Delivering a New Service Model for The 21st Century Chapter 2. Fully Integrated Community-Based Health Care

We have been working together to consider what the requirements set out in the NHS Long Term Plan mean for our residents, staff and health and care partner organisations across north central London (NCL). We have a collective commitment to deliver changes that will improve the health and wellbeing of residents and have listened to what residents told us is important to them.

We have developed a draft NCL delivery plan for fully integrated community-based health care and are now seeking the engagement and involvement of all local partners, stakeholder and residents to refine and finesse these plans. Over the next two months, we will cross-reference, financially cost and finalise our plan for submission in November.

If you have any comments, queries or think we have missed important points relating to any of the sections please get in touch with Sarah Mcilwaine (sarah.mcilwaine@nhs.net).

This chapter has been developed with input from partners across the system through the Health and Care Closer to Home Board as the System Review Group for initial draft (early August).

This board includes representation from a range of community and acute providers, GP federations, Healthwatch, the LMC, CCGs, clinical directors. This chapter has also been informed by the NCL strategy for General Practice (2018 – 2021). The NCL JOHSC commended the breadth of engagement carried out in developing the General Practice strategy on which much of this is based.

2.1.1 Meeting Funding Guarantees For Primary Medical And Community Health Services

Plan sets out indicative spending for four years (2020/21 to 2023/24) to:

- Cover primary medical, community health and continuing health care spend
- Mirror national funding increases across these areas
- Highlight how GP contract entitlements honoured over and above existing baseline spend Financial plan to be agreed and shared with the regional team.

Currently in development throughout September 2019.

2.1.2 Supporting Primary Care Networks

1. Outline development support for networks with engagement plans for community partners
2. Support plans designed with full involvement of the Clinical Directors of the Primary Care Networks and community health services partners.
3. Investment plans for networks indicated, including national/London funding streams

NCL commissioning leads are working closely to implement the new GP Contract Framework. The opportunity to use the Primary Care Network Contract DES (PCN DES) to build integrated frontline delivery for enhanced and community-based services (with a positive impact on 'core' general practice delivery) is clear.

The success of our PCNs will depend on all relevant partners working together, including the total alignment of community health services. Our focus over the next 12 months is the further development of the neighbourhood/PCN level operating model across primary and community (bringing together clinical/operational teams) and developing the borough Integrated Care Partnerships to shape and direct delivery and benefits realisation (senior managers and leaders).

We are aware of the opportunity to include community providers within PCNs. Some of our community providers have already begun to work with PCNs and GP Federations to identify opportunities to

collaborate under the PCN Network Agreement. This would cement and advance more informal arrangements for collaboration, which have developed at the strategic level.

We are planning events in Q2 and Q3 of 19/20. We will work first with primary and community separately, before bringing them together. Considerable engagement of primary care has occurred via the formation of PCNs. We are now bringing together community providers and NCL commissioners in a sub-regional event to explore the implications of PCNs, discuss NCL strategic commissioning intentions and update delivery plans.

We will then bring primary and community together at NCL and/or borough level to review a 'maturity' framework (focusing on progress to integration) and to coproduce a 'roadmap' that captures key tasks to mature integrated working between primary and community. This will build on the considerable work already undertaken to build care and health integrated networks or neighbourhoods in NCL, and to align frontline teams to this footprint. As part of PCN and clinical director development, PCNs and clinical directors will identify specific PCN service improvement projects that align with Long Term Plan priorities, to support the change management agenda at the frontline and to encourage cross-organisational working.

Further detail on the PCN development programme in development – to be added here.

For some time, NCL commissioners have been sharing strategic priorities for community services, including the interface with primary care. Commissioners have also been exploring a new approach to commissioning, with a shared commitment to moving away from traditional block contracts, to a model that sees a greater proportion of payment linked to outcomes. We have also been exploring ways to align primary care enhanced services (locally commissioned) and apply consistent outcome measures across these and our community contracts. One CCG in NCL has already aligned outcomes-based payments between the GP neighbourhoods and main community service providers in two areas: rapid response avoided admission and falls-related avoided admissions.

This joint working and focus on community services was signalled in the NCL CCGs' 19/20 commissioning intentions letters (sent September 2018). There is some way to go with providers and work is required to ensure aligned incentives are duly recognised and the operational joint working to deliver against these prioritised.

