprint
- enabling North London organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages
- facilitating the implementation of new models of care, providing a framework for the deployment of staff to new settings and areas of greatest need

We will develop initiatives to equip the existing workforce with new skills and ways of working, ensuring that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will implement plans emerging from the workstreams to equip people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model.

Since the inception of the STP, we have commissioned 446 postgraduate career development programmes and rotations for our nurses to develop the skills required to fulfil our vision of an agile, highly skilled, North London workforce. This work will continue over the life of the plan through initiatives such as the Capital Nurse programme (for which we have already affirmed our commitment to deliver) and through a single implementation plan for the sector, boroughs and organisations.

We have five successful Community Education Provider Networks (CEPNs) in North London who are starting to focus their work to the following core themes:

- Retention
- Clinical skills
- Widening participation
- Carers and communities
- New ways of working and new roles
- Building a stronger interface with secondary care to enable skills transfer

Our CEPNs are an example of a network/asset sharing based approach to improvement. Delivering improvements to primary and community care through initiatives such as Care Closer to Home Integrated Networks (CHINs) is fundamental to achieving the service ambitions set out in our plan.

**A note on mitigating the potential risks of Brexit: We do not currently know how the process of the UK leaving the EU will impact on health and care services but we do know North London is a cosmopolitan area with many people from the EU settled here as workers and residents. We know Brexit it is a real concern to staff, patients and residents – both in terms of who will provide their care, who will run their services and what it will mean for the livelihoods of friends and family. In the current political and economic climate, a safe supply of workers to meet the needs of our patients in North London. Our retention strategies are aimed at continuing to attract and retain the right people, thus reducing the reliance on overseas staff. Our HR community is working closely with the Mayor of London to ensure that overseas workers, who are vital to our health economy, remain part of our health economy.**



Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population but are employed outside of the public sector, including home care workers and personal assistants. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness.

We will implement initiatives to equip existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and enhancing emotional resilience in themselves, their teams and their patients. We have developed a health coaching competency framework which has now been rolled out across each of our Trusts, with each Trust now leading a specific person-centred conversation initiative.

We will support the Prevention workstream in training all frontline NHS and social care staff in Making Every Contact Count (MECC). Similar work will be undertaken to ensure that all non-medical frontline staff receive training in Mental Health First Aid (MHFA) and basic dementia awareness. We have created a Dementia Awareness programme in North London, which we will continue to develop and ramp-up to focus on Tiers 1, 2 and 3. This programme, developed by Health Education England and UCL Partners, has been nationally acclaimed.

While most of the people who will be engaged in delivering the North London vision are already with us, working in roles which will need to adapt or change in some way, we will also help to establish a number of new roles such as physician associates, care navigators and advanced clinical practitioners. We will support strategic workforce planning and redesign and commission training for skill enhancement, role diversification and new role implementation. Much of this work has begun, but others will be contingent on the definition of new clinical models.

To enable transformation, we will deliver system-level organisational development, supporting leaders and teams through the transformation journey. In addition, we will train everyone in a single approach to continuous quality improvement to deliver sustained clinical excellence and high quality care.

As part of our Delivery Plan we have brought together the health and social care workforce community under the strategic leadership of the LWAB (Local Workforce Action Board) and initiated a programme of work in the following areas that help deliver the six aims outlined earlier:

- Resourcing and integrated employment (aim 4)
- Learning and development (aim 5)
- Enabling new models of care (aim 2)
- Enabling productivity and back office rationalisation (aim 3)

We have launched collaborative work programmes to improve staff retention, manage temporary staff rates of pay, procure a shared bank and reduce levels of agency expenditure. We have already identified significant savings against these initiatives which we are committed to achieving. Building the brand of North London as a place of choice to train and work is a pivotal enabler to these ambitions; where permanent or temporary employment is deemed much more attractive than agency work; whilst remaining flexible.

We recognise the benefits of collaborating on learning and development and our delivery plan includes work on shared leadership, Organisational Development programmes and a review of Learning and Development capacity and delivery, as well as a joint approach to new arrangements for apprenticeships.

These initiatives, together with work on creating common employment policies and procedures, will improve employment portability and further the aim of achieving more integrated employment across North London.

**Exhibit 9: Integrated model of employment**



The Workforce workstream is a key enabler for the new models of care emerging from the workstreams. We will lead workshops and task and finish projects to facilitate agreed workforce plans. The NHS provider HR community is also collaborating on a review of back-office HR processes; shared HR systems and policies will facilitate this work.

For the next stage of the Workforce workstream, we will turn our focus to the clinical workstreams to accelerate the pace at which they develop new service models and define the workforce they require.

Engagement and the development of close working with the clinical workstreams has been a key element of our initial work and this now needs to progress into the delivery of workforce plans to transform services. We will support scenario modelling to assess the financial benefits of the new models and the impact of new roles and changing settings for providing care.

Below is an outline of the different areas we are working on:

| Work package  | Initiative   | Description   | Deliverable  |
|---|--|---|--|
| <b>New Models of Care (Workforce as an enabler)</b> | Package of work for each of the clinical work streams          | Support the new models of care leads in understanding changes to workforce resulting from the new models of care covering capacity changes, new roles, changed roles, skills, training, competencies, recruitment and professional and career development. Bring together professional expertise in pathway designers with HR expertise to ensure credible plans for implementation | <ul style="list-style-type: none"> <li>• Workforce modelling and analysis</li> <li>• Workforce design</li> <li>• Education &amp; Training design and delivery</li> <li>• Develop change management skills and capacity to support new models of care</li> </ul>  |
| <b>Primary Care</b>                                 | Recruitment & Retention<br>Training & Development<br>New Roles | Review and re-alignment of GP Training across London/ North London. Implementation of new role programme.<br>Implementation of retention schemes and training of existing workforce   | <ul style="list-style-type: none"> <li>• Workforce design to take place concurrently with CHIN development timelines</li> <li>• Delivery of workforce aspects of the GP Forward View</li> </ul>  |
| <b>Resourcing</b>                                   | Recruitment & Retention<br>Temporary Staffing<br>Bank          | To reduce turnover across North London and retain existing skills<br>To consolidate temporary resourcing activity across North London and to provide attractive and comparable rates and reduce agency spend<br>Single procurement for a shared bank platform/service   | <ul style="list-style-type: none"> <li>• Stage one qualitative “deep dive” assessment</li> <li>• Reward Assessment</li> <li>• Common Recruitment Policy and Processes</li> <li>• Pay data report to LWAB</li> <li>• Platform for one provider that enables Trusts to join the bank</li> </ul>  |
| <b>Learning &amp; Development</b>                   | Statutory and Mandatory<br>Shared provision<br>Apprenticeships | Standardise and streamline and extend one approach to statutory and mandatory training<br>Pooling resources across North London and developing shared capabilities for in house delivery of education, training and workforce development<br>Collaborative approach to apprenticeships  | <ul style="list-style-type: none"> <li>• Standard common approach , content, topics and standards implemented to delivery models for statutory training</li> <li>• Initial phase provides an in depth review of learning centres, e-learning platforms, library services, simulation facilities and current provision</li> <li>• Shared policies including pay, terms and conditions</li> <li>• Co-ordinated approach to capabilities</li> <li>• Joint procurement of providers</li> <li>• Joint planning of shared cohorts</li> </ul> |

| Work package                       | Initiative             | Description   | Deliverable  |
|------------------------------------|------------------------|---|--|
| <b>Integrated Employment Model</b> | Branding               | To encourage employment flexibility across the health and social care system. To implement employment portability and career frameworks that supports the new models of care. | <ul style="list-style-type: none"> <li>• Employment Concordat</li> <li>• Shared Vision</li> <li>• Programme of work</li> </ul>   |
|                                    | Employment portability |   |  |
|                                    | Career frameworks      |   |  |
| <b>Productivity</b>                | HR Administration      | Future HR operating models that consolidates HR transactional activity  | <ul style="list-style-type: none"> <li>• Standardisation and streamlining of policies and processes and procedures and an operating model for future delivery</li> </ul> |

