North Central London Sustainability and Transformation Plan

North Central London Sustainability and Transformation Plan 31 January 2017

DRAFT

Key information
Name of footprint and number: North Central London, no. 28 **Nominated lead of the footprint:** David Sloman, Chief Executive, The Royal Free NHS FT **Organisations within footprint:** CCGs: Camden, Barnet, Islington, Haringey, Enfield LAs: Camden, Barnet, Islington, Haringey, Enfield Providers: Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS FT, Central London Community Healthcare NHS Trust, Central and North West London NHS FT, Moorfields Eye Hospital NHS FT, North Middlesex University Hospital NHS Trust, Royal Free London NHS FT, Royal National Orthopaedic Hospital NHS Trust, Tavistock and Portman NHS FT, University College London Hospitals NHS FT, Whittington Health NHS Trust

Contents

1 Foreword

Welcome to the Sustainability and Transformation Plan (STP) for the health and social care services that serve the population of North Central London. The aim of the STP is to ensure North Central London (NCL) is a place that provides the entire population with access to the best possible health, care and wellbeing services, where no-one gets left behind.

This STP is not set in stone. It is a work in progress and we welcome your comments and input as we further develop the plan to meet the needs of local people.

For the first time, 22 sovereign organisations that are responsible for the provision and commissioning of health and social care services in NCL have come together as partners to plan how we will deliver excellent and future-proofed services for our local population over the next 5 years.

We know that the health and social care needs of our local people are changing. There are serious capacity and design issues affecting our ability to provide the consistent and high quality health and care services in NCL to meet these needs. The result is that people receive different care depending on where they go to obtain it: waiting times for some services, as well as the health outcomes may vary, and the quality of care and people's experience of health and social services is sometimes not as good as we want it to be.

On top of this, our financial situation remains challenging. Demand for health and social care continues to grow year on year. The growth in demand is exceeding any increase in funding. If we do nothing in NCL, we would face an unprecedented financial gap in relation to health services alone of nearly £900m by 2020/21. Add to this that people are living longer, but not necessarily in good health, which creates more pressure on the limited social care services and funding.

Given that we have to work within the resources available, we believe the best approach to meeting these challenges is to work together to tackle them head on. Working together we can find solutions that work across NCL and we can align the system around the interests and needs of local people rather than solely focusing on individual organisations.

It takes time to build relationships and trust in the context of a system that is fragmented and under increasing pressure, but we are all committed to this joint endeavour across the whole partnership.

This STP sets out our commitment to transforming care to deliver the best possible health outcomes for our local population; 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.

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 NCL. 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 and this is detailed later in section 10. We have also worked proactively with the Joint Health Overview & Scrutiny Committee in NCL to ensure that our developing plans are scrutinised and the robustness of our plan is challenged.

The plan sets out a mix of radical service transformation and the incremental improvements we believe we need to make across health and social care to deliver tangible benefits for our population: increasing the emphasis on prevention; shifting care closer to home to reduce demand on hospitals; reducing variation in quality; improving productivity and reducing waste.

The draft plan does not have all the answers. We are continuing to develop our thinking on the details of most parts of the plan. We have updated our plan at the end of January 2017 and will continue to work on the details so that we can produce an updated plan by the end of March 2017. We will continue to test the validity of our plan throughout this process with our partners, patients, service users, carers and with the NCL community and we will continue to make any necessary adjustments.

We recognise the sheer scale of the changes that we set out currently in the plan will stretch our capacity to deliver. We will need to 'stress test' the plan to ensure we focus on the most important improvements first.

Of equal importance, the plan does not yet balance the finances, either next year or by 2020/21. Unless we achieve this, we will not be able to afford all of the investments and improvements we aspire to deliver. We know that we may face some really tough decisions about where we can invest for improvement and where we will need to prioritise or make choices.

We need to resolve these questions between now and the end of March 2017. We will prioritise 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) to focus our energies on achieving maximum benefit. This will include trying to attract as much investment into NCL as possible. We will continue to further develop ideas in the parts of the plan which are not fully evolved. We will review the phasing of our specific priorities for the first two years of our plan in the context of the significant financial challenge we face. We will also seek to identify areas where we can go further and faster, and look for where might be appropriate for us to could defer our investment or effort.

We recognise there is much more work to do, and it is important that residents are involved. We are at the beginning of transforming health and social care for our population. It will require significant input and contribution from the people who use services in NCL. We look forward to working with our community to make designing, implementing and evaluating the plan a success.

2 Executive summary

It has been a year since we were asked to come together as a partnership of 22 health and care organisations in North Central London. During this time we have invested time, energy and resources into building strong relationships with each other and a shared vision for how the health and care system can become more sustainable and deliver high quality services to our community where and when they need.

The people of NCL are at the heart of our plan. Our vision is for our community to be happier, healthier and to live longer. 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 will develop and support a highly skilled and professional workforce to serve NCL.

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

Every day the media report on the pressure experienced by our health and social care system in London and across the country. We know that to meet the demands of our population now and into the future we need to 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 and they want care closer to where they live and work. Some of our boroughs, such as Islington and Haringey, already have a strong history of working together and we know there some similarities in the health and care profile of the NCL populations. We want to use this knowledge to deliver better health and care services to the NCL 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, however for many people, the last 20 years of their life is lived in poor health. As a result, these people often require a lot of support from health and care services.

Working together as North Central London, 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 NCL community.

Our greatest aim is to work together 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 all organisations at how services are provided and identify opportunities to add value, improve outcomes and eliminate duplication and reduce costs.

Our vision is for NCL to be a place where our people experience the best possible health and wellbeing. A place where no one is left behind. To deliver on our bold vision, we have designed a programme of transformation with four fundamental elements:

1. **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.
2. **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.
3. **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.
4. **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.

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

The draft plan we submitted in October 2016 projected a financial deficit across the NHS organisations in NCL of £75m by 2020/21. We continue to work to identify additional efficiencies that will help to reduce this residual gap. We will update our financial forecasts by the end of March 2017.

During 2016 we put in place a governance structure to enable NHS and local government organisations to work together in a new way to develop our plan. We are now reviewing this governance structure to ensure that it is fit for purpose as we move from planning to implementation. We put in place dedicated resources to support the planning process in 2016/17 and we are currently reviewing the capacity we need to drive forward delivery from April 2017. It is crucial that whole system is aligned and committed to the delivery of

the STP and we have ensured the two year health contracts that are in place for 2017/18 - 2018/19 are consistent with the STP strategic framework.

We recognise there is still work to be done and there is more detail to be provided around how we will achieve our vision. To make sure our work plans are robust and provide the necessary granular detail, we will fully engage with local people who use health and care services and we will work with the public to test our thinking to ensure our plans reflect their needs.

We are committed to being innovative in our approach; to focusing on improving the health and wellbeing of our NCL 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.

3 Context

North Central London (NCL) comprises five London Boroughs: Barnet, Camden, Enfield, Haringey and Islington, each of which is coterminous with the local Clinical Commissioning Groups (CCGs). Approximately 1.45m[1]people live in NCL. We spend c.£2.5bn on health and c.£800m[2] on adult and children's social care and public health. The population is diverse and highly mobile, with a large number of people living in deprivation[3].

We have many excellent health and care services in North Central London (NCL). However, services are not consistent and there are some examples of poor practice. We also face significant challenges over the next five years and this means we need to shift our model of care so that more people can be cared for in an out of hospital setting. This Sustainability and Transformation Plan (STP) is a collaboration between each of the major healthcare organisations and the local authorities within NCL. It sets out our vision for health and care services and how we are planning to address the challenges we face, improve health and care outcomes for our community and deliver high quality and sustainable services in the years to come.

We know that we have the commitment and the capability to provide excellent services and deliver the significant change that is required to make our system sustainable. However, there are some services across NCL that are inconsistent with the standards we know are our community deserves. We face significant challenges around the health and wellbeing of local people; and it is important that our health and care system is well placed to deliver the standard of care and quality of service we know we are capable of. Our current system is focussed on illness, rather than prevention. Yet we have the knowledge, skills and experience to support people to live well.

There is also a substantial financial challenge facing health organisations in NCL; the health system is already in deficit and this situation will continue if we do not address the inefficiencies, waste and duplications that we know exist. If we do nothing, within the next five years we estimate we will be c.£900m in deficit.

Local authorities are also facing significant financial pressures due to demographic changes, reduction in funding from the Central Government and policy inflation: by 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£300m.

[1] ONS, Mid-year population estimates, 2015
[2] 2015/16
[3] Office for national statistics, IMD 2015

If we are to have the health and care system our community deserves now and into the future we must find ways to be more efficient, to use the resources and tools available to us to create a system that will be sustainable and provide the highest quality of health and social care service. Below is an outline of the services within NCL:

- There are four acute trusts: The Royal Free London NHS Foundation Trust (whose sites include Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital in Hampstead), University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, and Whittington Health NHS Trust. There are two single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. Great Ormond Street Hospital for Children NHS Foundation Trust is within the NCL geography, but currently out of the scope of the STP.
- Community services are provided by Central and North West London NHS Foundation Trust, the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust.
- Mental health services are provided by the Tavistock and Portman NHS Foundation Trust, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust.
- There are 220[4] GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative.
- There are 497 active social care sites registered across NCL, including 273 registered care homes (47 of which provide nursing)[5]. Care homes are particularly high in numbers in the north of NCL, for example in Enfield where there are 97 registered care homes (in contrast to the 12 care homes registered in Camden)[6]. In addition, there are 214 registered domiciliary care providers[7].

The organisation of services in NCL makes the area unique and this has ramifications for how we plan to join up health and social care services: there is a particularly high concentration of specialised services across multiple providers covering a small geographic area. This means many of the patients treated in NCL do not live in NCL and consequentially, a large proportion of the income paid to our providers comes from commissioners outside of the area.

As individual organisations in NCL, we have a history of working together in different ways to meet the needs of our population. As a result, there are many excellent examples of

[4] Latest figures from NHS England, updated since publication of the NCL case for change
[5] Local Authority Care Quality Commission reports, 2016
[6] Local Authority Care Quality Commission reports, 2016
[7] Local Authority Care Quality Commission reports, 2016

collaboration. However, working collectively across *all* organisations remains a relatively new endeavour and we continue to build the working relationships and trust required to enable us to do so efficiently and effectively.

We are home to four national Vanguards: The Royal Free London NHS Foundation Trust is developing a provider chain model; University College London Hospitals NHS Foundation Trust Vanguard is focused on what can be done to improve the end-to-end experience for people with cancer; Moorfields Eye Hospital NHS Foundation Trust is developing an ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust is one of 13 partners developing a UK-wide chain of orthopaedic providers.

NCL is also home to two devolution pilots: one seeking to optimise the use of health and social care estate, and another focused on prevention in Haringey. In primary care, GP practices are already working together in a number of GP Federations to provide extended services to our residents.

In NCL, every borough has its own unique identity and local assets we can build on. Most people lead healthy lives, but when they do get sick we offer some of the best care in the country. We have a reputation for world class performance in research and the application of innovation and best practice, and we can harness the intellectual capacity of our workforce to ensure the best outcomes are delivered. There are many examples of excellent practice across health and social care in our area, which we intend to use to help ensure that excellent practice can be offered to all our residents.

Our track record demonstrates that we have the capability to deliver excellent services and also to significantly change our services when needed. Our ambition is that everyone is able to get the care they need, when they need it. This means ensuring people have the best start in life, and supporting them to be healthy throughout their lives. When people do need specialist care, we want them to be able to access it quickly and in the most appropriate setting, and to be fully supported to recover in the setting most suited to their needs.

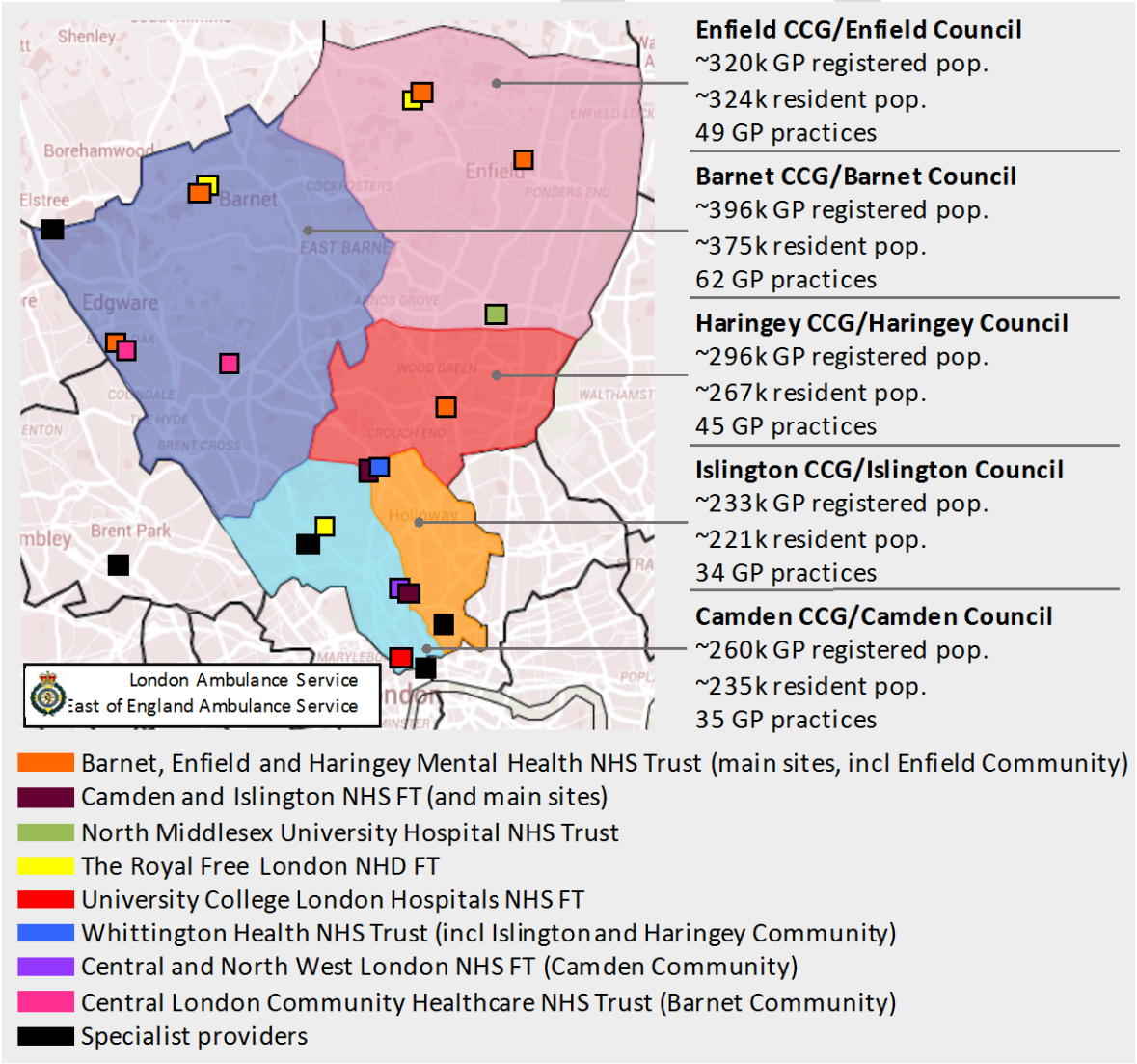
However, we are not consistently delivering our ambition to the standards we would like. We face significant challenges around the health and wellbeing outcomes for our population, the quality of our services and the financial sustainability of the health and care system. These are outlined in this document and set out in more detail in our case for change[8].