Particular commitments in the Long Term Plan lend themselves to aligned commissioning plans and incentives across primary and community. Providing 'anticipatory care' jointly and Enhanced Health in Care Homes are both areas where NCL has existing work underway in all five boroughs.

We are taking measures that enable integrated delivery at PCN level and each borough is exploring specific 'high impact changes' and enablers, sharing learning across NCL e.g.:

- Alignment of community services to the GP registered list and extraction of 'out of area' or 'cross border' arrangements;
- Testing of shared accountability at PCN/neighbourhood level for specific priority outcomes with shared registers and shared incentives for example Diabetes, falls, admissions for ambulatory care sensitive conditions.
- Multiple community providers have committed to wrapping their District Nursing (and other) teams around localities/neighbourhoods
- Discussions regarding the recruitment, development and deployment of new roles coming into PCNs
- Scope to review the interface between roles (for example community nursing) in particular for proactive and anticipatory care (call/recall; screening; vaccinations and immunisations; review)

- Strengthening the interface between domiciliary care providers and community health professionals to free up qualified professionals to perform more complex tasks and staff enabled and supported to work at the maximum capabilities and competencies
- Review of the local community based estate in each borough and extent to which it can meet the need for flexible and shared delivery space (locality planning as part of our STP Estates Board priority workstreams)

Primary care is central to the development of our integrated care system (ICS) and borough partnerships, and each PCN will support and shape our emerging ICS through their clinical directors, who provide the voice for primary care in the development of our local plans. The significance of the cultural shift required in general practice, and with other PCN partners, to work in this way cannot be underestimated. It is therefore crucial that we support the development of sustainable and resilient PCNs, with strong clinical leadership and collaborative working, and through the development of the wider workforce, which is imperative to supporting a multi-disciplinary approach. Working with NCL's GP federations will be important in achieving this.

In the delivery of integrated care, we are committed to our PCNs focusing on the whole person. PCNs have a role in prevention and addressing social determinants of health, in partnership with councils and the voluntary and community sector e.g. in opportunities to work closely with housing and advice. PCNs will also need to work closely with adult and children's social care to support continuity of care and to work pro-actively around safeguarding – social care will be core members of the multi-disciplinary team. In NCL some of the earlier Care and Health Integrated Networks (CHINs) were led jointly with the local authority.

The North London Partners' Health and Care Closer to Home (HCCH) programme brings together system partners from primary, community, and acute services, local authority, commissioning and the voluntary sector via its Programme Board.

The programme focuses on four priority areas:

- Improving access to primary care
- The development and support of PCNs
- Quality Improvement – reducing unwarranted variation and improving quality
- Social prescribing as a key enabler of the Universal care model *(please see personalisaiton chapter for more on this)*

Through this programme, the five CCGs in NCL refreshed the NCL Strategy for General Practice in late 2018 (strategy agreed by the five governing bodies). The strategy built on previous achievements in primary care. It focuses specifically on general practice, including collaboration in the form of CHINs, or neighbourhoods - a similar principle to PCNs. As such, practices and system partners have been working in this way across north central London for some time, with commissioning investment to support this way of working since 2016.

In line with national and regional policy, the strategy also signalled NCL's commitment to the development and support of large-scale general practice organisations, with the aim of ensuring resilient general practice.

The introduction of the new GP Contract and the support provided to forming PCNs was coordinated across NCL, supporting practices through a partnership of STP/ ICS team, CCGs, Local Medical Committee and large scale general practice organisations. All mainstream primary care services are included in PCNs and numbers of PCNs across NCL are:

- Barnet 7
- Camden 7
- Enfield 4

- Haringey 8
- Islington 4

PCNs are very new and at different levels of maturity, depending on how well established the working relationships are between member practices and with other partners; some have been collaborating on the same basis for some time, where other partnerships are much newer.

There are 39 clinical directors, with differing levels of leadership experience. It will be critical for clinical directors and other key partners to be involved in diagnosing and describing their support requirements in order to ensure the support is tailored appropriately. Clinical Director development will be a significant part of the plan for the PCN development investment.