Our Local Workforce Action Board has matured into a dynamic forum for improvement, bringing together the workforce community from across all our stakeholders as a key vehicle for developing, approving and assuring our plans. It will continue to provide oversight and challenge to current programmes, ensuring that benefits are realised while extending the reach of these programmes and bringing new ones on-stream.

Key challenges for 2017/18 will be to support the service in:

- Breaking down the boundaries that exist between hospitals and primary care, health and social care and between generalists and specialists
- Building the future workforce to tie in with the implementation of new service models, where there is a significant lead time in training new staff
- Investing, developing and deploying support staff to become a more flexible and cost-effective resource that reduces pressure on highly qualified staff
- Extending skills of registered professionals and training advanced practitioners to fill gaps in the medical workforce, provide rewarding clinical career options and mentoring for less experienced staff

#### **In 2017/18 we will:**

- Work with the Care Closer to Home workstream to ensure the required staffing mix is available
- Work with Primary Care colleagues to support the transformation of access to Primary Care seven days a week
- Work to reduce turnover across North London and retain existing skills to support delivery of the above
- Roll out a collaborative approach to learning and development and apprenticeships

## **Estates**

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

The priorities for development of our estates strategy are:

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

There are a number of barriers to achieving this including:

- in North London, there are a significant number of organisations and the differences in governance, objectives and incentives between each organisation, can result in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for non- foundation trusts to retain capital receipts, budget “annuality” and the difficulty of accessing capital investment for re-provision, especially in the constrained fiscal environment for the NHS
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government)
- the primary and community estate requires development to create ‘care closer to home’, improved access and to meet the needs of significant population growth. Capital funding to develop this estate is scarce and significant proportion of the community and primary estate is not owned by the partners in the Partnership

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

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative North London / national process (or devolved to sub-regional or London-level)
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation

It is anticipated that the London devolution agreement for health and care will be agreed in Spring 2017. In the currently agreed London timetable, North London expects to be able to use devolved powers in shadow form initially, moving to full use of devolved powers after 2017/18. We want to use devolution as an opportunity to accelerate the development of the estate needed for care closer to home, securing greater utilisation of community estate and capital for redevelopment from disposals of surplus estate. We also want to ensure that devolved powers enable us to address the need for better quality mental health in-patient facilities at greater pace.

A London Estates Board has been established to oversee the implementation of estates devolution in London. An early priority for North London in 2017/18 is to develop its legally constituted governance for devolved powers.

We anticipate the following benefits from the estates workstream and devolution:

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

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

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

The three trusts are currently refining their outline business cases, with outputs due mid-2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

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

The schemes are planned at a total capital cost of c. £400m with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that around £325m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

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

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

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- our modelling indicates that development of the estate required for care closer to home will need capital investment of circa £111m. North London has been successful in securing some investment from NHS England's Estates and Technology Transformation Fund and an allocation from the NHS Information Governance Fund. However, the funding secured, in common with other STP footprints, will not meet the full cost of development.

**In 2017/18 we will:**

- develop detailed business cases for the care closer to home estate to support the developing CHIN framework by working closely with the Care Closer to Home and the Planned Care workstreams
- use devolved powers and other avenues to secure capital to deliver these much needed improvements and reduce the running costs of this estate

## Digital

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

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

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

Our digital programme proposes the creation of a North London Population Health Management System (exhibit 10) which supports prevention, service transformation and productivity, and would assist in meeting the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

### Exhibit 10: North London Population Health System Management

|                 |  |  |                                    |                                   |
|-----------------|--|--|------------------------------------|-----------------------------------|
| <b>Activate</b> | <b>Digitally activated population</b> Personal Health Record; Self management; remote monitoring; digital transactions   | <b>Information Governance</b>  | <b>Data Quality and Validation</b> | <b>NCL Digital Delivery Model</b> |
| <b>Analyse</b>  | <b>Insights driven health system</b> Health system benchmarking; cohort stratification; patient tracking; case management; whole pathway decision support; predictive modelling                |  |                                    |                                   |
| <b>Share</b>    | <b>Integrated care</b> Shared health and care records; care plans  |  |                                    |                                   |
| <b>Link</b>     | <b>Integration and messaging</b> Health Information Exchange; information and messaging standards; document, image and data exchange   |  |                                    |                                   |
| <b>Digitise</b> | <b>Applications</b> Electronic health records; clinical documentation; ePrescribing and closed loop medication management; orders and results; device integration; alerts and decision support | <ul style="list-style-type: none"> <li>• CCGs</li> <li>• Primary care Social care</li> <li>• Acute, community, mental health and specialist providers</li> <li>• Care homes</li> </ul> |                                    |                                   |
| <b>Enable</b>   | <b>Infrastructure</b> Network; wifi; unified comms; email; collaboration tools; end user technology; virtual care services   |  |                                    |                                   |

The six elements that make up our digital strategy are:

- **Activate:** We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.

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

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

**In 2017/18 we will:**

- Develop and adopt a common Information Sharing Agreement
- Develop a connectivity strategy for North London
- Develop a system-wide approach for Integration and Data Platform
- Review the opportunities for the consolidation of the ICT services across providers
- Identify digital maturity investment objectives across providers
- Scope of Universal Capabilities reporting





# Addressing the financial gap

Not only do we aspire to provide the best services that improve outcomes and reduce inequalities, we need to make the system financially sustainable.

The financial analysis that we have undertaken (exhibit 11) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in North London and the growth in funding that the NHS expects to receive over the five years of the STP.