[8] https://www.uclh.nhs.uk/News/Documents/NCL%20case%20for%20change.September%202016.pdf

The national requirement to produce an STP is an extraordinary opportunity for NCL to address these challenges together and widen the scope of our collaborative working. This document articulates:

- our collective understanding of the challenges we face
- our vision for health and care in NCL in 2020/21
- the plans to deliver on our vision and address the challenges
- the delivery framework which will enable us to implement our plan
- the impact we expect to achieve through the delivery of our plans
- our plans for securing broader public support and engagement with our proposals
- our next steps for further developing proposals and responding to our residual financial gap.

Exhibit 1: Overview of NCL



Source: Population figures from 2014 ONS data.

4 Case for change: our challenges and priorities

In NCL we share many of the same challenges faced by health and care organisations across the UK (and internationally). 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. Across the system we have aligned behind this work and we all agree on the nature and scale of the challenge, which we have described in our case for change which was published in September 2016.

4.1 Health and wellbeing gap

We have a diverse and highly mobile population. There are people from a range of Black and Minority Ethnic (BME) groups: these groups have differing health needs and health risks. A quarter of our local people do not have English as their main language[9], which creates challenges for the effective delivery of health and care services. The mobility of our population, with 8% of local people moving into or out of NCL each year[10], has a significant impact on access to services and delivery.

Poverty is a crucial determinant of health, and is widespread across the boroughs that make up NCL[11]. Many NCL children and adults are living in poverty. Significant inequalities exist, which need to be addressed; for example, men in the most deprived areas of Camden live on average ten years less than those in the least deprived areas[12]. We face challenges in addressing other wider determinants of health, for example, there are high levels of homelessness and households in temporary housing with all five boroughs in the top 10% for number of households in temporary accommodation[13]. Social isolation also remains a critical issue across the sub-region.

The children of NCL do not always get the best start to life. 30% of children grow up in child poverty and 6% live in households where no one works. Sixty children take up smoking every day[14]. Although there have been some improvements recently, London as a whole has the highest rates of obesity nationally: 1 in 3 children are obese in Year six (age 11) and we need to do more to tackle this, particularly working with the schools in NCL[15]. Although many of our residents are healthy and people are living for longer, good health does not always continue into old age. Our older people are living the last twenty years of their life in worse health than the England average[16].

[9] NCL case for change, 2016
[10] ONS mid-year population estimates 2014
[11] Census 2011
[12] IMD 2015, ONS
[13] https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
[14] CENSUS 2011
[15] Public health outcomes framework tool, 2015
[16] Office for National Statistics, HSCIC CCG Indicators, 2014-15

Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) putting their health at risk[17]. However, they have not yet developed a long term health condition. Many of these lifestyle-related clinical problems are risk factors for NCL's biggest killers - circulatory diseases and cancer. These diseases are also the biggest contributors to the differences which exist in life expectancy.

There are high rates of mental illness amongst both adults and children in NCL[18], and many conditions go undiagnosed[19]. 50% of all mental illness in adults begins before 14 years of age and 75% by 18[20]. Children whose mothers experience mental ill health are much more likely to develop mental health issues themselves. Three of our boroughs have the highest rates of child mental health admissions in London[21] There are high rates of early death amongst those with mental health conditions[22], particularly in Haringey and Islington, and the rate of inpatient admissions amongst this population is above the national average. A strong focus on mental health is central to our approach with a clear aim of treating mental and physical ill health in a joined up way and with "parity of esteem."

4.2 Care and quality gap

Currently, our system does not sufficiently invest in those people with a life-style related clinical problem, which would help stop them from developing the long term conditions which, in aggregate, are a huge burden on our health and social care system. Only 3% of health and social care funding is spent on public health in NCL[23], and that is despite evidence showing that between 2012 and 2014 around 20% (4,628) of deaths in NCL could have been prevented[24]. There is a great opportunity to prevent many of these deaths by refocusing our efforts towards prevention and making every contact with patients and residents count towards a potential first step in better health and wellbeing. This focus should also address the wider determinants of health such as poverty, housing and employment, all of which have a significant impact on individuals' health and wellbeing.

Disease and illness could and should be detected much earlier, and managed better in a community setting. It is thought that there are around 20,000 people in NCL who do not know they have diabetes, while 13% of the population are thought to be living with hypertension[25]. Some people are being treated in hospital for long term conditions (LTCs)

[17] Camden and Islington GP Linked Dataset projected to NCL level
[18] QOF data 2014/15
[19] NHS England Dementia Diagnosis Monthly Workbook, April 2016
[20] Dunedin Multidisciplinary Health & Development Research Unit. Welcome to the Dunedin Multidisciplinary Health and Development Research Unit (DMHDRU).
[21] Fingertips, 2014/15
[22] Healthy Lives, Healthy People 2010
[23] Based on 2015/16 public health budget of each NCL council
[24] Public Health Profiles Data Tool, PHE, 2012-14
[25] QOF 2014/15

that might be better managed by the individuals themselves with the support of professionals in the community. Many people with LTCs – over 40% in Barnet, Haringey and Enfield – do not feel able or supported to manage their condition[26]. This would help avoid the high levels of hospitalisation we experience for the elderly and those with chronic conditions and improve both their outcomes and experience.

One of the disease specific challenges we face is in the provision of cancer care. In our region of London, late diagnosis of cancers is a particular issue, alongside low levels of screening for cancer and low awareness of the symptoms of cancer, particularly in some minority ethnic groups. Wait times to see a specialist are long, and so are wait times for diagnostics. Additionally, referrals to specialists have almost doubled in five years. There is a huge shortfall in diagnostic equipment and workforce, as well as a lack of services in the community, particularly at weekends. A further issue is that some hospitals are seeing small numbers of patients with some types of cancer, in some cases less than two per week.

There are challenges in primary care provision; however, this is a mixed picture which creates inequity. There are too few GPs in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person across all areas, but particularly in Camden and Haringey.

There are high levels of A&E attendances across NCL compared to national and peer averages[27], and very high levels of first outpatient attendances[28], which indicate probable gaps in primary care provision. Acute providers are not consistently meeting emergency standards.

In the acute setting there are differences in the way that planned care is delivered with variation based on differences in clinical practice rather than patient need and this needs to be addressed. The number of people seen as outpatients in NCL is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

We are using hospital beds for people who could be cared for at home, or in alternative care settings. 59% of acute bed days are used by people with stays over ten days, and the majority of these people are elderly. 85% of the mental health bed days in NCL are from patients staying over 30 days. Delayed discharges are also high in some hospitals. Staying

[26] Office for National Statistics, HSCIC CCG Indicators, 2014-15
[27] RightCare Atlas of Variation in Healthcare, September 2015
[28] NHS England Activity Data 2014-15

longer than necessary in hospital is not good for a person's health, especially the elderly whose health and wellbeing can deteriorate rapidly in an acute environment.[29]

We face challenges in providing appropriate mental health services. People do not always have easy access to the right information and community based support, and our community mental health services are under huge pressure. There is also no high quality health-based place of safety for those suffering a mental health crisis in NCL. Unfortunately many people receive their first diagnosis of mental illness in Emergency Departments.

Many people are admitted to hospital under the Mental Health Act. There is inconsistent access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care: most of the liaison psychiatry and CAMHS services in hospitals in NCL fail to see children within one hour at weekends and overnight admissions[30]. There is also limited perinatal community service in NCL, in the northern boroughs there is no specialist team and in the southern boroughs the service does not meet national standards[31].

Our current use of information and technology does not support integrated health and social care across NCL. This means that although a person may interact with different health services it is currently not possible to have their information shared among health professionals who may be providing treatment or care. There is a variable level of digital maturity across providers and most are below the national average for digital capabilities, particularly in their ability to share information.

Some of our buildings are no longer fit for purpose and there may be opportunities to use our estates better. Eleven sites in NCL have facilities management costs at least 10% more than the Carter benchmark (£319 p sq. m), with a further three sites within 10% of the benchmark. Eight sites have a higher proportion of unutilised space than the 2.5% benchmark contained within the Carter report, and over half of the sites analysed were found to have a higher proportion of non-clinical space than the Carter benchmark (35%).

NCL has a significant health and care workforce challenge, including high staff turnover and retention issues across a range of professions. There is an over reliance on agency staff and Human Resource policies which do not transfer across organisations.

[29] Philip et al. (2013) Reducing hospital bed use by frail older people: results from a systematic review of the literature. International Journal of integrated care.

[30] Mental health crisis care ED audit, NHS England (London), 2015

[31] Maternal Mental Health Everyone's Business

There is consensus across the system that the current approach to commissioning and providing health and social care services across NCL could be better aligned to support the implementation of our emerging vision within the STP. The delivery of a population health approach and genuine integrated care is significantly constrained by:

- the rigid separation of commissioning and providing responsibilities within the NHS
- the limited integration between health and social care that does exist
- the fragmentation of providers of health and care into many sovereign organisations
- increased financial risks across CCGs and providers
- stretched capacity and capability in the current organisational form.

We need to design new commissioning and delivery models that will transform care in a way that is sustainable.

4.3 Baseline financial gap

Our population is growing and demand is increasing: people are accessing health services more often, and while people are living longer, often they are living with one or more long term conditions. These trends have a significant impact on the way and how often, people access health and social care services.

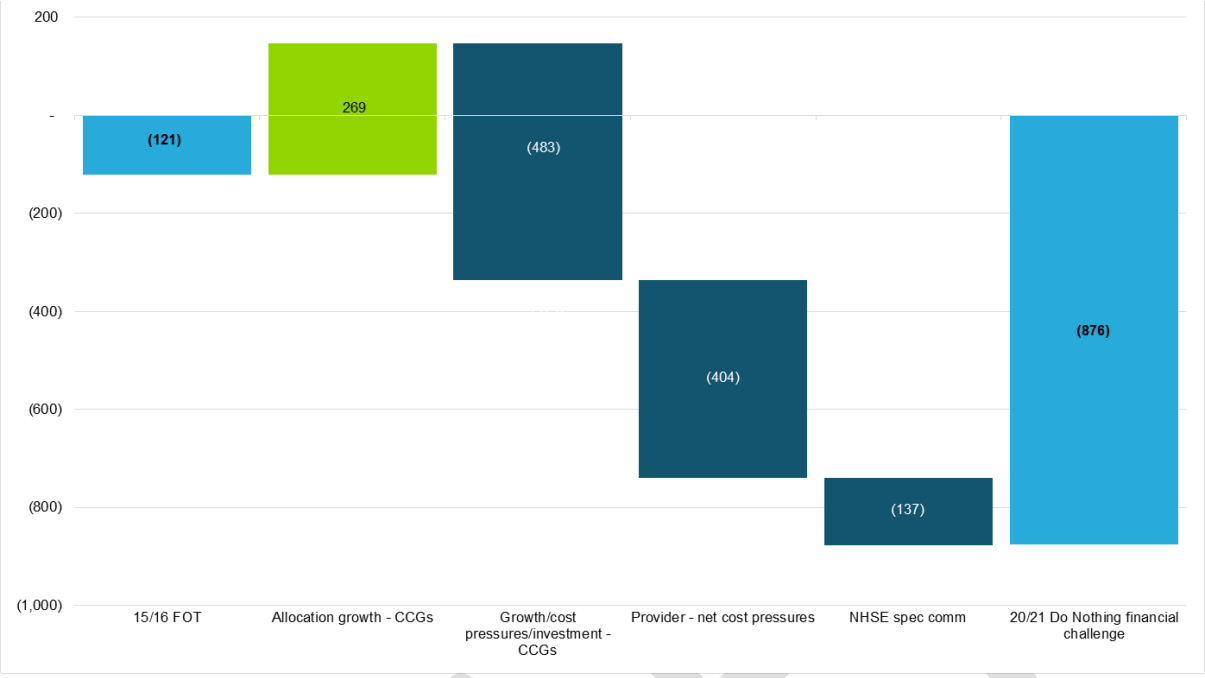
NHS funding

Meanwhile, the NHS's costs are rising more than inflation across the UK economy (to which allocations are linked). The upshot of this is that not only is the system responding to greater demand, but also that the sum cost of activity is growing faster than allocations.

Put simply, funding increases in NCL of £269m over the next 5 years will not meet the increases in numbers of local people and growth in demand for health services of c.£483m, plus increased cost of delivering health care of c.£404m.

This means that there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers were already £121m in deficit in 2015/16 and, if nothing changes, this will grow to £876m in deficit by 2020/21.

Exhibit 2: The 'do nothing' financial gap for NCL



The 'do nothing' specialised commissioning financial challenge is estimated at £137m (this estimate is currently being validated). This excludes Tavistock and Portman NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Foundation Trust which would add a further £2m and £36m respectively. The specialised commissioning challenge is driven by advances in science; an increasingly ageing population with LTCs; and rising public expectation and choice for specialised treatment. In addition there are increasing financial pressures for specialised services, including the increasing volume of expensive new drugs. Spending on specialised services has increased at much greater a rate than other parts of the NHS, and this is expected to continue.

Social care funding

The current combined net budget for the 5 boroughs in NCL is £760m for Adults and Children's Social Care (CSC) and Public Health services. However, we know that between 2010/11 and 2020/21 the average reduction in borough spending power will be 35%. Adult Social Care (ASC) budget reductions during this period will total at least £154.5m. This reduction in funding requires that a significant savings programme be delivered whilst ensuring the vision within this STP can be realised.