PCN development funding is recurrent for five years from 19/20, with the focus likely to change year to year. For the first year (19/20), in order to determine investment, over the next two months, we are supporting PCN clinical directors to work with their member practices to complete a diagnostic self-assessment, to confirm the development needs of both the PCNs and the individual clinical directors. This process will involve a wide range of partners and their expertise, including Training Hubs, academic partners, large-scale general practice organisations and other providers involved in PCN delivery. Following self-assessment of PCNs and CDs, priorities for investment will be based on local need and linked to the domains within the PCN development prospectus. These describe what good looks like in terms of:

- Organisation development and change
- Leadership development support
- Supportive collaborative working (MDTs)
- Population health management
- Social prescribing and asset-based community development
- Clinical director development support
- Identifying, evaluating and sharing learning

In subsequent years, we expect there to be more focus on partnership and system working.

<u>Engagement and indicative timing</u>
The proposed development approach for 19/20 aligns with the national and regional approach, and was designed and discussed with stakeholders including commissioning leads and clinical leads for primary care, and will be discussed with PCN clinical directors in August. The outline was presented to the Health and Care Closer to Home Board (August) for discussion and comment.

The intention is to produce development plans for 19/20 by the end of September, with the aim of mobilising in October.

By March 2020, PCNs will be expected to:
- Know where they are in terms of maturity and where they are aiming to get, and that they are making progress against their plans
- Be functioning effectively as teams, making use of additional roles, working with relevant partners to ensure staff working in the community are aligned with an MDT
- Be working on a service improvement project
- Developed already established links with other local partners, including community service providers, other NHS organisations, local authorities and the voluntary sector
- Have a role at both place and system level
- Be ready to deliver the new PCN DES service specifications

This approach is complemented by the development of our at scale GP provider organisations, including the six GP federations in NCL. We are committed to co-creating a roadmap for at scale GP

providers, building on work in 18/19 to progress the regional Strategic Commissioning Framework using Transformation Funding.

2.1.3 **Improving The Responsiveness Of Community Health Crisis Response Services**

1. Plan for community services delivering crisis responses within two hours, and reablement care within two days

NCL's Urgent and Emergency Care Board brings together partners from primary, community, and acute services, local authority, commissioning and the voluntary sector. The programme has already delivered the crisis response within two hours across NCL, providing crisis response from 8am-8pm, 7/7. Working with our three community providers, we have a high degree of consistency, including standard approaches to referral processes, eligibility criteria and operating hours.

In some of our boroughs, crisis response is already achieved in a maximum of two hours and is often delivered much quicker than that. However, this is not currently a standard contract KPI. The commitments in the Long Term Plan mean this will be sought from 20/21 onwards across the five boroughs in NCL.

In the main our crisis teams provide a two hour response where judged to be clinically appropriate (for example, for all LAS referrals and/or where recommended by another clinician). Other patients are seen either within four hours, or the next day, subject to need.

We are working with local authority colleagues to ensure reablement care is delivered consistently within two days.

We are also seeking to increase the speed at which patients access community-based rehabilitation; a transition plan for contractual KPIs will see a shift from an expectation of a two week wait, to a two day wait, by 2023.

Bed-based rehabilitation has varied. Significant work has taken place to embed an effective Discharge to Assess model with as much emphasis on 'home first' as possible. Beds remain in place however are subject to review. Further work is being undertaken in each borough with local authorities; usage is often dependent on local authorities locating appropriate accommodation for patients deemed to require a supported care arrangement.

Standardisation has allowed scaled approaches to increase use and promote the service; we have a single referral process through 111; all clinicians have access to crisis response. As well as direct referrals, this will allow increased dispositions from 111 to rapid response services following assessment. We will continue to review and expand the eligible patient cohort, consider 24/7 responses and further integrate with reablement services. We are also working to consider how Discharge to Assess services can be further aligned to crisis response services, creating a more robust service and simplifying the offer for patients and referrers.

We meet the two- day reablement target across all five CCGs for community provision; crisis response is able to start reablement care the same day. We are working to further integrate this offer with 'downstream' care. There is more variable patient experience around access to bed based reablement (Intermediate Care); work has begun to map the provision and develop sharing arrangements across CCGs to better manage capacity. We will accelerate this work to address this standard.