**Exhibit 11: The 'do nothing' financial gap for North London**

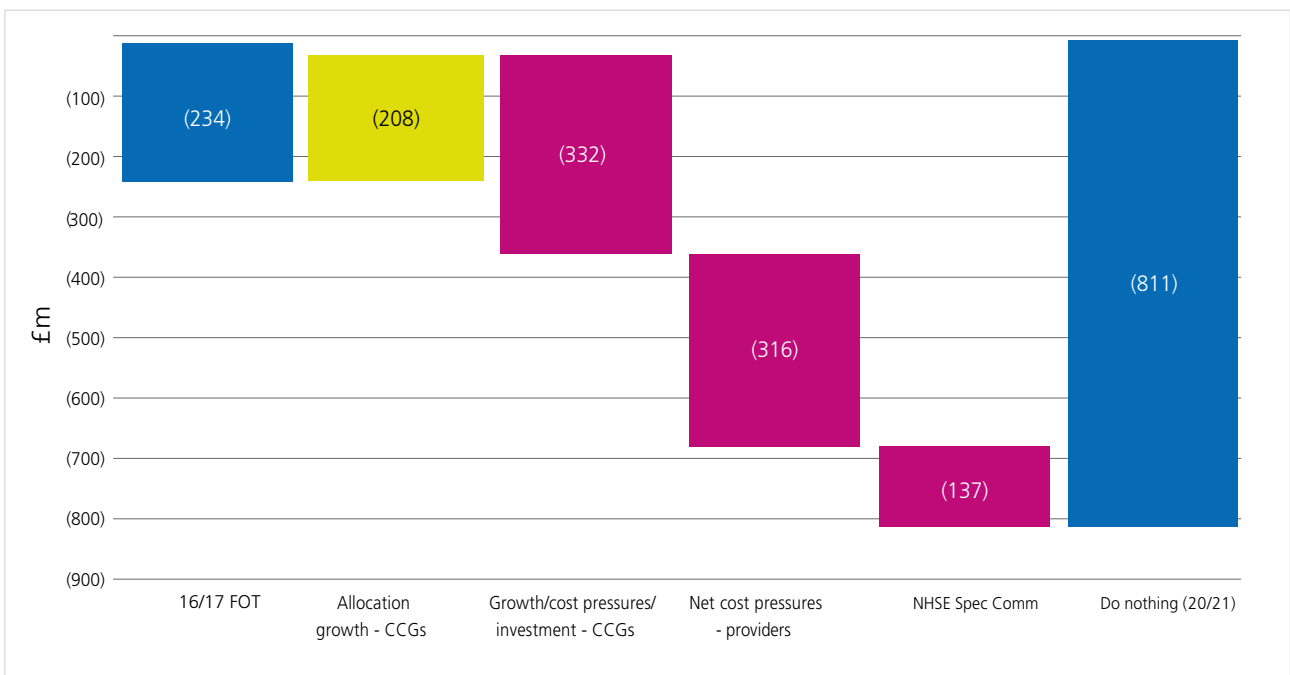
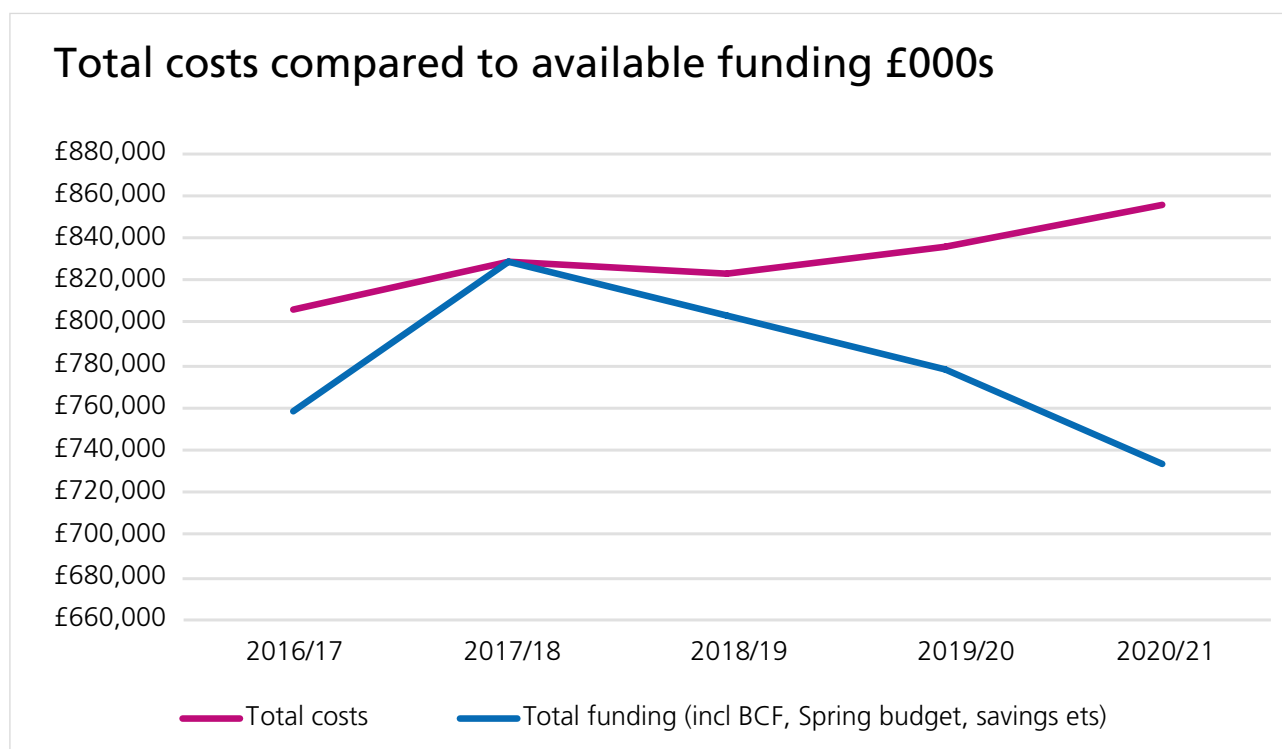


Exhibit 12 shows the financial pressure facing Councils in North London (for children's and adult social care and public health), which includes additional funding announced in the 2015 Spending Review, 2016 Autumn Statement and 2017 Spring Budget.



Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, we will have an estimated £811m deficit across the NHS in North London in 2020/2021. North London Councils will face a budget pressure of £247m for social care and public health by 2020/21, even when all additional funding announced by the Government has been taken into account. Local government finance legislation states that Councils must deliver a balanced budget each year, so North London Councils are using a variety of measures to offset this financial pressure, including increasing the pace on the delivery of transformation programmes, using savings from elsewhere in the organisation, and drawing from financial reserves accrued in previous years.