The collective 2016/17 forecast budget pressures for the 5 boroughs in ASC and CSC is £39m (£26m ASC, £13m CSC). Both ASC and CSC will continue face considerable pressures from demographic growth, inflation and increasingly complex care needs. By 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£308m, which is equivalent to a 28% reduction on the current Councils' total

budget. Councils may have the option to raise a 2% precept for social care in future years, but this will be subject to political agreement and will not come close to closing the gap.

We cannot address the NHS financial gap without considering the current status of social care in the five boroughs. There is an ever reducing budget and lack of suitable facilities while the demand for social services within the local authorities continues to rise.

5 Vision

Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind.

Developing our vision in NCL has taken time, and we have harnessed our high quality clinical and practitioner leadership at every stage of the process. The vision for NCL initially drew on existing local work which was underway before the STP process started. Leaders across the system then agreed the vision in September 2016. This process, alongside the series of borough-based public engagement events in September and October 2016, has ensured that our vision is collectively owned across the system. We are committed to fulfilling our vision through this plan, and have identified a set of core principles to support our ambition.

Our core principles

- 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 NCL.
- 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 NCL.

The work in the coming months will include staff and resident engagement to make sure we develop a dialogue with the local community, and their representative organisations to ensure we deliver 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 section 10 of this document.

6 The Plan: our Strategic framework

To deliver on our vision and achieve the triple aim as set out in the Five Year Forward View (to increase health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency), we have designed the STP to be a programme of transformation with four aspects:

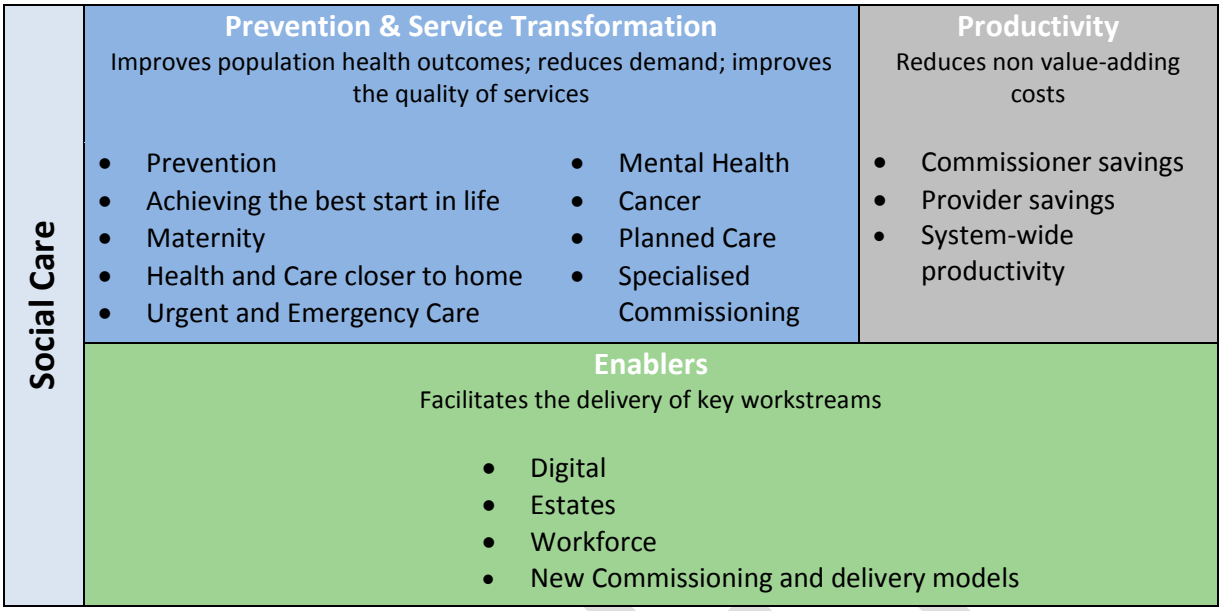
1. **Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in NCL is preventable. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population, which will reduce health inequalities, and help prevent demand for more expensive health and care services in the longer term.

2. **Service transformation:** To meet the changing needs of our population 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. Social care plays a key role in service transformation.

3. **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.

4. **Enablers:** We will focus on delivering capacity in key areas that will support the delivery of transformed care across NCL. This includes digital, workforce, estates, and new commissioning and delivery models.

Exhibit 3: The NCL STP strategic framework



6.1 Implementing our plans

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. We will continue to develop the details of the delivery plans over the next few months as we agree the detailed phasing and investment timetables.

The delivery plans will be live documents and will continue to be iterated as the programme develops. In addition, each workstream is required to develop a full programme initiation document which will provide a reference point for every workstream to ensure planned delivery is on track, and to support the effective management of interdependencies between workstreams.

6.2 Measuring our success

We have established the anticipated impact of each of our workstreams to ensure we remain on track to close the key gaps as set out in our case for change. However, to ensure that the breadth of our workstreams collectively meet the scale of our ambition, 11 overarching outcomes have been developed by the London Health Commission for the Better Health for London strategy. These have been adapted for NCL and endorsed by the clinical cabinet for our STP. We will know if we have been successful by measuring impact against these outcomes over the next four years.

Exhibit 4: NCL STP outcomes

- Ensure that all children are school-ready by age 5. Achieve a 10% reduction in the proportion of children obese by Year 6 and reverse the trend in those who are overweight
- Help all our residents to be active and eat healthily, with 70% achieving recommended activity levels
- Reduce working days lost due to sickness absence
- Reduce smoking rates in adults to 13% - in line with the lowest major global city.
- Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 5%
- Increase the proportion of people who feel supported to manage their long-term condition to the top quartile nationally
- Transform general practice in in NCL so residents have access to their GP teams 8am-8pm, and primary care is delivered in modern purpose-built/designed facilities
- Work towards having the lowest death rates for the top 3 killers: cardiovascular disease, Cancer, respiratory disease and close the gap in care between those admitted to hospital on weekdays and at weekends
- Fully engage our residents in the design of their services, and achieve a 10 point increase on the poll data regarding engagement in designing services.
- Put NCL at the centre of the global revolution in digital health and ensure this improves patient outcomes
- We want to reduce air pollution across NCL, to allow our residents to live in healthier environments

7 The Plan: our key priorities

Strategic approach

To meet the changing needs of our population we will transform the way that we deliver services, shifting the balance 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 health 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.

We are working with our local authority colleagues so this transformation is owned and delivered by every part of the health and care system. This collaboration will lead to more joined up health and social care services, this integration is a key success factor in the realisation of our plan.

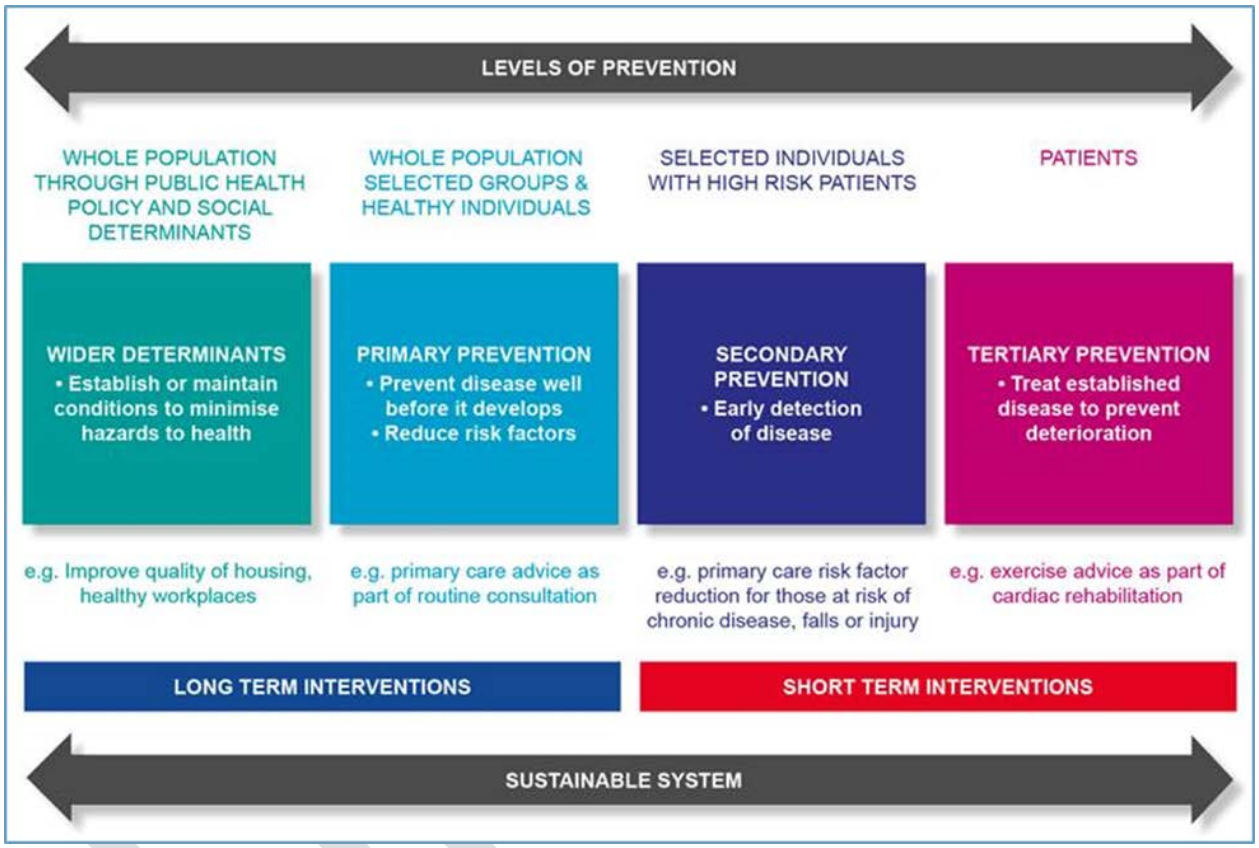
7.1 Prevention

We will embed prevention and early intervention across the whole health and care system and deliver evidence based preventative interventions to our NCL population. We will improve NCL health outcomes and reduce the health inequalities in our community by harnessing available assets within and across the community. This will include council services, social care and the voluntary and community sector. This focus on helping people to stay well will have a positive impact on the overall health and wellbeing of our NCL community

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 (AAOT) by the hospital alcohol liaison worker. This support will enable him to put in place foundations that will help him towards abstinence 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 AAOT, which will include psychological help.

Our prevention plan focuses on interventions and system change across the whole spectrum of prevention (exhibit 5), where there is strong evidence of effectiveness and return on investment within the 5 year period of the STP[32]. We have identified opportunities where we could quickly build upon successful local initiatives across NCL to achieve economies of scale.

Exhibit 5: Approach to prevention



We will concentrate our efforts on:

- **Creating a 'workforce for prevention'** so that every member of the local public sector workforce in NCL is a champion for prevention. *Specific interventions: Making Every Contact Count (MECC); Mental Health First Aid (MHFA); dementia awareness*

- **Ensuring that the places where residents and employees live and work promote good health.** This will include: reversing the upward trend in childhood obesity; supporting people with mental ill health and other long term conditions to stay in work; pioneering new approaches to tackling gambling, alcohol misuse and smoking;

[32] Interventions have been identified from the Public Health England (PHE) Supporting Pack for STPs and the return on investment work undertaken for Healthy London Partnerships by Optimity.

and supporting the workforce across NCL (including our own staff) to become healthier. *Specific interventions: Haringey Devolution Pilot; improving employment opportunities for people with mental ill health through individual placement support (IPS); Healthy Workplace Charter; Healthy Early Years / Healthy Schools accreditation*

- **Supporting NCL residents to look after their health: by smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing.** This will all reduce hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths. We will protect and ensure high quality universal services for vulnerable families by starting direct conversations with schools to proactively identify at risk families, and collaborating to map across primary care, social care, early years, therapies, paediatrics and secondary care. We will support people to stop smoking by embedding smoking cessation programmes in maternity services as well as services for children and young people, and targeting parents and older children. Drawing on the experience of our local authorities in running large scale health promotion we will design and deliver a campaign across NCL to address a range of strategies to maintain wellbeing or improving term conditions through a single preventative message with common NCL branding. *Specific interventions: smoking cessation; alcohol screening, liaison and outreach teams; weight management programmes; diabetes prevention programme; multifactorial falls intervention; long-acting reversible contraception; community resilience; increased access to mental health services for children and new mothers; London's digital mental health programme.*

- **Diagnosing residents with clinical risk factors and long term conditions much earlier to increase life expectancy.** Once diagnosed, giving people the tools and resources to better manage their own condition(s) alongside proactive management by health professionals to prevent the development of further conditions and complications. *Specific interventions: increasing awareness and case finding (including national cancer screening and HIV testing) and appropriate medications to control conditions for people with high blood pressure, diabetes, atrial fibrillation; self-care and structured self-management for long term conditions; reablement offers in social care and care navigation.*

We will build upon on the individual strengths that each part of the public sector in NCL 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. We also recognise the key 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.

7.2 Social care

Social care is central to many of our workstreams, particularly care closer to home, transforming care, and mental health, as well as children's and public health interventions. We are working with local authorities across NCL to design and developing proposals specifically for social care. This includes critically important areas of workforce sustainability; , the sustainability of social care providers, the sustainability of the registered workforce and making sure the personal assistant workforce is adequate in both number and skill. We will ensure that our plans factor in practical steps that we can take as partners to address provider failure and the huge risks around capacity and quality in the domiciliary market.

The role of social workers will be essential to delivering on our model for health and care closer to home. We also need to address the shortage of home care workers, personal assistants, and how to better blend the roles of district nurses and care workers. The workforce workstream will focus on how to better define career pathways, making career offer s more attractive to support improve the long term sustainability of the workforce. We will quantify any investment that might be needed in workforce from a social care perspective such as increasing numbers of domiciliary care workers and by drawing on the learning and evidence available , we will quantify the return on investment.

Social care is also built into our mental health model, including a broader dimension of public service support such as employment support workers. Learning disabilities is a key area of focus. Half of all social care spend is on this group, and children with special educational needs and learning disabilities have unsatisfactory long term outcomes in both health and education. We need to start supporting people with learning disabilities from early childhood, through early detection and appropriate intervention. Many of our interventions, including health visiting, early years, community paediatrics, CAMHS, and working directly with schools will ensure that we better support these children. We plan to scale up our Transforming Care work to implement enhanced community provision; reduce inpatient capacity; upgrade accommodation and support for those with learning disabilities; and roll out care and treatment reviews in line with published policy to reduce long lengths of stay in hospitals and improve independence.