2. How anticipatory care will be provided jointly with primary care in joint enterprise with GP practices as part of Primary Care Network delivery

Integration of primary and community services, together with local authority and voluntary sector providers, is critical to delivering effective anticipatory care. Across different patient cohorts we have a number of exemplar models that we will look to build on as greater detail around the PCN DES is made available.

PCNs in NCL have been formed on the basis of geographical contiguity between practices; many are on the same footprint as the earlier CHINs/ neighbourhoods, where community providers were partners. In the development of integrated care partnerships at a borough level, community providers will be working to configure their teams on the same footprints, with a plan to develop a roadmap for alignment, to ensure readiness and ability to deliver the anticipatory care PCN DES specification in partnership from April 2020.

We have developed effective models of practice around different patient cohorts e.g. frailty, long term conditions, SMI). Each borough has developed multidisciplinary working with key elements of the health and care closer to home approach embedded (population segmentation/development of register, proactive case finding based on risk, outreach, care planning, multidisciplinary review and proactive case management, support to self-care and self-manage).

Through the HCCH Board and increased collaboration across NCL, we are working on how we will develop a consistent approach in line with national specifications. By working with GP Federations, Primary Care Networks and community providers, we have a strong basis on which to develop the offer for our frail population.

All of our community providers have committed to wrap around the PCNs / neighbourhoods. During 19/20 the detail will be further developed – this will involve consideration of caseloads, location, volume of activity, needs within different boroughs & communities, operating policies and procedures, alignment of objectives and incentives and development of joint working between operational managers/leads so the supervision of and support to frontline staff is clear.

Self-Care is at the heart of our plans *(please see the chapter on giving people more care over their own health and more personalised care for more on this).* In one borough, we have introduced the Patient Activation Measure (PAM), focusing first on completion of a PAM level and NCL residents' level of knowledge, skill and confidence when it comes to managing their own condition. This is key to patient-centred care planning and self-care.

A key aspect of ensuring that we successfully remove the barriers between Primary and Community care will be the drive to improve technological capabilities – both the technology that supports direct patient care and technology that supports planning and proactive delivery of key population health outcomes. *Please see digital chapter for more on this.*

We are implementing a local digital solution to support effective anticipatory care at a population level. HealtheIntent will create more data-driven care, integrating near real time data to deliver actionable analysis on which patient cohorts will benefit from anticipatory or proactive care.

There is much work in progress. Two local NCL providers are contributing to the national programme on developing a community currency, which will support improved use of the community data set. We also have models being tested for effective e-rostering, for example with District Nursing teams, to better manage capacity and demand. As our analytics develop, we will move to use of integrated datasets as default case-finding tools helping focus care planning on those patients most at risk of non-elective hospital admission.

3… Enhanced health in care homes

NCL faces significant challenges in how we commission, deliver and monitor services for care home residents. Care home residents have increasingly complex needs with multiple long-term conditions, significant disability and frailty, affecting their physical and mental health.

The 230 care homes in NCL are an important part of our health and care infrastructure, with care homes providing homes to 6,000 of our frailest residents outside of hospital (there are more care home beds than NHS beds in NCL). It is also important to recognise that there is uneven distribution of care homes across NCL, which is a challenge for supporting primary care networks to offer a consistent service. For example, there are around 90 care homes in Barnet (>70% of care home beds in NCL are in Barnet and Enfield), whereas there are only eight within Islington.

NCL's care home residents experience high acute admissions and LAS call outs, costing £42m in admissions 2017/18. This is above peer benchmarks and the London and national averages. One factor driving this is the lack of consistent service delivery against the Enhanced Health in Care Homes Framework and as mandated in the LTP for achievement by 2023/24. Given this, it is essential that NCL commissioners work with care home providers and partners across the system to ensure that this population group receives equitable access to services and high quality care.

The complexity of residents' needs makes them the most vulnerable in our society, and at higher risk of harm, hospital admission and ill health. Working partnership with the Local Authorities, NCL have developed a Joint Care Homes Strategy and a Care Home Quality Framework. These seek to improve quality and outcomes across nursing and residential care making the most of the variety of health and social care offered across NCL, and join up dedicated services so they can work together for the benefit of the individual.