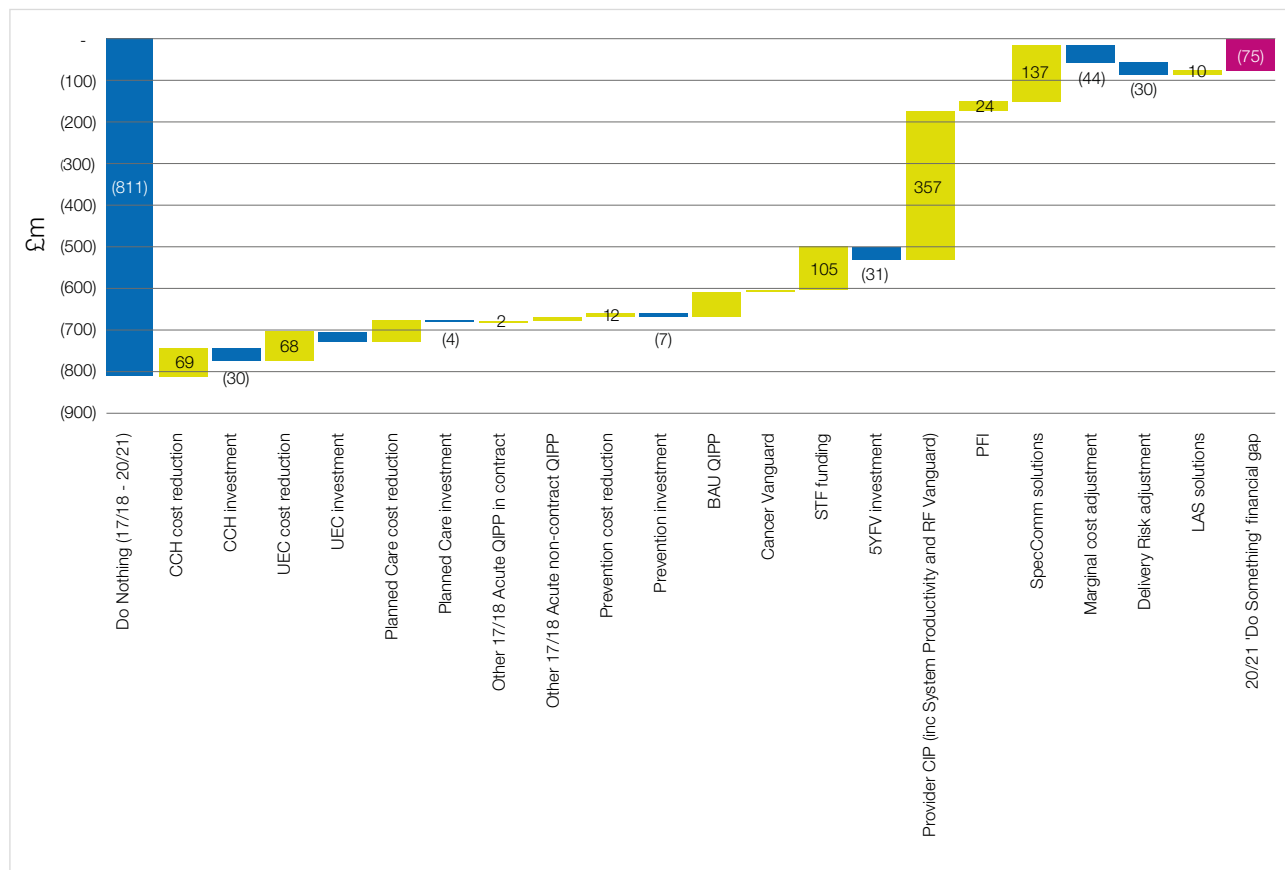
Further work is being undertaken to develop a full understanding of the financial pressures on North London Councils, particularly in adult social care, with a view to working closely together in 2017/18 to understand how we can jointly address the financial gap we face as a system. In particular, the NHS within North London is seeking to learn from local authority colleagues’ best practice in relation to reducing cost whilst improving the experience of service users and the public.

As such, the rest of this section refers to plans to address the financial gap across the NHS in North London.

This ‘do-nothing’ financial gap has been calculated on a normalised recurrent basis (i.e. excluding one-off items) in accordance with NHS England and NHS Improvement guidance. The main drivers of the financial gap are the increased projected demands on the NHS as a result of the increasing population, and within this the demographic changes of an increasing elderly population in particular, as well as the increasing costs of providing healthcare, e.g. due to inflation. Although the NHS in North London is receiving additional resources, the combined impact of the projected increase in demand and cost increases are forecast to be greater than the increase in resources. This therefore results in the ‘do-nothing’ recurrent projected deficit in 2020/21 increasing to £811m, from the forecast 2016/17 outturn of £234m.

The STP in North London has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 13) whilst this addresses more than 90% of the financial gap, we recognise that further work is needed to close it entirely.

**Exhibit 13: The 'Do something' financial gap to 2020/21**



The key elements of the plan are set out in detail earlier in this document. Exhibit 13 shows how these contribute to the improvement in the annual financial position of the North London system over 5 years. The savings that will be delivered from the key areas of transformation are:

- **Care closer to home:** savings of £69m have been estimated from improving access to primary care and providing community-based care (with £30m of investment);
- **Urgent and Emergency care:** savings of £68m (with £20m of investment) to proactively identify early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; provide ambulatory-based care; and reducing delays to discharge.
- **Optimising the planned care pathway:** savings of £49m (with £4m of investment) through redesigning outpatient and planned care pathways.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £12m, with £7m investment.
- **UCLH Cancer Vanguard**, savings of £4m and Royal Free Hospital Chain Vanguard, included in the provider CIP section below.
- **Productivity** savings are planned to be achieved, including both 'business as usual' cost

improvements across providers, and wider system savings through working together of £357m in total. Business as usual QIPP schemes (non-acute) total £57m. Further details of the productivity savings projected are set out below.

## **BAU productivity**

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity. Lord Carter's report on hospital productivity has shown that there is variation in how productive different NHS services are, and provides a "model hospital" website to help providers to understand where productivity improvements can be made. In addition to specific Carter initiatives within providers, each organisation will also have an intensive programme of cost improvement opportunities. The assumed levels of provider CIP in each year for 2017/18 and 2018/19 are based upon providers' detailed operating plans. Beyond this, a general assumption of 2% per year productivity improvement is made – this is a "net" figure as trusts usually experience additional external cost pressures each year (for example, PFI charges, rates increases and education funding losses) which must be offset with new savings first, before delivering an overall productivity improvement.

Analysis by NHS Improvement, provided by an independent firm, has indicated that a figure of around 2% per year is a reasonable maximum expectation in relation to annual productivity improvement for NHS providers. In an environment of reducing activity growth, for example as a result of the STP's work to provide patient care in more appropriate and less acute settings, it becomes more challenging to deliver a higher level productivity improvement.

## **System-wide productivity**

Notwithstanding the above, we know from the Carter work that we have opportunities to improve productivity further without detriment to the service we provide our patients and service users. Much of this comes from working more closely across different organisations within the STP in addition to work within organisations. North London has already consolidated many services across organisations, both clinically (such as cardiac, cancer and neurosurgery) and non-clinically (such as payroll, pathology laboratory services and procurement) which means there are fewer opportunities remaining.

However, we have identified a number of additional opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together rather than in isolation) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from more efficient contracting between CCGs and trusts. As the STP has developed, it has become the norm for organisations to work together in realising savings, and these savings are incorporated within the CIP plans of each provider.

Specific initiatives to improve productivity are described in the sections below.

### **Workforce**

The Delivery Plan for Workforce includes a range of initiatives that have the effect of sharing back office workforce activity. These include:

- Standardising and streamlining statutory and mandatory training to deliver a standard common approach
- Pooling training resources across North London and developing shared capabilities in the delivery of education, training and workforce development

- Developing a common approach to Apprenticeships including joint procurement of providers with the aim of maximising the benefit from the levy
- Reviewing and standardising rates of pay for temporary staff across North London with an initial focus on locum medical pay
- A integrated review on workforce supply and reward to inform a new North London specific pay and non-pay benefit strategy for our permanent workforce
- Developing a platform for one staff bank which enables trusts to join at a time of their choosing. UCLH is leading a collaborative procurement to appoint a new provider not just for UCLH but for all other provider organisations within the STP who wish to join. This will reduce administrative costs and increase the number of temporary staff that are paid through a “staff bank” rather than through more expensive agency arrangements

These initiatives will help improve the efficiency of our HR functions as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We also commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.