As part of our plan we will explore collaboration and consolidation opportunities between local authorities in areas such as the hospital discharge pathway and the mental health enablement process. We will consider what can be commissioned differently and/or at scale - particularly across health and social care, such as nursing homes. We will focus on

increasing the use of data analysis and risk stratification; working cohesively with public health across the patch; leveraging telecare; and sharing of ideas and learning about best practice in health and social care integration. Our pan-NCL bed state analysis will consider non-health beds, including the 6,440 care home beds in NCL, so that we gain an in-depth understanding of why people are in these beds and how their needs might be met elsewhere (as well as the resources it would take to do this).

We recognise the co-dependencies between health and social care: any change in either sector may have a significant impact on the other. As we continue to develop our plans, we will partner with local authorities so we can mitigate risks together, and transform the system to one that is truly integrated.

7.3 Achieving the best start in life

Children are approximately 25% to 30% of the population across the NCL footprint. This means that service transformation must include a specific focus on our children and young people. We recognise that providing children with the best start in life is critical for their long term development and health. We have identified interventions across pathways, from prevention to acute care, that are focussed specifically on improving health and outcomes for children and young people.

In the context of a 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. We 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 children. We will leverage the work of our NCL Maternity Network to ensure that our local maternity system implements the findings of the National Maternity Review: Better Births. NCL will be taking part in the National Maternity Transformation programme as an Early Adopter.

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 NCL will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

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

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 voluntary sector initiatives like *Hope Tottenham* that are already established and working directly with families and young people. As part of our Child and Adolescent Mental Health Services (CAMHS) and perinatal initiative led through the mental health workstream, we will:

1. **Develop a shared dataset for CAMHS** to enable comparison and shared learning across the 5 boroughs.
2. **Tackle eating disorders** by establishing dedicated eating disorder teams in line with the waiting time standard, service model and guidance.
3. **Upskill our workforce** to meet the mental health and psychological wellbeing needs of children and young people, including developing a children and young people's IAPT workforce capability programme.
4. **Build on our Transforming Care initiative** by supporting children and young people with challenging behaviour in the community in order to prevent the need for residential admission.
5. **Improve perinatal mental health services** by developing a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL.
6. **Implement a Child House model** following best practice to support abused children.
7. **Create a 24/7 crisis pathway for children and young people**, including local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of s136.
8. **Develop a co-commissioning model for youth justice** working with NHS England.

The principles of THRIVE will be used as an overarching approach to our CAMHS work, with the aim that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

7.4 Health and care closer to home

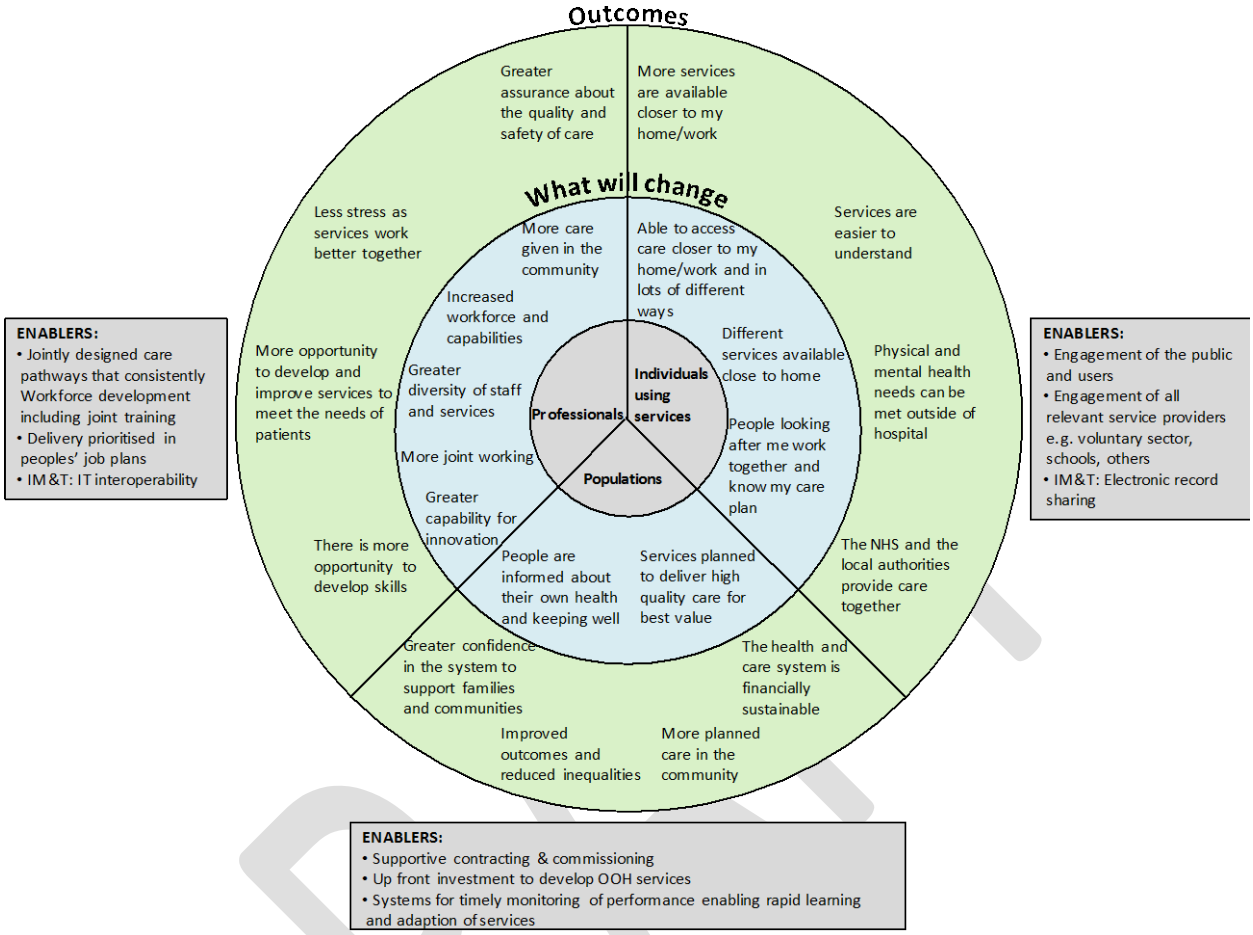
Health and care will be available closer to home for all, so people receive care in the best possible setting at a local level and with local accountability. We already have many high quality services outside acute settings across NCL. Our health and care closer to home model will focus on scaling these services up, reducing variation and making this the default approach to care. Social care will be integral 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.

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.

At the heart of the care closer to home model is a 'place-based' population health system of care delivery. This model draws together social, community, primary and specialist services. It will be underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. We will deliver the right care at the right time to the whole population. The care closer to home model is one of the key vehicles by which we will contribute towards the overall delivery of the Better Health for London outcomes.

Exhibit 6: Delivery of the Better Health for London outcomes through the health and care closer to home model



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

- **Developing 'Care Closer to Home Integrated Networks' (CHINs):** 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 focussed on the strengths of residents, families and communities; 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. We have already piloted CHINs, for example the Barnet Integrated Local Team (BILT)[33] hub which provides coordinated care for older

[33] Barnet integrated Care Locality Team, 2016

residents with complex medical and social care needs, as well as providing support to carers. The BILT hub has been open since April 2016 and is a joint funded health and social care pilot.

- **Extending access to primary care:** 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.
- **Supporting healthier choices:** in line with our prevention agenda, the care closer to home model will include up scaling our smoking cessation activities by 9-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across NCL; scaling up weight management programmes with integrated physical and wellbeing activities; and reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception.
- **Improving access through technology and pathways:** telephone triage, virtual consultations and online booking systems will be available for all patients.
- **Supporting patients through social prescribing and patient education:** 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.
- **24/7 access to specialist opinion in primary care:** primary care will be able to provide more complex patients with a number of options for specialist opinion outside of the hospital itself. These range from: 1) advice only 2) an urgent 'hot clinic' appointment in an out-patient clinic 3) assessment in an ambulatory emergency care facility and 4) admission to an acute assessment unit. In addition, consultant-led clinical assessment and treatment services offered in CHINs will enable more patients to be managed in the primary care setting. Specialties to be considered include gynaecology; ENT; urology; dermatology; musculo-skeletal; and ophthalmology.
- **GP front door model in Emergency Departments:** we will review the existing provision across NCL of GP led triage, treatment and streaming for all ambulatory patients will be provided at the front door of Emergency Departments. GPs and nurses on the door make decisions about where the patient is best treated – which could be in the urgent care centre or emergency department, or redirection to alternative services.
- **Falls emergency response team and multifactorial intervention:** multifactorial interventions combining regular exercise, modifications to people's homes and regular review of medications will prevent people from falling in the first place. If they do fall, falls partnership ambulance vehicles will be available with advanced,

multi-disciplinary practitioners. In addition, a specific falls service will support patients to remain at home after a fall.

- **Enhanced rapid response (ERR):** a rapid response team will prevent an admission to hospital for those in crisis, providing enhanced therapy, nursing and social work support to support people to stay in their own home.
- **Acute care at home:** where there is a medical need, acute clinical care will be provided at home by a MDT to provide the best possible patient experience and outcomes, and enable the patient to benefit from holistic integrated care.
- **Frailty units:** a dedicated service, such as that already in place at the Whittington, that will be focussed on rapid assessment, treatment and rapid discharge of frail older people that could potentially be co-located within the Emergency Department. This will enable ambulatory care for people aged over 65. These would be rolled out across NCL.
- **Enhanced care home support:** provided to stabilise and / or treat residents in the care home where appropriate thereby reducing the level of conveyances, unplanned attendances and admissions to secondary care. The care closer to home model will prevent emergency readmissions from care homes through development of a care home bundle, including a proactive approach to prevention and early identification of complications.
- **End of life care:** we will support people at the end of life to receive the care that they need to support them to die in their place of choice via rolling out the Co-ordinate My Care (CMC) planning programme, and making sure the new Integrated Urgent Care service has access to CMC plans.

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.

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) and establish a single LCS contract framework for the whole of NCL. 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 IPC 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.

Improving outcomes will be the crucial measure of success of the care closer to home model. Using national and international evidence, we have estimated that some of the outcomes that our health and care closer to home model could potentially deliver are:

- 70% of people at the end of their life will have a care plan to support them to die in their place of choice
- 4% decrease in unplanned pregnancies
- a reduction in alcohol consumption with 10% fewer alcohol-related hospital admissions
- up to 150,000 fewer emergency department attendances
- 63,000 fewer non-elective admissions
- 35,000 fewer outpatient attendances
- 10% reduction in falls-related hospital admissions
- a halving of the numbers of late HIV diagnoses
- 50,000 weight management referrals leading to a reduction in excess weight
- 66% of people with high blood pressure have it diagnosed and controlled
- 55% of people with atrial fibrillation are receiving anti-coagulants
- 69% of people with diabetes have controlled blood glucose.

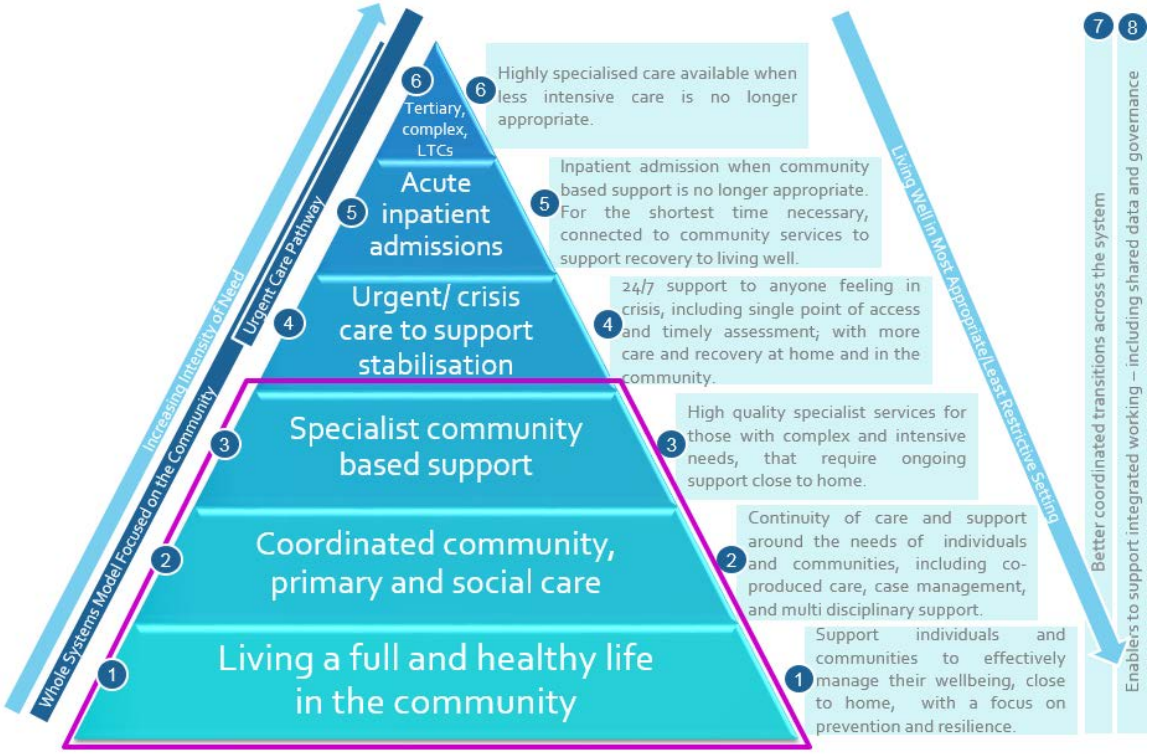
7.5 Mental health

We will develop a 'stepped' model of care (see exhibit 7) to support people with mental ill health to live well, helping them to receive care in the least restrictive setting for their needs.[34] We recognise the key role and accountabilities of social care for people with long-standing mental ill health and drawing on this will be central to the success of the stepped model.

[34] As identified in the Mental Health Taskforce Report

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 NCL.

Exhibit 7: 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. This will improve overall mental health outcomes across NCL, 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.