The intention is to shift the reactive, expensive reliance on acute care, to a pro-active community based model that delivers better outcomes for our residents. Alongside in-reach service provision, the five local authorities, working with the STP, have developed an innovative workforce programme that is supporting social care providers to recruit and retain staff, develop progression pathways that increase staff skills and leadership capacity, which will support the NHS to meet the health care needs of care home residents. This includes the development of the Proud to Care North London recruitment and development portal for care staff as well as apprenticeship programmes for Trainee Nurse Associates and Registered Managers http://proudtocarenorthlondon.org.uk/ . All of this work is supported by robust quality monitoring and quality improvement functions across Councils and CCGs in NCL.

The Care Homes Review and Quality Framework recognised that there are a range of locally commissioned services for care homes in parts of NCL, including GP in-reach and MDT support and a range of quality and workforce initiatives and interventions to support care homes. However, there are different models of care in each borough and some gaps, for example, benchmarking identified considerable variation in primary care input to care homes between boroughs, with more work needed to ensure all care homes have access to a named GP and a consistent level of service is provided to residents.

The national and local policy context and evidence base indicates a strong case for change to work jointly around care homes and we are defining the scope of this work currently. This work will support the development of our ICS approach, particularly through the partnership of NCL CCGs and local authorities, which will support the delivery of improvements in care quality and experience for this vulnerable resident group.

We are taking a number of immediate actions that will support PCNs. We are commissioning a care home dashboard to give us up to date information on activity levels and quality, which will make it

easier to target and track the impact of interventions. We are contributing to the development of the national PCN DES specification for enhanced health in care homes, which we understand to be a baseline to build upon (some parts of NCL are likely to commission above this already).

In September 2019, we have a Darzi fellow starting, who will focus on care homes. This position will help bring the system together to co-design and implement a new model for primary care input in line with the EHCH framework. It will also support the development of an evidence-based model of care that will provide clinical leadership and support outcomes that are more consistent across NCL. The fellow will work in partnership with emerging PCNs, and with care homes to develop their capacity and workforce. They will draw in wider stakeholders from health and social care, including MDT in-reach from other parts of the system, ensuring they work together to maintain health and wellbeing for residents to stay well.

Implementing new models of care across an STP involves striking a balance between standardisation of systems and processes, and necessary adaptation to local context. Our Fellow's clinical leadership will enable us in addressing unwarranted variation from the system, whilst ensuring sustainable change, which delivers the outcomes residents need. In addition, the five local authorities will continue to lead a workforce programme for care homes, supported by the STP and NHS partners, that increases the skills and capacity of social care providers to deliver good quality care in partnership with the NHS.

Collectively the impact of this activity should see major improvements in outcomes for care home residents and a sustained reduction in acute activity from this cohort.

4… **Build capacity and workforce to achieve these goals by implementing the Carter report and using digital innovation**

Our NCL workforce programme, and specific Health and Care Closer to Home workforce action plan describe our plans to develop, retain and recruit our workforce (more below). Through use of tools such as e-rostering, greater standardisation of shift patterns and the adoption of Care House per Patient Day, we are able to better understand staffing requirements.

We have a comprehensive digital programme, which includes the introduction of a population health management approach and a health information exchange across NCL as priority areas, and the development of a patient-facing digital record. With the introduction of (PHM and HiE, and analytical capability (e.g. in working with our GP federations) we will be able to capitalise on the wealth of data in individual systems, and better understand how what happens in secondary care impacts on primary care, and vice versa. We are working to align primary, community, mental health, NHS 111 and out of hours providers. In one borough, work is underway to align the community health care service system with that of GPs to include e-referrals, e-care plans and shared care planning, using the same system. Some community health services in NCL are exploring operating from GP premises, including services for MSK, COPD, diabetes and asthma.

This is in addition to dedicated digital projects, including the development of digital and telephony-based services, which, in primary care, will increase capacity and support delivery of more efficient care e.g. through better use of estates/ using physical clinical space as necessary. In primary care specifically, we are introducing online and video consultations, and many patients are already able to book appointments, access test results and order prescriptions online.

For detail on digitally enabled primary care, please see digital chapter. This will include more about online and video consultations, booking appointments, getting results online.