### Digital and ICT Consolidation

There are two main themes in relation to the use of digital technology across the STP – firstly the transformational ICT initiatives that will help improve the way in which organisations communicate with each other and their patients (which is described elsewhere in this document), and secondly reducing the costs of providing existing technology such as PCs, telephony, networks and other IT infrastructure. This second area is being addressed through a new digital technology partnership with Atos, a large IT company, which has the potential to significantly reduce costs across STP organisations by consolidating expenditure whilst also improving the resilience and quality of services. UCLH have already signed a contract with Atos that will reduce costs by c. £30m over ten years, and this was procured in such a way that other STP organisations can readily join.

### Other Workstreams for System-wide Productivity Improvement

- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management. This will be driven through the procurement shared service that already exists for 5 of our North London providers, with further collaborative work across the Shelford Group and the London Mental Health network augmenting this work.
- **Back office:** We have worked over the last 4 months to review opportunities for back office consolidation, centralisation and outsourcing, supported by external consultancy and internal project management. Although in many areas the external work suggested limited opportunities for further productivity improvement in the short term, we are actively seeking to reduce our overheads and improve service resilience across the footprint and are progressing with the following key workstreams in addition to those highlighted above:
  - o Enhance and extend the existing shared procurement arrangements (which serve most NHS providers within North London) to reduce non-pay costs; maximise use of wider procurement networks for large teaching trusts and mental health trusts.
  - o Review with HR Directors and our workforce workstream the opportunities and enthusiasm for HR transaction consolidation.
  - o Review with Finance Directors opportunities for process alignment, resource sharing and cost reduction across organisations’ finance directorates.
  - o Progress further outsourcing of payroll functions and take opportunities to consolidate contracts where feasible to do so.

- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.
- **Operational and clinical variation:** all acute providers are actively progressing plans in relation to the Carter productivity work. Reducing variation is a key part of the Royal Free's Group model, and we will also be working collectively to reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the planned care workstream.

### **Commissioner business as usual efficiencies (QIPP)**

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

- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services includes an assumption of increased efficiency equivalent supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care assumes increased efficiency supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing assumes increased efficiency including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.
- **Private Finance Initiatives (PFIs)** – whilst we recognise the role that PFI projects have had on modernising the NHS's buildings, we also believe that they don't represent value for money for individual NHS Trusts. We have modelled a conservative estimate of the saving (£24m per year) that could be made from terminating these contracts and bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, or alternatively to seek additional central funding for these schemes if terminating them is not possible, recognising that there are a number of constraints.
- **Other** - Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the North London proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. North London hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

These improvements cannot be achieved without investment. The plan is based on investment of £20m in urgent and emergency care, £7m in prevention, £30m in care closer to home, and £4m in planned care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the Health and Care Cabinet within North London we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £44m marginal cost (i.e. stranded costs) and £30m 'delivery risk adjustment' in the financial analysis.

## **Delivery through 2 year contracts in North London**

Delivering the STP is a priority for health and care commissioners and providers in North London - and our commissioning intentions, operating plans and contracts reflect this. All NHS contracts within the STP incorporate the impact of the STP's planned initiatives, particularly those that seek to provide care to our patients in a more appropriate, less acute setting. This strategic alignment, working as a system, will help support delivery. Whilst we recognise that implementation will look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Having two year contracts based around our STP delivery plans will help these plans to be implemented quickly, as well as supporting a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for working more closely as a system between commissioners and providers in the future.

We have also ensured that organisations' operating plans are strategically consistent with the STP. In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money.

Recognising that we have still not achieved financial balance in the current plan to 2020/21, we will continue to look for further opportunities for further efficiencies, in line with the Five Year Forward View Next Steps document, published recently by NHS England.

## **2017/18 position**

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London.

Although there are plans in place to reduce the recurrent deficit in 2017/18, the targets set for 2017/18 are for an in-year surplus. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this. Recognising this, we are continuing to work on reducing the risks of delivering existing plans for 2017/18, as well as looking for further immediate opportunities for further efficiencies, beyond those set out above, including one-off non-recurrent measures that could improve the financial position in 2017/18, pending the full implementation of the transformational changes planned over the period to 2020/21.

To support our plan, NHS England and NHS Improvement have initiated a Capped Expenditure Process, to help the NHS produce a set of affordable plans for 2017/18. This aims to help us deliver the best possible clinical outcomes for local people within the funding available.

## Capital expenditure

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

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

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

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

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

- Estates redevelopment relating to our St Pancras/St Ann’s/Moorfields proposals - £404m, assumed to be funded through disposals (£326m), DH loans (£39m) and Donations (£37m), of which £272m (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above;
- Primary Care for Care Closer to Home and Five Year Forward View investment (£111m – assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- IT investment (£159m with a further £21m in 2021/22) – all assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in North London to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to



assume that such investment is not required and won't deliver value simply because of the stage in development of these plans that North London is currently in.

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

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



# Communications and Engagement

Since November 2016, we have been working with the NCL Joint health oversight and scrutiny committee (JHOSC). We have presented at the JHOSC and shared with the committee and members of the public our draft plan and introduced some of the areas of work. In January, the committee presented a report which included a number of recommendations to the NCL STP. We have responded to these recommendations and will continue to attend the JHOSC meetings to share our progress and respond to questions and feedback with a commitment to transparency and collaboration. As part of our work with the JHOSC, we have agreed a number of principles to guide the NCL process:

- Put the needs of individual patients, carers, residents and communities truly at the centre;
- Recognise that local patients, carers, residents and communities themselves are a resource for knowledge, for information, for understanding and for change; work with patients, residents and communities to harness their strengths;
- Trust and empower local patients, carers, residents and communities to drive change and deliver sustainable improvements;
- Co-design, co-produce and co-deliver services and programmes with local patients, carers, residents and communities;
- Focus on building resilient patients, carers, residents and communities -and on where resources can have the biggest sustainable impact.

The full report responding to the JHOSC recommendations can be found at <http://democracy.camden.gov.uk/documents/s57037/response%20to%20JHOSC%20report%20January%202017%20-%20final.pdf>

We have come a long way since being asked to come together as 21 health and social care organisations with disparate views in December 2015. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

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

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

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

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

## Our future plans

To help us meet our communication and engagement commitments we have formed a communications and engagement workstream. Membership of this group includes representatives from the 21 partner organisations, Healthwatch, voluntary sector representatives and lay people.

Working together as partners, we have established an evidence based engagement model and drawn of the expertise of communications leads from our CCG's, local authorities and provider organisations. We have identified key population groups and those members of your community that can at times be hard to reach. Working alongside Healthwatch and the voluntary sector we are now taking our proposals to the community for input and advice.