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

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

- **Improving community resilience:** both for the general population, and those at risk of developing mental ill health or of becoming more severe. 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. 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[35]; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies.[36] 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, reminiscent therapy and engaging with local shops to raise awareness.

- **Increasing access to primary care mental health services:** ensuring more accessible and more extensive mental health support is delivered locally within primary care services, developed as part of the CHINs; enabling both physical health and mental health needs to be supported together[37]. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services[38], and more care to be offered through CHINs rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need[39] 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

[35] Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within NCL)
[36] Five Year Forward View - Reduce suicide by 10%
[37] FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within NCL)
[38] Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within NCL)
[39] Five Year Forward View – increased IAPT to reach 25% of need by 2020/21

that more people can have their mental health supported in primary care rather than secondary care.

- **Improving the acute mental health pathway:** building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to 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 ensure effective discharge, enabling more people to live well in the community. In the south of NCL a plan is being developed to close the A&E HBPoSs, and moving to a purpose built suite at Highgate Centre for Mental Health, this is expected to open in 18/19. In the north of NCL there are plans for the potential development of a complex rehab ward

- **Developing a Female Psychiatric Intensive Care Unit (PICU):** we will ensure local provision of inpatient services to female patients requiring psychiatric intensive care, where currently there is none. This will enable patients to remain close to their communities, with a more streamlined and effective pathway ensuring a focus on recovery.[40] A potential site within NCL has been identified, and work is underway to develop the plan further.

- **Investing in mental health liaison services:** scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments, ensuring that more people in Emergency Departments and on inpatient wards with physical health problems have their mental health needs assessed and supported. An implementation plan is being developed to get all our ED sites up to Core24, looking to test pilot initiatives, such as Peer Support Workers, in our busiest EDs in 17/18, and based on results to roll out to all A&Es in 18/19 and 19/20.

- **Focusing on perinatal and child and adolescent mental health services (CAMHS):** as 50% of all mental illness in adults begins before 14 years of age and 75% by 18[41], and with the majority of costs associated with perinatal mental ill health associated with negative impacts on the child's life and mental wellbeing[42], children and young person mental health and wellbeing and perinatal mental health is a key priority to improve the long term mental health outcomes for our population. As such eight priority areas have been identified which form the joint aspect of the NCL Children and Young People (CYP) Transformation Plans: shared dataset to enable comparison and shared learning across NCL; investing in eating disorders; planning for a workforce that meets the mental health and psychological well-being needs of children and young people in NCL, including CYP IAPT workforce capability programme; supporting children and young people with challenging behaviour in the community, preventing the need for residential admission; develop a specialist

[40] Five Year Forward View - inappropriate out of area treatments for acute mental health care should be eliminated in all areas by 2020/21.
[41] Cavendish Square Group
[42] Centre for Mental Health and London School of Economics

community perinatal mental health team so that more women have access to evidence based specialist perinatal mental health care[43], this team is currently being recruited to; following best practice to support abused children in NCL, investment has been secured for the Child House Model; develop an NCL 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 to eliminate out of area placements for non-specialist acute care by 2020/21[44] and review of s136 provision; and working with NHS England to develop co-commissioning model for youth justice. The principles of THRIVE 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.

- **Investing in a dementia friendly NCL:** looking at prevention and early intervention, supporting people to remain at home longer and supporting carers to ensure that we meet national standards around dementia, including a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

There are a number of interdependencies across the NCL mental health workstream and the other elements of the NCL STP. We are working closely with these workstreams, such as with the workforce workstream who are supporting us in identifying the workforce which we need in order to deliver these initiatives, which includes new roles and skills.

Another important enabler of a number our initiatives is the redevelopment of both 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 estate 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.

[43] Five Year Forward View - 30,000 more women have access to evidence based specialist perinatal mental health care (~750 within NCL)
[44] Five Year Forward View

The delivery of these initiatives, and the realisation of the proposed benefits, is critically dependent on increased investment in mental health by local commissioners. Despite meeting funding commitments in line with national parity of esteem policy at present, there is a shortfall in investment on top of transformation funding pump priming (£6m for 17/18, and £10m for 18/19) of £3.3m for 2017/18 and £13.4m for 2018/19 to implement our full ambitions. Currently there is a risk that the increased investment will be focused on meeting demand growth in the short term, rather than funding the transformational initiatives which are necessary to manage demand in the longer term.

7.6 Urgent and emergency care[45]

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 work collectively to solve problems that affect someone's care. We will explore new ways of delivering our services to provide the best quality services for the resources we have available; from the moment somebody identifies that they have an urgent or emergency need through to when they return home.

[45] 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.

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

Our aims are to:

- **Create a consistent and reliable UEC service across NCL:** all UEC services in NCL will be accessible to the public and easy to navigate and inspire confidence. They will meet National and London-wide quality standards[46] which will promote consistency in clinical assessment and the adoption of best practice. Patients will be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service.

- **Develop and implement a high quality integrated urgent care service:** Building on the newly commissioned Integrated Urgent Care Service in NCL (NHS 111 AND GP Out of Hours), all urgent care services across NCL (including NHS 111, GP out of hours, Urgent Care Centres) will work together to offer consistent care.

- **Address and transform the multifactorial issues that can delay discharge from hospital:** Patients will be supported to leave hospital more quickly, with an improved experience by developing hospital, social care and community services (including step down facilities) that work well together. These services will be available 7 days a week, for both new and existing patients. We will support 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.

[46] As defined by the NHS E UEC designation process

- **Develop high quality, responsive 7-day community-based services:** where possible, people will be supported and treated at home by community, social care and ambulance services. For those people who do require ambulance transfer, the ambulance services will be able to use any UEC service that meets that person's needs.

- **Develop high quality ambulatory care services across NCL:** we will develop a service that reduces avoidable, unplanned admissions to hospital, such as that already in place at the Whittington. All UEC services will create consistent ambulatory care pathways that support people to have their care on a planned basis, wherever possible. This will provide same day emergency care to support patients to be assessed, diagnosed, treated and able to go home the same day without an overnight admission. This model will be rolled out across NCL.

- **Develop a high quality, acute frailty pathway throughout NCL:** we will develop a pathway that delivers rapid assessment, treatment and rapid discharge for frail older people, ensuring there is a seamless transition between services.

- **Improve the quality of care for people in the last phase of life and support them to die in their place of choice:** we will improve the identification and co-ordination of care for people in their last year of life, ensuring they have access to specialist palliative care, advanced care planning and a multi-agency shared emergency care and treatment plan, as the norm.

- **Support Care Homes to prevent hospital admissions of their residents, through the development of a proactive approach to care planning, prevention and early identification of need.** Each care home resident will receive high quality care, including advance care planning and the development of an emergency care and treatment plan as the norm. These plans will be shared with multiple agencies to support admission avoidance. Where admission is unavoidable, we will support the care home in early supported discharge, thereby reducing hospital length of days.

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 patient experience, improve outcomes and make sure that people have their care on a planned basis wherever possible.

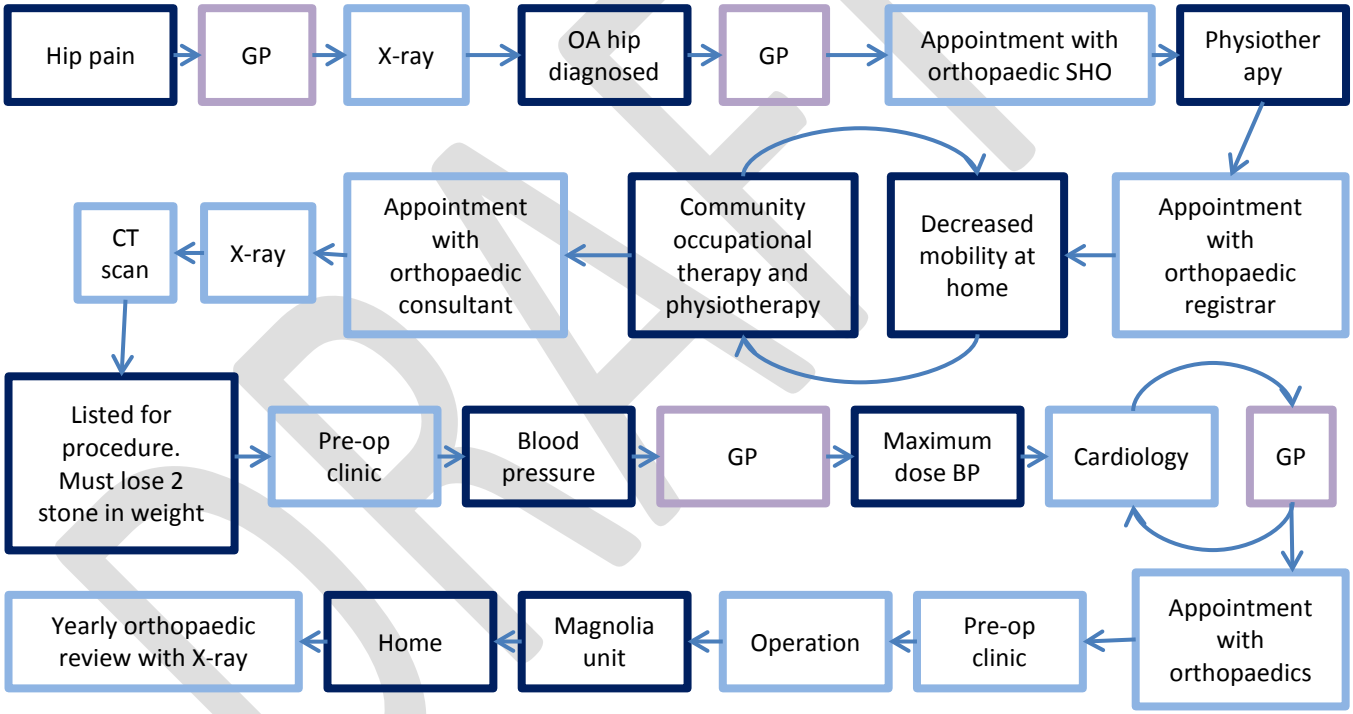
7.7 Optimising the planned care pathway

Building on the opportunities identified through RightCare[47], we will reduce unwarranted variation in planned care across providers in NCL. This will include;

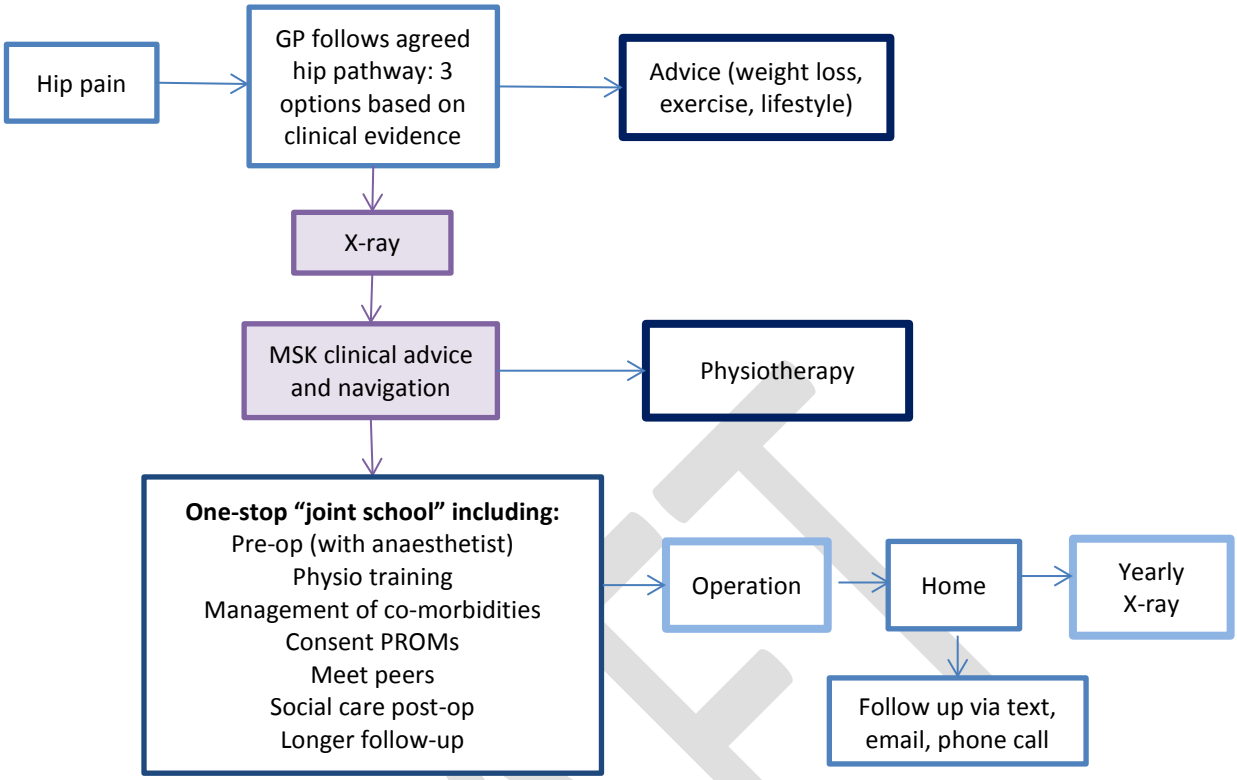
[47] RightCare Atlas of Variation in Healthcare, September 2015

- Reducing variation in the length of stay in hospital
- Reducing variation in the number of outpatient appointments received by patients with similar needs.
- Optimised pathways will 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 NCL to ensure parity of care regardless of patient's postcode.

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



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



We will draw on local examples of best practice, such as the South West London Elective Orthopaedic Centre; and international best practice, such as Intermountain's hip replacement pathway redesign, which reduced the cost of total hip replacement by 25%.[48] 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.