2.1.4 **Implementing Service Improvements And Achieving Impact** -

1. **Phasing and delivery of the new GP Contract**

   We have taken a one CCG approach across NCL to support the introduction of the new GP Contract, led through the Health and Care Closer to Home programme, working in partnership with all five CCGs, primary care finance, the LMC and GP federations (as appropriate). We have mapped the requirements of the new Contract, identifying leads and resourcing for each priority. This approach includes development of consistent information, communication and support for practices – ranging from co-produced and presented practice-level information events (April and May) to a coordinated approach to PCN and clinical director support.

   The success of the PCNs in delivering the seven new national service specifications will be dependent on significant cultural change, and on geographical alignment between partners within PCNs – a focus in 19/20 (described above).

   Further detail on links to the seven PCN DES specifications and when we expect to implement them, to be added here.

2… **Full implementation of the final years of the pre-existing GP Forward View commitments**

North Central London CCGs have been investing GPFV funding into primary care since 2016. We will continue to support the implementation of this funding until March 2021. With the exception of investment to progress online consultations, which is managed once for north central London, and extended access, each GPFV funding stream has been allocated to CCGs on a capitated basis. We have submitted investment plans to NHSE/ I on this basis for 19/20. Progress is monitored via local Primary Care Transformation Groups and the NCL Health and Care Closer to Home programme board.

We will continue to build on progress since the publication of the GPFV. Examples of investment in recent years include:

<u>Online consultations</u>

To enable efficiency of scale, this funding to date has been pooled across NCL and we will continue to do so up until 2021. A single online consultation provider procured to deliver an online consultation solution to our population. The initial pilot sites went live in July 2019, and we are working to up to 100% coverage by March 2020. This means that every general practice in NCL will have had the opportunity to offer an online symptom checker to their patients. It is expected that by March 2020 we will also have begun to pilot video consultations. This is in line with the expectation that all patients will have access to video consultation by March 2022.

<u>Practice resilience</u>

NCL CCGs have worked together with LMC colleagues to develop a shared approach and principles around how resilience funding is made available to our general practice teams. We will continue to work together in this way in both 2019/20 and 2020/21.

<u>Extended Access</u>

The GPFV access funding in 19/20 and 20/21 will continue to be committed by all five NCL CCGs to the running of extended access services. These services ensure that our population can access general practice appointments between 8am – 8pm seven days a week. The new GP contract makes it clear that extended access services of the future will need to be linked closely to our primary care networks. We are committed to improving access to primary care overall (a priority programme within NCL) and will work closely with our PCNs and other GP at scale providers to co-design the future service model could look like, ensuring this is aligned with the findings of the national access review taking place in 2019/20.

3**… Major capacity boosts to community services to support long-term plan goals**

NCL commissioners came together in 2018 to share strategic priorities for community services and explore a new approach to commissioning community services. We wanted to move to a model that supports and develops:

- Population health management
- New technology and data sharing
- Outcome based payments
- Prevention and self-care including social prescribing and wellbeing

Work is underway to co-ordinate a strategic approach to community service development and identify opportunities to collaborate across a wider footprint, e.g. for "fragile" services, often small scale and reliant on a few skilled workers.

To support community providers coming together, with each other, with primary care, and to increase collaboration, we are planning an NCL workshop (October 2019) for community providers to come together to start this conversation. This will be an opportunity to co-create both local and NCL conversations about the future of community services, including alignment with PCNs, and working with clinical directors, to start planning the pace and scale up of approaches.

We are testing models such as clinical pharmacists who provide both face-to-face clinical care in practices and support specific projects to reduce the prevalence gap – e.g. improving identification and treatment of Atrial Fibrillation across NCL. We have used pharmacists to develop templates and improve coding so that those at risk are invited in to a clinic where the clinical pharmacist can review and initiate anti – coagulation, leading to a reduction in the prevalence gap. We are now working with Clinical Directors across NCL to ensure we build on this work with the new roles coming into PCNs.

In HCCH we have a workstream supporting social prescribing, which has included developing role descriptions and templates for PCNs in recruitment. We have tested navigator roles and are engaging local VCS organisations across NCL to ensure social prescribers build on existing infrastructure. This supports the work in emergent borough partnerships focussing on prevention and early intervention.