- In partnership with CCGs and Healthwatch we will participate in pan-NCL events on the overall plan and any specific issues that may arise at pan North London or individual borough level.
- Each workstream area has an engagement plan and will hosting meetings and events with patients, service users, carers and with the public on focussed topics such as urgent and emergency care, primary care, and mental health. This will help us to get more in-depth input from the community about their needs and how they expect services to be delivered.
- Our website will provide opportunities for online surveys and an online FAQ which will be kept current
- Our website will feature animations, infographics and relevant resources that will help people better understand the plan.
- We will link our website to social media and to promote our public engagement programmes and share information. We will also use these channels push residents and stakeholders to our website to test ideas and share progress on local priorities.

### **To do this, we will:**

- Work alongside Healthwatch and the voluntary sector, to identify representative groups, resident associations and other interest groups, local authority engagement networks and the many other networks available to the 21 partner organisations to reach out to the public and share proposals.
- We work in partnership with the communications and engagement teams across North London health and care organisations and together access their community activities and channels to share information about our proposals and progress and invite feedback and participation when appropriate.
- We will use existing online engagement tools used by partners to engage specific audiences and reach those who may be unable to attend our events.

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

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to submit our work to the Joint Health Overview and Scrutiny Committee (JHOSC) ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all FOI requests, public enquiries, media stories and providing an update to the Transformation Board and meeting with elected members.

The health and care workforce is a significant stakeholder in the STP process. We have been providing a weekly update from the convenor of news and important meeting dates.

To engage more fully with our health and care workforce we are developing a staff engagement strategy in partnership with the workforce workstream. This will include identifying and training workplace champions, well versed in the priority areas of work who can speak at staff forums and events on the STP programme and articulate the implications and benefits of a more sustainable health and care system.

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- face-to-face meetings with professional organisations (e.g. Royal College of Physicians) to seek advice on communicating and engaging with specific cohorts within the health and care workforce and the most relevant issues.
- participating in or hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This includes joint commissioners and working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- working with membership organisations to showcase the range of work which is happening across North London and share with staff the proposals and what the future health and care workforce will look like and how changes to how health and care is delivered may affect them.

We will continue to build our communications and engagement capabilities across the system. The Communications and engagement workstream meets monthly to develop and co-design the communications and engagement strategy. This forum is designed to build skills and expertise in engagement and brings together communication and engagement practitioners, clinical expertise, Healthwatch, voluntary sector and layperson representative in one room with a commitment to best practice in engagement.

There are many stakeholders in this programme of work. The most important is the residents of the five North London boroughs. Communicating with such a large and diverse audience is challenging. We will utilise the existing communications channels available through the 21 partner organisations and our network of voluntary sector organisations, Healthwatch and professional colleges and bodies.

The workstreams will identify specific key audiences appropriate to their proposals and engage with these groups of patients, service users, carers and other interested parties. It is through this work we can make sure that services meet the needs of people rather than the current system that is often disparate and disjointed for the person accessing.

## **Public consultation**

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

Each of the partner organisations has conducted numerous engagement activities over past two years. This has included events, resident and staff surveys, forums, public meetings as well as input and feedback via organisational channels.

This data has helped us build a comprehensive picture of local views and concerns about health and care services. We know that people expect:

- People want more joined up health and care services

- People want health and care closer to where they live or work
- Services that are flexible, that adapt to people's differing needs
- People want to tell their story once
- Good signposting and information
- Access to services for a diverse population including interpreting services
- Simple, effective admin process which support patients to access the right service
- Compassionate healthcare professionals
- Access to a wide range of community support
- To not forget about carers and family

The launch of our North London Partners in health and care website (July 2017) will provide a single platform for information of the STP for residents, staff and other stakeholders.

On the website we will provide the most up to date information about our plan and the progress we are making to improve the health and wellbeing of the people of North London.

It is on our website where we will share stories of real local people and how the changes we are proposing make a difference to how they access care but also improving their health and care outcomes. It will also be our platform for inviting local people to participate in activities and events to help as co-design and co-produce services.



# Equalities analysis and impact assessment

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

The analysis has considered the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate any unintended consequences for some groups. The analysis of the plans to date found that no groups will suffer a negative impact from the plan, rather the plans will have a broadly positive impact on health inequalities. Exhibit 11 summarises these impacts, indicating for each workstream, what is the expected impact on health inequalities for each protected characteristic. Detailed impact assessments for each workstream and each protected characteristic are available by emailing us at [nclstppmo@nhs.net](mailto:nclstppmo@nhs.net).

**Exhibit 11: summary of impacts by workstream**

| Protected characteristic \ Workstream | Disability      | Sex             | Race            | Age             | Gender reassignment | Sexual orientation | Religion or belief | Pregnancy and maternity | Other groups    |
|---------------------------------------|-----------------|-----------------|-----------------|-----------------|---------------------|--------------------|--------------------|-------------------------|-----------------|
| Care closer to home                   | Positive impact | Positive impact | Positive impact | Positive impact | Positive impact     | Positive impact    | Positive impact    | Positive impact         | Positive impact |
| Urgent & Emergency Care               | Positive impact | Positive impact | Positive impact | Positive impact | Positive impact     | Positive impact    | Positive impact    | Positive impact         | Positive impact |
| Mental Health                         | Positive impact | Positive impact | Positive impact | Positive impact | No impact           | No impact          | No impact          | Positive impact         | Positive impact |
| Cancer                                | Positive impact | No impact       | Positive impact | No impact       | No impact           | No impact          | No impact          | No impact               | Positive impact |
| Planned Care                          | Positive impact | No impact       | Positive impact | No impact       | No impact           | No impact          | No impact          | No impact               | No impact       |
| Productivity                          | Positive impact | No impact       | No impact       | No impact       | No impact           | No impact          | No impact          | Positive impact         | Positive impact |
| Prevention                            | Positive impact | Positive impact | Positive impact | Positive impact | No impact           | No impact          | No impact          | Positive impact         | Positive impact |
| Digital                               | No impact       | No impact       | No impact       | No impact       | No impact           | No impact          | No impact          | No impact               | No impact       |
| Estates                               | Positive impact | No impact       | No impact       | Positive impact | No impact           | No impact          | No impact          | Positive impact         | No impact       |
| Workforce                             | Positive impact | Positive impact | Positive impact | Positive impact | No impact           | Positive impact    | No impact          | Positive impact         | Positive impact |
| Maternity                             | Positive impact | Positive impact | Positive impact | Positive impact | Positive impact     | No impact          | No impact          | Positive impact         | Positive impact |
| Communications and Engagement         | Positive impact | Positive impact | Positive impact | Positive impact | Positive impact     | Positive impact    | No impact          | Positive impact         | Positive impact |

No impact Positive impact

## Disability

Most workstreams will have a positive impact on inequalities associated with disabilities, which include physical, visual, and sensory impairment, and mental health problems or learning difficulties.

Some workstreams specifically aim to reduce health inequalities experienced by residents with disabilities. For example, the **Prevention workstream** will develop smoking cessation services that specifically target people with learning disabilities, including a payment to incentivise providers to

target this population group.

Patients with disabilities and their carers frequently experience disjointed health and care provision that fails to consider their needs in the round, or put the patient at the centre. Multiple workstreams, such as **Urgent and Emergency Care, Planned Care, and Care Closer to Home**, will seek to develop better integrated care to enable people with complex needs to have their needs more proactively assessed and met and to experience more joined up care.