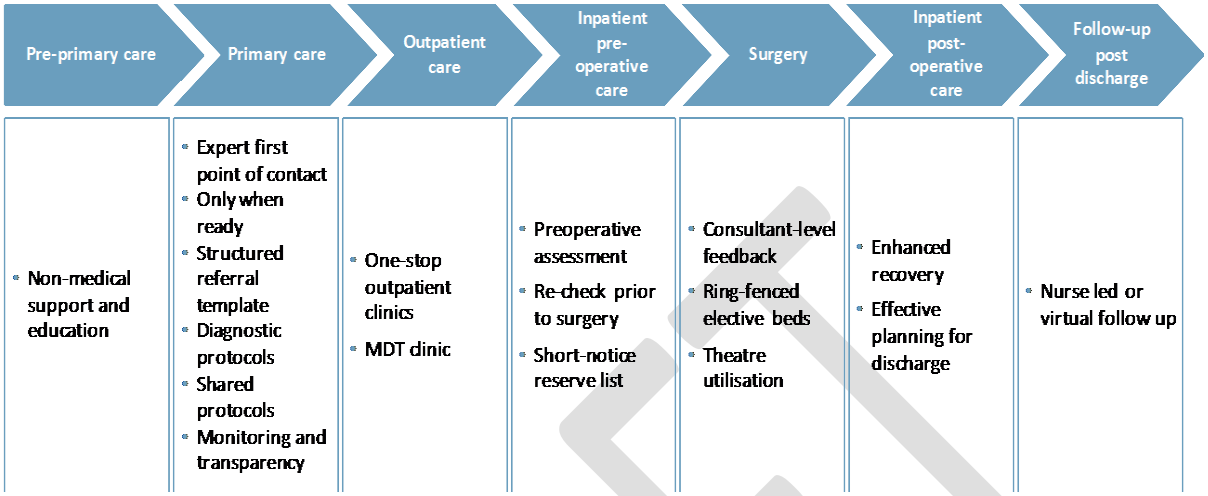
We will leverage the following opportunities for improvement to planned care pathways:

- 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 C2C 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.

[48] James and Savitz (2011). How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts . Health Affairs

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 in exhibit 8.

Exhibit 8: Interventions that support optimised planned care pathways



For orthopaedics, 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 NCL 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 addition to the improvements being worked through for orthopaedics, further specialties have been identified for focused pathway design. These are:

- Urology
- General surgery
- Colorectal surgery
- Hepatobiliary and pancreatic surgery
- Upper gastrointestinal surgery
- Gynaecology
- Gynaecological oncology
- Ear, Nose and Throat (ENT)
- Vascular surgery
- Breast surgery
- Musculoskeletal (MSK)
- Ophthalmology
- General medicine
- Gastroenterology
- Endocrinology
- Dermatology

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 PoLCEs (potential decommissioning down the line)
- Standardised approach to C2C referrals

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.

Within NCL in areas where enhanced triage and clinical advice and navigation services have been in place, work to date on proof of concepts, has demonstrated impact:

Gastroenterology and Cardiology pilot *(All data from Feb 2016 at time of evaluation. Sample size 897)*

- 32% of GPs considering referral did not refer after advice
- 93% of GPs rated the service and advice as helpful and that they believed it helped empower primary care
- 50% said it gave them reassurance with the plan they had in mind
- 43% said it suggested a good new or additional course of action

GP feedback:

'I thought the clinical advice I received from the cardiology consultant was thorough, helpful and well structured. There was even an offer for further advice after the ECG was done, and a possible diagnosis which would have explained the clinical findings.' (GP evaluation)

'It is a great resource for GPs who think they are doing the right thing but just need that bit of reassurance rather than referring in a patient.' (GP evaluation)

Teledermatology *(Sample size at time of evaluation 138, based on three months data)*

- 60% discharge rate from pilot areas
- 71% of non-discharged patients booked straight to test or treatment
- Maximum time to teledermatology appointment 2 weeks, compared to longer waiting times for face to face appointment

Reducing variation will also improve staff experience, including ensuring access to the right professional expertise when needed, better access to high quality diagnostics, improved

relationships between professionals in different care settings and increasing sharing and learning from best practice across the local professional communities.

7.8 Cancer

Working in partnership as the UCLH Cancer Collaborative, we aim to save lives and improve patient experience for those with cancer in NCL and beyond. Commissioners and providers across north central and north east London (NEL) 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.

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 three priority areas are;

- to achieve earlier cancer diagnosis
- ensure effective use of cancer outcomes information and;
- adoption of recognised "best practice" across the full spectrum of cancer pathways.

Our NCL STP 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 NCL, 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 NCL, 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 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.

7.9 Maternity

In 2014-15 there were approximately 20,000 births to North Central London (NCL) residents and 24,000 births delivered by the local Trusts. Within NCL 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. NCL includes areas of deprivation and women who are older, more likely to be overweight or obese and to experience medical complications in pregnancy such as gestational diabetes, when compared with the national averages.

Across NCL, 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 could be offered close to home or work. Currently, not enough women are being offered choice of care setting or receiving continuity of antenatal or postnatal care. There are also lower than national average scores for experience during the antenatal, intrapartum and postnatal periods and perinatal mental health support is varied.

In November 2016, NCL were successful in their bid to become an early adopter of the National Maternity Transformation Programme which 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, NCL's main objectives for their Maternity Programme are:

- To improve the experience of women accessing maternity services in NCL
- 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

Areas of transformation have been identified and summarised into 3 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 system facility. Continuity will start from the initial booking visit through the availability of a centralised booking service offering appointments, information and advice. Maternity information will be shared across NCL 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 to enable the system to become more responsive and learn from events. Duplication will be prevented 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-professional workforce which is able to work across organisations to support new models of care and improve staff safety levels.

7.10 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 NCL 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 NCL-driven activity in the March refresh of the STP.

7.11 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.

In London, two thirds of early deaths in people under 75 are from cancer and heart disease, there is a high risk of heart disease among the local population and the number of people diagnosed with cancer is growing. Specialists, technology and research are spread across too many hospitals to provide the best round-the-clock care to all patients. If we were to improve local survival rates for heart disease and all cancers in line with at least the rate for England, over 1,200 lives could be saved each year. (Source: UCLH news, 14 March 2014)

UCLH, Bart's Health, the Royal Free and a number of other north London trusts implemented a significant service reconfiguration to address these issues. Cardiovascular care services provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital were combined to create an integrated cardiovascular centre in the new building at St Bartholomew's. For five complex or rare cancers, specialist treatment is provided in centres of excellence across the area. Services for other types of cancer and general cancer services, such as most diagnostics and chemotherapy, continued to be provided locally.

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in NCL. 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. Where there is a 'burning platform' and it is widely accepted that a service needs urgent attention (such as addressing issues of workforce sustainability), consolidation will be explored as an option. Releasing cost savings to support overall system sustainability is another driver for exploring potential consolidation opportunities.

This work is at an early stage. No decisions have been made, but we have identified services for review to determine if some form of consolidation may be worth consideration. It is recognised that fundamental, large scale reorganisation may take longer than the five year strategic horizon of the STP. As such, we have made no assumptions of financial benefit from this work.

To understand where we should focus further work, senior clinicians have systematically assessed services based on whether consolidation or alternative networking is required and / or could be beneficial. This has enabled us to identify a long list of services potentially in scope for further work over the five year period, for example:

- Emergency surgery (out of hours)
- Maternity services, in the context of the Better Births initiative (see section 6.2.1)
- Elective orthopaedics
- Mental health crisis care and place of safety
- Mental health acute inpatient services
- Histopathology
- General dermatology services

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 Clinical Cabinet will retain oversight of this work to maintain a whole system perspective.

7.12 Productivity

Commissioner productivity (BAU 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 was c.£133m in 2015/16. There is an assumption of increased efficiency equivalent to 1.5% per annum supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care was c.£90m in 2015/16. There is an assumption of increased efficiency equivalent to 2.1% per annum supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing was c.£205m in 15/16. There is an assumption of increased efficiency equivalent to 2.5% per annum including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness. This is in the context of assumed growth of 5-7% per annum.
- **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.

Provider productivity (BAU CIP)

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.

System-wide productivity

We have identified opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from improvements to contracting between CCGs and trusts which will be realised system wide.

Specific initiatives to improve productivity include:

- **Workforce:** we will establish a shared recruitment and bank function across providers meaning that staff can be deployed between providers in the system; 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 commit to complying with the maximum total agency spend and hourly rates set out by NHS 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.
- **Back office:** we will create centralised functions for payroll and pensions, finance and estates in order to reduce our overheads and improve service resilience. In addition we will:
    - Consolidate IT services to reduce costs whilst improving the resilience and quality of services
    - Enhance the existing share procurement arrangements to reduce non-pay costs
    - Pool our legal budgets and resources, considering options to consolidate outsourced resources or appoint an in-house legal team.
- **Operational and clinical variation:** we will collectively reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the planned care workstream.
- **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.

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. To achieve this, we will work as a sector to share and transform the vehicles that underpin delivery.

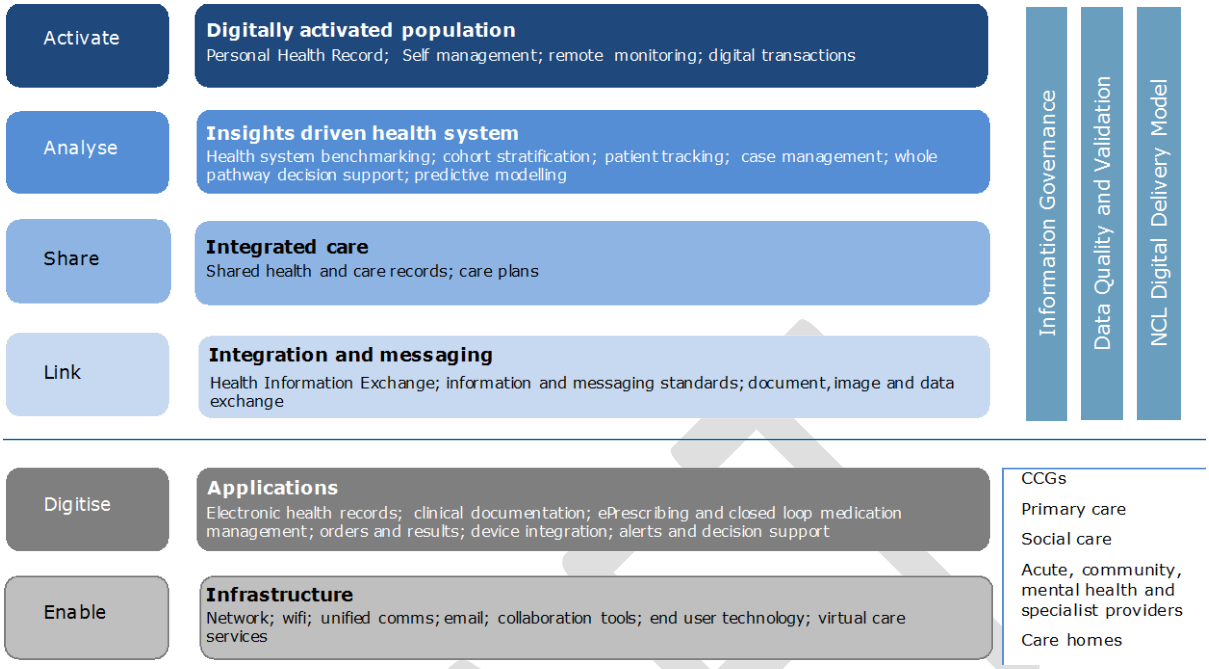
7.13 Digital

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 NCL 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 an NCL Population Health Management System (exhibit 9, 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 9: NCL Population Health System Management



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 (see section 8).

7.14 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
- to enable the delivery of a portfolio of estates transformation projects that support the implementation of clinical change in the STP

There a number of barriers to achieving this, including:

- in NCL, 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 STP.

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 NCL / 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 early 2017. In the currently agreed London timetable, NCL 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 NCL 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 NCL, 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 NCL
- 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 3 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 eventual 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 decisions due in 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.

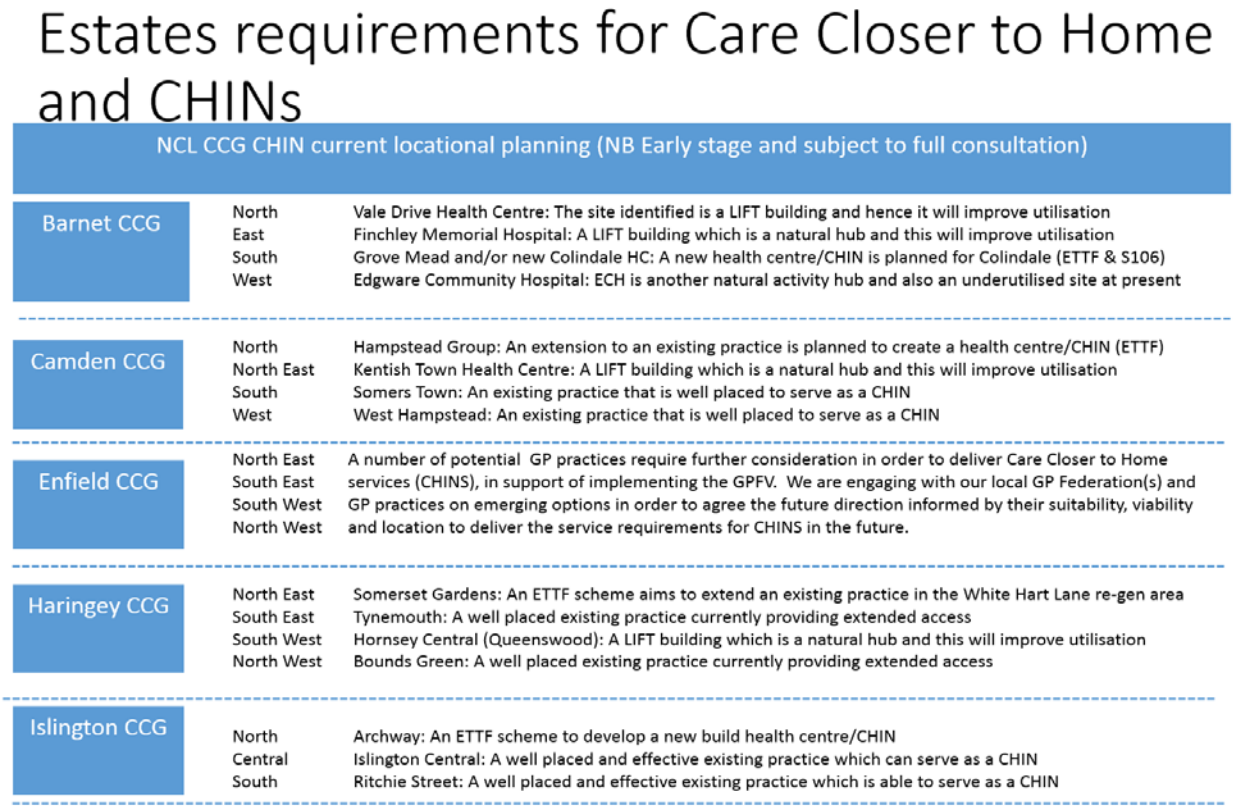
The schemes are planned at a total capital cost of c. £400m (see section 8.3) with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that £326m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

Progressing 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 NCL 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. NCL has been successful in securing ETTF investment and an allocation from the NHS IG Fund. However, the funding secured, in common with other STP footprints, will not meet the full cost of development. A priority for the STP is to develop detailed business cases for the care closer to home estate, based on the developing CHIN framework and the planned care workstream outputs, and use devolved powers and other avenues to secure capital to deliver these much needed improvements and reduce the running costs of this estate.