We have started to scope out the estates implications and the development of potential community hubs. Many practices cannot accommodate additional staff due to space limitations. We have held Locality Estates workshops to bring system partners together to scope out opportunities and barriers to new ways of working.

Our workforce strategy has included developing new roles, e.g. peer coaches, who can support new approaches such as social prescribing. We have secured funding from HEE to develop a programme to support foundation level pharmacists recognising the opportunity that these emerging roles bring to new areas of health and care. The programme will facilitate supervised rotations through different sectors of pharmacy i.e. community settings, mental health, acute hospitals, with a focus on multidisciplinary working. We also want ensure provision of the independent prescribing qualification, and facilitation of 'specialist' rotations e.g. care homes, urgent care centres, GP practice, to support developing advanced practice in Year 3. By providing experience in more than one setting, and by providing strong clinical leadership and training we think this will develop strong networks of pharmacists who understand how to deliver optimal care in an integrated way.

To support the move towards integration, we are also establishing joint transformational posts within some Community Service providers. For example, Barnet have established a joint transformation

team that sits across both the CCG and Royal Free to deliver joint QIPP. We are taking the learning from this project to create a similar team that will sit across the CCG and CLCH. This post will provide a population health management focus, and will be responsible for ensuring the right information is being collected and reported to enable risk stratification to take place. The aim is to develop a single transformation team across primary, community and acute sectors, which will demonstrate the impact of increased preventative resources at a primary and community level.

4….**take into account and address major workforce challenges**

NCL faces significant challenges for its future workforce across all sectors. Primary care is particularly stretched, with 25% of the GP workforce likely to retire within the next ten years, and there is a shortage of general practice nurses – we have the second lowest number of practice nurses nationally. There are low numbers of GPs per patient in Barnet, Enfield and Haringey, and low numbers of practices nurses in all CCGs. fewer GPs are looking for partnerships, and there are recruitment and retention challenges. In addition, social care has 1,000 fewer nursing beds than the average for London, and an extremely high use of agency staff.

In response to the challenges, we have developed a workforce plan for health and care closer to home, in collaboration with system partners. The plan is intended to support delivery of the ambitions of the NCL Strategy for General Practice. It covers general practice staff (GPs, nurses and PCN new roles, the wider and community workforce and social care) and focuses on:

- Retention – experienced and valued staff and skills are needed across the health and social care system
- Recruitment – to meet the high requirement demographic and attrition rates
- Transformation – new ways of working

Our priority is to retain those we have already invested in, while transforming some of the ways in which they work to better meet the needs of people's health and care in the 21st century. However, it is evident that we also need to recruit additional numbers to meet the growing demands upon our health and care services. We will be supporting our PCNs in order to recruit their additional workforce, and recognise we may need to work with the rest of the system in order to ensure need is met – e.g. through employment passports. The opportunity is to consider which roles could have the most appropriate skills to meet this increasing demand rather than continue with current models. Such organisational development will require significant work with current staff to ensure their engagement.

1. **Decide how carer identification and support addressed locally, improving carer outcomes**

In developing our PCNs and local borough partnerships, we will develop new ways of identifying and supporting carers. We already work closely with local authorities who lead on the local offer for carers. Our carers' hubs are an opportunity for PCNs to understand the changing needs of carers, and to improve the way carers are identified and supported.

We know there is more to do, and we need to build on successes within our local authority partners. However, some of our work already supports this, e.g. a programme to transform outpatients will offer more options for phone or screen-based consultations at home, which are easier for people who may be, or require, carers. Practices can flag carers, and we want to look at best practice around the development of services, e.g. the development of a carers' passport for health settings. As we develop our universal personalised care offer, we will prioritise how we can support carers by, e.g. through providing good information on out of hours options, and promoting better understanding for how to care for their loved one. Camden and Islington Foundation Trust have developed a recognised model for supporting carers of those recently diagnosed with dementia

(START programme). As our PCNs develop across NCL we will look at opportunities to share this best practice and develop a similar model for the north of the patch.

Young carers are provided with support from local authorities and we are working to ensure more consistency in NCL, e.g. through Child and Adolescent Mental Health provision, and using new digital solutions to provide support and advice to young carers.

2. **Systems should include prospective quantified impact of new integrated community-based health model on downstream hospital NHS utilisation and outcome improvements**.

   In development through September 2019.