Physical access to facilities and the availability of suitable equipment to meet the specific needs of people with different disabilities also figures prominently as a concern. The work by the **Estates workstream** is particularly relevant for this, as the review, re-purposing and reinvestment in estate will be done in the context of ensuring access for residents and patients with disabilities, e.g. in terms of level access/ramps, and in terms of ensuring premises are located at places that are most accessible by public transport etc. The work of the **Communications and Engagement workstream** will also aim to ensure that all venues used for events are assessed for accessibility for people with disabilities. Additionally, the review of office space and flexible working arrangements planned by the **Productivity workstream** and enabled by the **Digital workstream** may result in encouraging more flexible working opportunities for staff with disabilities.

As an overarching programme, the **Mental Health workstream** will have a positive impact for people suffering from mental ill health. For example, building community resilience will increase mental health basic awareness, reduce stigma, and increase mental health self-awareness. The **Workforce workstream** will also contribute to reducing stigma by ensuring that staff recruitment, training and retention practices are fully compliant with best practice.

Some ways of delivery of these projects will further facilitate access to services for people with disabilities. For example, the new care model proposed by the **Cancer workstream** has a strong emphasis on care closer to home, which has the potential to improve access for patients with disabilities. The **Workforce workstream** will also contribute to facilitating access by promoting a workforce that is better able to deliver care in appropriate settings, closer to home.

The **Maternity workstream** expects to have a positive impact on inequalities related to disability. Specific work is being planned to engage service users and community organisations to help ensure the needs of residents with disabilities are firmly built into workstream plans and implementation.

## Sex

Men and women do experience different health outcomes. However, these differences are difficult to isolate as being caused by gender alone, as gender interacts with other characteristics such as ethnicity and age, leading to considerable differences in the determinants of health for each population group.

However, some differences can be identified. For example, men are typically underserved by mental health services. The **Mental Health workstream** will target men in its community resilience, primary care mental health, and acute pathway projects, in order to address this inequality. Men may also be less likely to engage with preventive services delivered in 'traditional' healthcare services and settings, e.g. general practices. The **Prevention workstream** will use voluntary and community sector organisations to provide services to harder to reach groups, hopefully increasing the uptake of those services by men.

Some workstreams have identified other differences between men and women that will be addressed during the implementation phase. For example, men are generally more likely to die prematurely from

chronic diseases than women. In the **Care Closer to Home workstream**, the Care Closer to Home Integrated Networks (CHINs) will need to redesign services to make them more accessible to men and to find ways of engaging them earlier and to build resilience and self-care more effectively. Additionally, data from the recent Urgent and Emergency Care stocktake demonstrates that women use some services, such as walk-in centres, more than men. Resident engagement work by the **Urgent and Emergency Care workstream** will ensure that both genders are engaged in the design of Urgent and Emergency Care services across North London.

Men and women still carry significantly different burdens of work, caring, and other responsibilities. The **Workforce workstream** will seek to improve access to flexible employment arrangements, providing North London workers with a wider variety of work options.

The **Maternity workstream** also expects to have a positive impact on male partners as well as on women, although this needs to be further explored as these plans develop.

## Race

Language and cultural factors can determine health inequalities in groups defined by race and ethnicity.

The focus on healthier environments and settings as part of the **Prevention workstream** is fundamental to the reduction of health inequalities. By promoting positive changes in the settings where people grow, live, and work, we will be positively impacting on equality of opportunities, helping to reduce the health inequalities experienced by groups with certain characteristics, such as race and ethnicity.

One important determinant of different health outcomes between ethnic groups is differences in health service use. Greater involvement of and working with voluntary and community sector services and organisations at a local level in the planning and delivery of care and support should help professionals to become more responsive to the diverse needs of the communities they serve. This should enable more people to access advice and services that they might otherwise not access or use. The focus on working with and engaging the community is an important focus of the work of the **Prevention, Care Closer to Home, Cancer, Planned Care, and Mental Health workstreams**.

The investment and strengthening of primary care, expected through the **Care Closer to Home workstream**, should impact positively on inequalities in health and in particular improve the health of people from ethnic minorities.

The **Urgent and Emergency Care workstream** aims to improve the monitoring of ethnicity data within Urgent and Emergency Care services and is working alongside Healthwatch to develop a co-production strategy to engage harder to reach communities. Ensuring services are accessible and reach key population groups, including recognising language as a key determinant of access, will be a key consideration for this workstream.

The population served by maternity services is diverse, with high immigrant populations and in particular those who do not have English as their first language. Services can be difficult to navigate, with greater choice available to those best able to work their way through the system. The **Maternity workstream** aims to improve information regarding women's choices and the services that are available, and will equip staff to better signpost and guide women and their families through their maternity journey.



The **Workforce workstream** will ensure the recruitment, retention and development of underrepresented groups in North London, thus improving equality of opportunities.

The **Communications and Engagement workstream** will ensure opportunities for engagement are accessible to people from different cultural or ethnic groups, and will ensure all communication are made available in easy read or key community language.

## Age

Age is a major determinant of health and care needs, health outcomes, and service utilisation. The services provided by each workstream will seek to benefit different age groups and tackle age-related inequalities.

A major goal of the **Care Closer to Home workstream** is to provide better integrated care. This will enable frail older people to have their needs more proactively and holistically assessed and met, and to experience more joined up care.

There is a growing population of older people in North London. The **Urgent and Emergency Care workstream** has developed a frailty pathway project to address the specific needs of an ageing population. This will be considered in a range of areas, such as relationships with staff, accessibility of buildings, accessibility and cost of transport, and their overall experience of local healthcare. Additionally, future service design within this workstream will consider accessibility to specific facilities by target age group.

The **Prevention workstream** will maintain a focus on supporting children and young people to have healthy lives, ensuring that the settings in which they spend much of their time – early years' childcare and nurseries, and schools – give them the opportunity to be healthy. Additionally, it will make use of digital technologies and analytics to deliver interventions (e.g. apps), in order to promote access to services to young people. This workstream will also ensure that working age adults have the best chance to be healthy at work, by ensuring that the North London workforce (in its widest sense) is supported by organisational environments and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

The **Mental Health workstream** also includes projects that target specific population age groups, such as developments in children and adolescent mental health services, to better meet the needs of children and young people with mental health needs. This workstream will also invest in developing a dementia friendly North London, to better support older people living with dementia.

Experiences of maternity services can be very different according to maternal age. The **Maternity workstream** will link into existing services for young people under twenty. There are greater numbers of women over forty having babies in London than in other parts of the country. This workstream will examine the specific needs of this group and will create appropriate pathways of care for them.

The **Estates workstream** will ensure that the transformation of services and premises will be carried out in such a way as to consider the needs of the old and young, and target improvements in service provision. The **Workforce workstream** will guarantee that staff recruitment, training and retention practices would be fully compliant with best practice. The **Communications and Engagement workstream** will look to ensure that venues for engagement events are accessible for older people, who more frequently have mobility needs.

## Transgender

People who experience their body to be different from their assigned gender at birth remain a vulnerable group that suffers from an array of health inequalities. Some people may choose not to access services because their assigned gender on clinical records does not match how they personally experience their gender, which could cause distress and anxiety for the individual having to explain this to staff.