Exhibit 10: NCL CHIN estate planning



Update on redevelopment of St Ann's Hospital:

Following approval of Barnet Enfield and Haringey Mental Health Trust's Strategic Outline Case (SOC) by NHS Improvement, the Trust is now moving forward to the next stage of the redevelopment of St Ann's Hospital. This involves:

- Development of detailed design for the new inpatient building to replace the current very poor wards
- Securing final Planning approval for the new inpatient building from Haringey Council
- Preparing for the sale of the land on the St Ann's site which is now surplus to NHS needs
- Development of the Outline Business Case (OBC)

The Trust's timetable is for completion of this stage by July 2017, leading to NHS Improvement approval of the OBC and final Planning approval by Haringey Council by November 2017. This should then allow the sale of the surplus land to commence and a start on site for the new mental health inpatient facilities by spring 2018.

7.15 Workforce

Our vision is to support NCL 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 NCL 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 NCL 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 NCL 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 clinical 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, NCL workforce. This work will continue over the life of the STP 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 NCL 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 STP.

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. 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 Central 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 NCL 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.

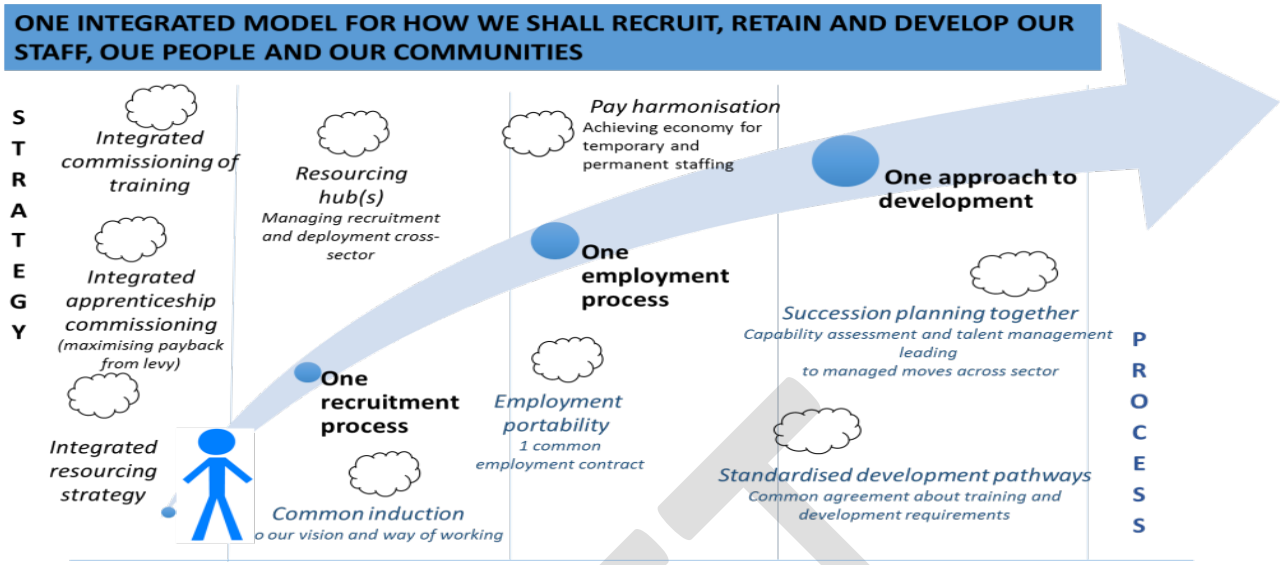
To enable transformation, we will deliver system-level organisational development, supporting leaders and teams through the transformation journey. In addition, we will train everyone in a single approach to continuous quality improvement to deliver sustained clinical excellence and high quality care.
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 NCL as a place of choice to train and work is a pivotal enabler to these ambitions; where permanent or bank 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 NCL.



The Workforce workstream is a key enabler for the new models of care emerging from the clinical 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.

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

7.16 New commissioning and delivery models

As part of the STP development process, and in response to the changing healthcare landscape in NCL, 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 Vanguard
- 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 (see section 9.2); 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 in section 9.2., to ensure that health commissioning in NCL 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. Recruitment to the Accountable Officer post took place in January 2017 with the expectation that the new leadership will be in place by 1 April 2017.

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 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 all organisations across the system to get views on the different options for new delivery models, and the broad consensus includes moving 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

Further work needs to be done to resolve issues and differences of view around the following:

- the organisational form for the new delivery vehicles
- the optimal population size for population health management
- the geography over which new delivery vehicles should operate
- the form and governance of the strategic commissioning function
- which commissioning functions should remain with the strategic commissioning function and which should be undertaken through the new delivery vehicle
- the scope of the new delivery vehicles
- unresolved issues such as how to manage patient choice, specialised services and other flows outside of the delivery vehicle and a full understanding of the legal framework which might impact on implementation
- speed of implementation

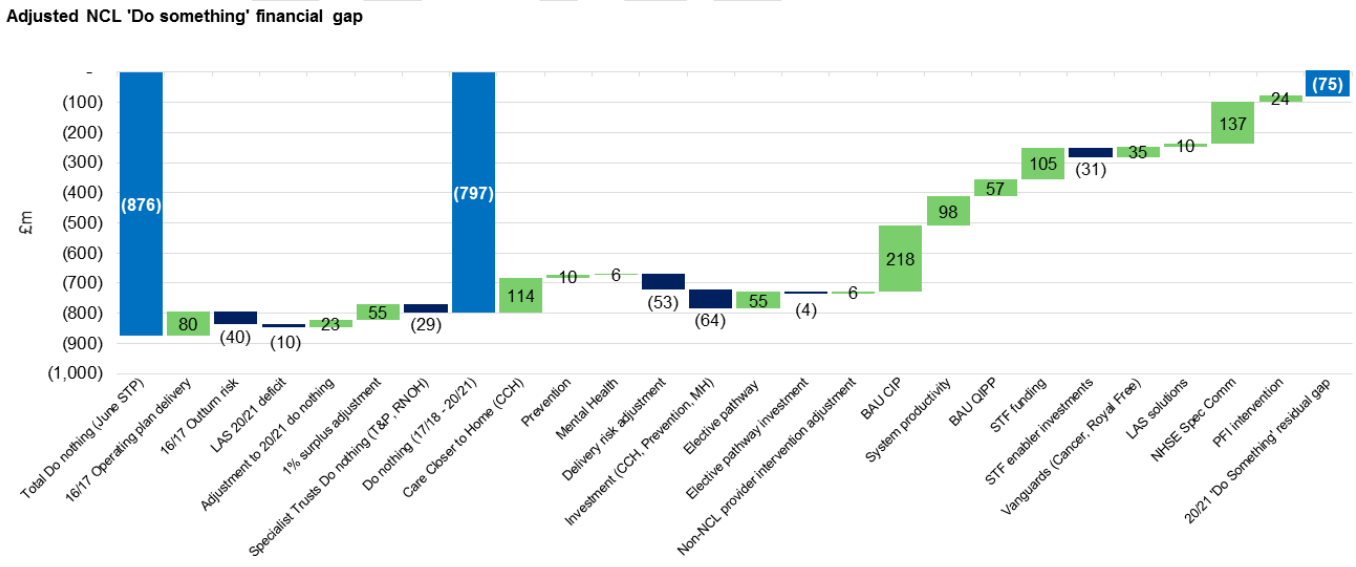
Discussions continue across health and care commissioners and providers in NCL to establish agreement about the nature and scale of new delivery vehicles. Different care models are still being considered, and this work is being steered through the STP governance framework. We plan to hold a workshop in April/May 2017 to take these discussions forward.

8 Bridging the financial gap

The financial analysis that we undertook in October 2016 (see exhibit 2) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in NCL and the growth in funding that the NHS expects to receive over the 5 years of the STP. Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, this would leave us with an estimated £876m deficit in 2020/2021.

The STP in NCL 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, our draft plan produced in October 2016 showed that we would reduce the annual deficit over the next five years to £75m (exhibit 11) – whilst this addresses more than 90% of the financial gap, we recognised that further work is needed to close it entirely. We have continued to work on addressing the residual financial gap since we submitted the draft plan in October 2016. This work is ongoing and we will update the financial analysis by the end of March 2017. This will also include the impact of the updated operating plans.

Exhibit 11: Bridging the financial gap to 2020/21



The key elements of the plan are set out in detail in section 7 of this document. Exhibit 11 shows how these contribute to the improvement in the annual financial position of the NCL system over 5 years. The key areas of work are:

- **Care closer to home:** savings of £114m have been estimated from improving access to primary care; proactively identifying need and early intervention to avoid crisis;

rapid response to urgent needs to prevent hospital admissions; providing community-based and ambulatory-based care; and reducing delays to discharge.

- **Prevention and the support of healthier choices:** this is estimated to result in savings of £10m.
- **Mental health outreach and liaison:** this is estimated to result in savings of £6m.
- **Optimising the planned care pathway**: savings of £55m have been estimated from benchmarking against best practice; working closely with clinicians; optimising flow through theatres (increasing throughput); and reducing length of stay - in addition to the excellent work that our hospitals and other providers do to improve productivity each year.
- Additional plans are being developed relating to the **UCLH Cancer Vanguard** scheme and **Royal Free Hospital Chain Vanguard** which are estimated to deliver £35m.
- **System level productivity** savings of £98m are planned to be achieved alongside the 'business as usual' cost improvements across providers in NCL of £218m and local commissioner business as usual efficiencies (QIPP) of £57m.
- We have identified a potential saving of £24m per year through 'buying out' a number of **Private Finance Initiative** hospitals, 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, recognising that there are a number of constraints.
- Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the NCL 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. NCL 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).
- Further work is ongoing in relation to developing a fuller understanding of the social care financial position and pressures. At present no financial values have been included as advised by NHS England, but this has not prevented the STP from working very closely across both health and social care. In particular the NHS within NCL is seeking to learn from local authority colleagues' best practice in relation to reducing cost whilst improving the experience of people who use services and the public.

These improvements cannot be achieved without investment. The plan is based on investment of £64m in urgent and emergency care, prevention and 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 clinical cabinet of clinical leaders within NCL 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 £53m 'risk adjustment' in the financial analysis.

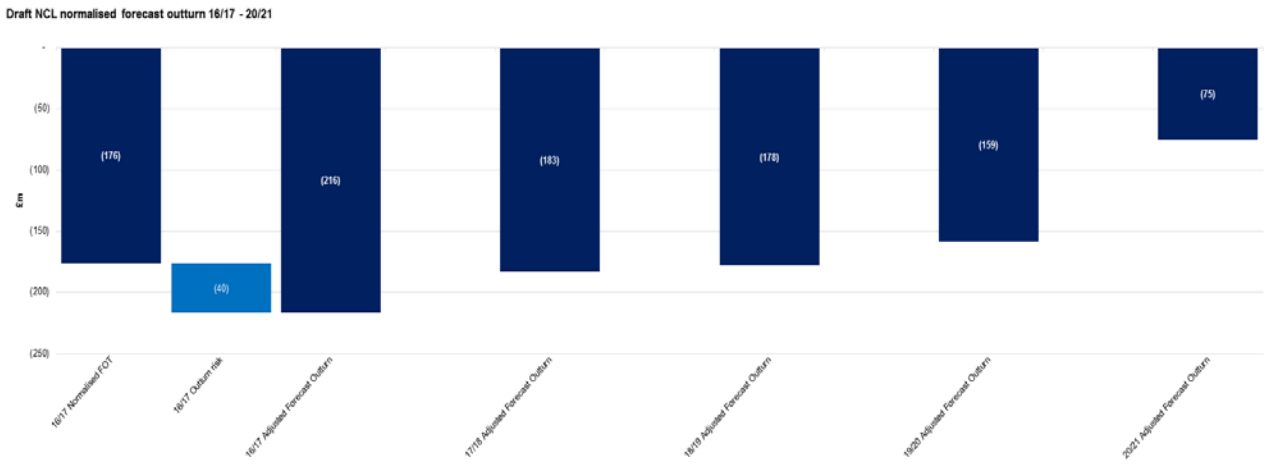
Normalised forecast outturn by year

At the time of the STP, it was recognised that each year there will be a number of one-off costs and income streams to the commissioners and providers within NCL. Our 5 year financial analysis is initially based upon the "normalised" (or underlying) financial position in 2016/17 which is then projected forward. We estimate that 2016/17 outturn will be a normalised deficit of £216m (£101m on an in-year basis). Significant one-off figures within this include UCLH's transitional funding that it is receiving to compensate for the financial impact of moving cardiac services to the new, world class centre at Bart's hospital, and the Royal Free's transitional funding in relation to the merger with Barnet and Chase Farm. The underlying figure also includes a £40m adjustment which is an estimate of the combined risk to the NHS provider and commissioner forecast outturn. This has arisen as a result of potentially different assumptions between NHS commissioners and providers about the value of work undertaken by the end of 2016/17. We have reached an agreed view on forecast outturn activity and will continue to work urgently to ensure consistency of payment assumptions between different parts of the NHS within NCL. All parties have agreed a more 'open book' approach to contract agreements that will ensure a consistent, system-based approach.

The STP plan shows a gradual improvement in the financial position over the 5 years of the STP (exhibit 12). The normalised position improves year on year. This pattern is in part caused by the requirement for majority of the investment in the early years of the STP, with benefits accruing in the later years.

Work on modelling the financial gap and intervention is ongoing and we will update the financial analysis by the end of March 2017. This will also include the impact of the updated operating plans.

Exhibit 12: Normalised forecast outturn by year[49] (Oct '16 STP)



2017/18 NHS operating plans

In 2017/18 the operating plans developed in December 2016 show that our in-year position will be a £43m deficit for NCL healthcare organisations (excluding specialised commissioning and specialised trusts) against a system control total of £43m surplus. This incorporates significant investment during the year on service transformation and delivery of the Five Year Forward View. However this position depends on the development of plans to deliver a significant number of additional efficiencies which have not yet been identified.

We will continue to look for further opportunities for efficiencies and work on the detailed delivery plans for our existing plans between now and end March 2017, to include confirmation of investment requirements and projected activity and financial impact.

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. NCL 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 NCL.

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:

[49] The 16/17 in year FOT of £101m together with the £107m 16/17 normalizing adjustments represents the normalized 16/17 position excluding the specialist trusts (RNOH, T&P). Including the specialist trusts normalised 16/17 position (£8m) brings the combined 16/17 normalised deficit to £216m

- **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. This scheme, including an assumption of DH loan funding, has yet to be agreed, and will be subject to normal Business Case processes through NHS Improvement.
- **Primary Care for Care Closer to Home and 5YFV 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 NCL 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 will not deliver value simply because of the stage in development of these plans that NCL 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 as an STP 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 NCL make best use of its current assets to support the delivery of our STP vision. This is being further reviewed and will be updated by the end of March 2017.

Next steps to address the financial gap

We are very clear that we have more to do to close the financial gaps across the next 4 years of the STP. We have started a period of further intensive work up until end March 2017 both to improve confidence in delivery of current estimates and develop a detailed understanding of the Local Authority financial position whilst concurrently working on other areas to further improve the position.

However, we do believe that there is a risk that the gap will not be fully closed in every year whilst ensuring that we continue to prioritise the quality of and access to services, particularly as we balance the need to invest in the early years to deliver transformational benefits in later years. It is also essential that STPs and their constituent organisations and leadership are given the regulatory headroom to develop longer term plans, and that the 'new models of care' being developed give clarity of financial accountability to support the financial challenges that the STP faces.

We continue to work on the areas we identified in October 2016, including:

- early delivery of high impact care closer to home interventions
- accelerated delivery of stretch targets for high impact planned care pathways
- increased effort in terms of delivering efficiencies through provider productivity schemes
- reducing any non-value added contracting costs
- implementation of pay harmonisation and shared principles around usage of bank and agency staff
- leveraging existing capacity in NHS providers to reduce outsourcing of activity to the independent sector
- other non-recurrent savings measures
- assessing and incorporating the impact of 2017/18 tariff changes.

There are also a number of areas that we will explore further as we believe there may be significant savings to be found. These include:

- maximising clinical productivity across providers, for example introducing shared clinical rotas
- developing alternative pathways for the London Ambulance Service to avoid conveyance to Emergency Departments
- rolling out standardised pathways to all specialities
- identifying opportunities to reduce the length of stay for patients receiving specialist services
- reviewing any plans that require capital and have not yet been agreed to establish the most cost effective way to deliver agreed outcomes
- rapid implementation of cancer initiatives, including early diagnosis, new models of care, end of life interventions and research and innovation
- re-providing cost effective services for the c. 20% of people we estimate are currently in hospital beds but are medically fit to leave
- putting in place a peer review challenge approach across all areas of spend to identify further opportunities to reduce or avoid spend, and to aid collective delivery of plans.

9 How we will deliver our plan

9.1 Delivery through 2 year contracts in NCL

Delivering the STP is a priority for health and care commissioners and providers in NCL - and our commissioning intentions, operating plans and contracts reflect this. All NHS contracts are strategically aligned to the STP, thus enabling its 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 2 year contracts based around our STP delivery plans will both enable rapid implementation and support a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for the development of new commissioning and delivery arrangements.

We have agreed operating plans and contracts that 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. We will focus our energies on achieving maximum benefit and we will seek to identify areas where we can further and faster to build confidence and momentum.

Recognising that we have still not achieved financial balance in the plan to date, we will continue to look for further opportunities further efficiencies.

9.2 Decision making in the programme

The STP is a collaboration between a range of sovereign organisations in NCL, each with its own governance and decision-making structures. We have not to date introduced any collective decision-making structures. However, we have worked together to produce both the Case for Change and the STP.

The STP remains a work in progress and therefore has not been formally signed off by any of the organisations within the STP. The draft plan as submitted in October 2016 has been discussed at the public sessions of each of the NHS provider boards, CCG governing bodies and Local Authorities for their support and input into the next steps.

This refreshed version of the plan remains work in progress. We aim to continue to work on the plan up until March 2017 when we will publish an updated version.

Going forward, in order to support a more collaborative commissioning approach across NCL, the Governing Bodies 5 CCGs have agreed to establish a Joint Committee for some elements of commissioning including:

- All acute services including core contracts and other out of sector acute 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)

An appointment has been made to a new single Accountable Officer for the five CCGs across NCL. Work is underway on finalised other parts of the structure.

9.3 Programme architecture

In coming together as an STP footprint, we have developed a governance structure, which enables NHS and local government STP partners to work together in new ways. To date the STP has been overseen by the NCL STP Transformation Board brings together executives from all programme partners on a monthly basis. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. Three subgroups feed into the Transformation Board: the Clinical Cabinet, the Finance and Activity Modelling Group and the Programme Delivery Board (formerly the Transformation Group).

The Clinical Cabinet currently meets fortnightly to provide clinical and professional steer, input and challenge to all 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, 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 also meets fortnightly, to oversee the finance and activity modelling of the workstream plans as they develop.

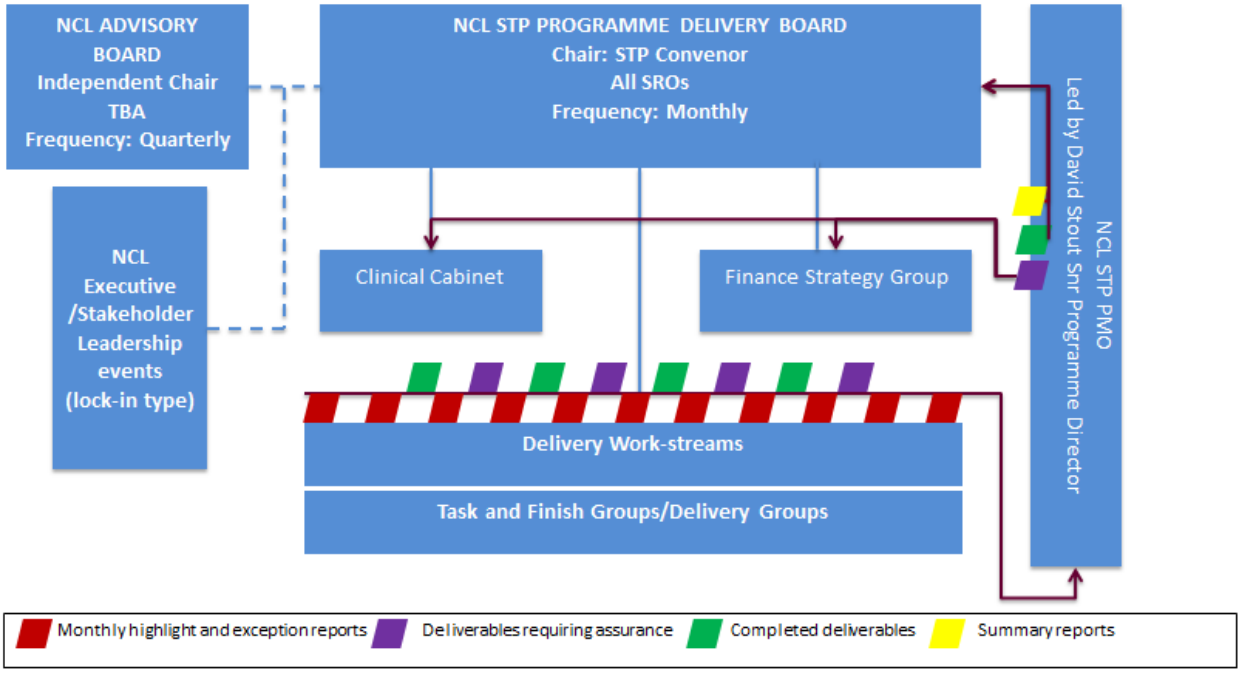
Until recently the practical work of the STP was overseen by the STP Transformation Group (made up of a sub-set of the Transformation Board members) which met fortnightly. Responsibilities included agreement of deployment of the STP programme budget. This has been replaced from January 2017 by the Programme Delivery Board. It is an executive steering group made up of a cross section of representatives from across NCL. This group is specifically responsible for providing accountability for the delivery of the STP workstream delivery plans. Membership includes the SROs of all workstreams and SRO leads for CCGs, Providers and Local Authorities.

Additionally, the NCL STP has a full time PMO which facilitates and coordinates the meetings of the main governance groups, as well as delivering communications and engagement support to the programme.

The component workstreams of the NCL STP 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 review of STP governance undertaken by the Transformation Board in December 2016, to ensure it is now fit for purpose as we move forward with implementation. Our initial proposal for discussion is set out in exhibit 13. This proposal is currently under discussion. The current STP Transformation Board will continue to operate until March 2017 while new arrangements are being finalised.

Exhibit 13: Proposed future programme architecture



This structure would comprise the following new groups:

- **STP Advisory Board:** It is proposed that 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 proposed 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. It is proposed that this group meet quarterly and might benefit from an appointed Independent Chair.

- **STP Programme Delivery Board:** To drive and oversee the progression and delivery of the STP. It is proposed that the delivery board meet monthly. This would replace the Transformation Group.
- **Executive leadership events:** CEOs and other relevant executive directors and stakeholder representatives would meet periodically as requested by the Delivery Board in order to resolve delivery issues.

9.4 Programme resourcing

We have dedicated resources in place to support the delivery of the STP, with an agreed overall programme budget of £5m in 2016/17. 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. Each SRO is supported by a dedicated programme manager, and in some cases a broader team of support. A programme budget for 2016/17 has been allocated to each of the workstreams based on their proposed requirements. STP partner organisations are also giving in kind to each of the workstreams to ensure high quality plans can be delivered at pace.

We are currently reviewing the requirements for 2017/18 and beyond as we finalise the delivery plans and phasing of implementation. We have estimated that the overall cost of implantation of the STP will be around £10m per annum. However we have agreed that the majority (at least 75%) of that cost should be met in 'kind rather than in cash' thorough redeploying existing resources so that implementation of the STP becomes business as usual. We will therefore look to establish an STP implementation budget of up to £2.5m for 2017/18.

9.5 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, it will be important that we engage with HWBs as we develop the STP. Engagement of HWBs will also be an important means of ensuring engagement of local political leadership in the STP process. The proposed membership of the STP Advisory Board includes the chairs of each HWB.

9.6 Overview and scrutiny committees

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area. Commissioners and providers

of NHS services (including NHS England, CCGs, NHS trusts, NHS foundation trusts and private providers) must consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Ordinarily, where the services in question are commissioned by NHS England or CCGs (as the case may be), the commissioners carry out this exercise on behalf of providers. 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 across NCL which 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. We will ensure that we liaise closely and constructively with the JHOSC as the STP plans develop so that we can plan ahead for any likely need for public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

10 Communications and Engagement

In November 2016, we published our draft plan and a summary document. Since then, we have been working together to add more detail to our plan and will publish an updated version at the beginning of April 2017.

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

The following section remains essentially the same as the previous version of the draft plan. It remains a work in progress as we build relationships across our footprint and develop the details of our plans, so that together, we can find the best way to engage with the residents, service users and carers, patients, staff and other interested individuals and groups on changes that affect them.

We have come a long way since being asked to come together as 22 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 5 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.

10.1 Our future plans

We will now build on the success of our initial public engagement events by:

- holding pan-NCL events on specific issues that may arise in support of the borough level events
- hosting meetings with the public on focussed topics such as urgent and emergency care, primary care, and mental health to get in-depth input from the community
- online surveys and regular updated online FAQ
- developing a designated YouTube channel and populating it with relevant resources.
- using partner digital media channels – Twitter, Facebook, Instagram – to promote our public engagement programmes and information. We will also use these channels to test ideas and progress on local priorities which will help us develop our plans further.

To do this, we will:

- use Healthwatch, other patient representative groups and resident's associations, local authority engagement networks and the range of other networks available to reach out to the public and share our draft plans
- work in partnership with communications teams across NCL organisations and use their wide range of community channels to socialise the STP, for example Camden CCG's citizens' panel and Enfield's Patient Participation Groups Network.

- use existing online engagement tools that CCGs, local authorities and providers have 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 share progress updates of the STP at all meetings at 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 media stories and regularly updating the Transformation Board and those meeting with elected members on the STP as it develops, media development and any public concerns.

There is also a need to engage more of our own workforce in the planning process. We will do this via:

- 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
- hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This will include working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- running events within our membership organisations to showcase the range of work which is happening across NCL and to ensure staff understand the current plans, and how they may affect them as we progress into implementation.

We will continue to build our communications and engagement capabilities across the system. We are planning to host a workshop with communications leads from across sectors to co-design the future engagement strategy, having now identified the key audiences that we need to engage with across the 5 boroughs. The strategy will include the design of a programme of deliberative-style events which will bring together different groups to more directly shape our plans. We will establish a designated communications and engagement workstream to oversee delivery of the strategy, with a Senior Responsible Officer for engagement.

10.2 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.

We are already beginning to develop a comprehensive picture of local views and concerns through our early engagement, building an extensive stakeholder and community database and contacts which will enable us to develop a detailed plan of those affected by any proposed changes.

We also have an existing relationship with both general and specialist media outlets (including digital). We are already working on STP stories with these stakeholders and will continue to do so whether formal consultation is required or not.

10.3 Equalities analysis and impact assessment

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

Our equality analysis will consider 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 against any unintended consequences for some groups. We are committed to undertaking an Equalities Impact Assessment as our plans become more fully developed.

We already have a good overview and analysis of equality information from across the NCL footprint through our existing and ongoing partnership work with the 5 local authorities, CCGs, providers and other representative organisations. We are building 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 through the STP. 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 our 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 STP progresses.

11 Conclusion and next steps

The STP remains a work in progress and we recognise that, notwithstanding the progress made since October 2016, we have much more work to do to develop and implement the detailed plans that deliver the vision we have set out.

The immediate next steps between now and April 2017 are to:

- to take steps to stabilise our financial position, developing more detailed ideas in the areas we have not yet fully explored
- agree the priorities for implementation in the first 2 years of the STP 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
- as a sector, sign-off and commit to the implementation of the delivery plans within each of the workstreams and move to implementation as soon as is practical to do so

At the same time, we are clear that we will not lose focus on the longer term transformation that will support sustainability.

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.