The **Care Closer to Home workstream** will aim to provide this group with the same quality and accessibility of services as for the rest of the population: improved access to more proactive and integrated care and the services better tailored to the needs of diverse local communities.

Under the **Urgent and Emergency Care workstream**, each service will develop its own policy regarding transgender and transsexual service users to ensure there is no discrimination and they are treated considerately and with respect. Regional or national organisations that represent individuals who are / have undergone gender reassignment will be invited to share their perspective within the formal consultation process.

Although the potential impact is not fully known, greater personalisation of care and improved choice provided by the **Maternity workstream** should have a positive impact on this population group.

The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language and venues are welcoming and consider the needs of all, including bathroom facilities that are trans-friendly.

## Sexual Orientation

There are clear differences in health outcomes between people of different sexual orientations. These differences will be addressed by the **Care Closer to Home** and **Urgent and Emergency Care workstreams** by improved access to more proactive and integrated care, by providing adequate training for all staff and by gathering further evidence and insight from local residents, organisations and groups to better understand their experiences of services and care. The **Workforce workstream** will further contribute by guaranteeing adequate staffing and skill mix, which should promote positive outcomes for all patients. Staff recruitment, training and retention practices will be fully compliant with best practice. The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language.

Furthermore, several workstreams plan to use voluntary and community sector organisations to deliver their interventions. This approach is intended to facilitate access to services by groups of people who are traditionally harder to reach.

## Religion or belief

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure there is no discrimination of service users according to their religion or belief, by providing improved access to more proactive and integrated care, delivering services that are better tailored to the needs of diverse local communities, and giving consideration to physical, cultural or behavioural barriers in the design of new services. The **Communications and Engagement workstream** will consider days of worship and cultural holidays or festivities.

The use of voluntary and community sector organisations to deliver interventions by several workstreams will also further facilitate access to and engagement in services by groups of people who are typically harder to reach.

## Pregnancy and Maternity

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure that, when designing new services, access and mobility issues will be considered for visitors and the ability for mothers to breastfeed and for parents to change babies as part of providers' consideration of service use.

The **Mental Health workstream**, through greater mental health support in primary care, will raise awareness of mental ill health in the perinatal period. Additionally, through the perinatal mental health programme, this workstream will support more women with their mental health in the perinatal period.

The **Productivity, Estates, Communications and Engagement, and Workforce workstreams** will all contribute to increasing opportunities for pregnant women and people with parental duties by reviewing flexible and remote working arrangements, encouraging more flexible working opportunities.

The **Prevention workstream** will develop projects with a specific focus on pregnant women. For example, smoking cessation services will specifically target pregnant women, including a payment to incentivise providers to target this particular population group. This will ensure that appropriate treatment is available to pregnant women, as traditionally not all services offer support for this group.

This is a particularly important group for the **Maternity workstream**, whose major impact is likely to be on pregnant women and parents. In terms of women and families using the services, increased access to care closer to home, improved choice and personalised care should improve access during pregnancy.

## Other Groups

The eight protected characteristics defined by the 2010 Equality Act do not exhaust all determinants that can lead to health inequalities. One major determinant is socioeconomic circumstance – income, education, employment, occupation, among others, can have significant impacts on an individual's health. Several workstreams will have an impact on socioeconomic health inequalities.

The **Prevention workstream** aspires to follow a model of proportionate universalism, which seeks to offer a universal service that is accessible to all but also target communities and groups where additional needs exist. Accordingly, it is not anticipated that a specific group of residents would be discriminated against, and this active approach will likely lead to a decrease in health inequalities. Some actions that will be suggested to guarantee this include:

- Setting specific targets for communities that carry a disproportionate weight of ill-health, in order to guarantee that their increased need is met with adequate services;
- Working with a variety of organizations, such as public, voluntary, and community sector, will allow a wider reach, ensuring residents of many social groups have the opportunity to be involved;
- Working in a variety of formats, such as the better use digital technologies, will facilitate this wide reach of North London residents;
- Maintaining a focus on contextual determinants – such as opportunities to eat a balanced diet, to exercise, or to work in a health-promoting environment – as key to guaranteeing equality

of opportunities, absence of discrimination, and promotion of good relationships between communities.

The **Care Closer to Home workstream** also explicitly seeks to address inequalities. Each Care Closer to Home Integrated Network (CHIN) will be provided with public health information showing where there are inequalities in health in their population which need to be addressed and they will be monitored on how effectively they deliver this outcome. Investing in primary care services is shown to reduce inequalities in health, reduce costs, improve access to more appropriate services, reduce in-hospital mortality, and reduce hospital admission rates. This is particularly important in North London, as there are high levels of A&E attendances across North London compared to national and peer averages, and also very high levels of first outpatient attendances.

Homelessness is of particular interest to the **Urgent and Emergency Care workstream**, as homeless people attend A&E more often than the general population, are admitted more often, and once admitted tend to stay longer. These and other issues regarding other vulnerable groups will be taken into consideration and addressed through local engagement groups and the co-production of Urgent and Emergency services.

The prevalence of severe mental illness varies amongst the North London boroughs, but is high across all areas. North London lies in the bottom quartile nationally, with varying outcomes across the boroughs. The **Mental Health workstream** will aim to reduce inequalities across the five boroughs so that no matter where someone lives in North London they can expect to receive the same high quality of care.

The **Cancer** and **Maternity workstreams** will also support work to understand where inequalities to access exist and will look to build evidence based solutions to address these. For example, the Cancer Vanguard includes a project to review the relative effectiveness of different types of invite to participate in screening.

The **Productivity** and the **Workforce workstreams** will also contribute to reducing health inequalities by encouraging more flexible working opportunities.

The **Communications and Engagement workstream** will seek to have a positive impact by ensuring that all communications and engagement activities use inclusive language.

Based on work previously done by the Islington CCG in building their personal health record, the **Digital workstream** will consult extensively with the public and patients to ensure that design, data presentation and access mechanisms are inclusive and support accessibility good practice.

We will continue to build on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions of the plan. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

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



## Conclusion and next steps

We have made significant progress in developing our specific ideas for how we will achieve this. We have worked hard over the last few months to further develop our thinking, building on the evidence and by involving hundreds of members of staff from each of the provider and commissioning organisations and local authorities within North London. We held public meetings in each of the boroughs in September 2016 as the starting point to an ongoing conversation with the local community. We recognise there is more work to be done to engage with the community in the months ahead.

We have also worked proactively with the Joint Health Overview & Scrutiny Committee in North London to ensure that our developing plans are scrutinised and the robustness of our plan is challenged.

The STP has been developed to deliver the vision we have set out, the vision that the public has told us they want. As a sector, we have committed to the development and implementation of the delivery plans within each of the areas outlined above that can achieve the much wanted and much needed change. At the same time, we are clear that we will not lose focus on the longer term transformation and prevention work that will support sustainability.

Our work to April 2018 will focus on:

- taking steps to stabilise our financial position
- implementing our priorities as set out in this document in to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly
- build on the early engagement with the public and staff

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

For further information or to contact us please email [nclstppmo@nhs.net](mailto:nclstppmo@nhs.net).



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