North Central London Sustainability and Transformation Plan

North Central London
Sustainability and Transformation plan

Health and Care Closer to Home

Workstream - High Level 5 Year Delivery Plan and Detailed Plan for 17/18

NHS England
NHS Camden Clinical Commissioning Group
NHS Enfield Clinical Commissioning Group
NHS Haringey Clinical Commissioning Group
NHS Islington Clinical Commissioning Group

BARNET LONDON BOROUGH
Camden
ENFIELD Council
Haringey LONDON
ISLINGTON

Barnet, Enfield and Haringey NHS
Camden and Islington NHS
Central London Community Healthcare NHS
Central and North West London NHS
North Middlesex University Hospital NHS
Royal Free London NHS Foundation Trust
University College London Hospitals NHS
Whittington Health NHS

DEFINITION / PLAN

Objectives and Scope

North Central London Sustainability and Transformation Plan

High level objectives	• To establish a 'placed-based' system of care delivery which draws together social, community, primary and specialist services in a seamless, integrated way • To ensure the local population gets the right care, at the right time, in the right place • To improve access to services and reduce health inequalities • To improve the quality of primary care and reduce unwarranted variation • To improve the management and prevention of chronic disease • To provide support for people to self-care
Scope and Exclusions	➢ **In scope:** • In scope: provision of health, care and wider social services in the community setting to prevent people from going to hospital unnecessarily and support independence • Delivery of services through CHINs (Care closer to Home Integrated Network) ➢ **Exclusions (out of scope):** ▪ Primary care contracting ▪ Elective care transformation ▪ Urgent and emergency transformation ▪ Mental health service transformation

DEFINITION / PLAN

Strategic Narrative
North Central London

North Central London Sustainability and Transformation Plan

Improved 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

Care Closer to Home Integrated Networks (CHINs)
CHINs may be virtual or physical, and will most likely cover a population of c.50-80,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focused on the strengths of residents, families and communities and support from specialist consultants to enable GPs and the teams to manage more care closer to home. CHINs will integrate local mental health services and will align with urgent and end of life care.

Quality Improvement Support Teams (QISTs)
These GP-led teams will be tasked with improving quality in primary care and reducing unwarranted variation. They will play a central role within the CHINs, providing hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients, helping to roll out best practice, clinical innovation and new technology in a systematic and consistent way. This will include support to maximize case finding and proactive management of high blood pressure, atrial fibrillation and diabetes.

DEFINITION / PLAN

Strategic Narrative – Improved Access
Barnet CCG

North Central London Sustainability and Transformation Plan

- The Barnet extended access service will be provided from 9 GP Practices within each of the 4 hubs within the borough.
- Barnet CCG is in the process of ensuring that each site is registered for a license to enable interoperability between EMIS and Adastra systems to support direct booking from NHS 111.
- Direct booking from NHS 111 has already been implemented at one site in Barnet since November 2016.
- Patients currently access the extended access service via their own practice or via NHS 111, but from 1 April 2017 the provider will have in place a central call handling arrangement to ensure that patients have easy access to the service out of hours.
- All GP practices in Barnet have a data sharing agreement which allows access to a shared appointment book on EMIS Community. When the software becomes available, patients will be able to book on line
- Across the GP practices in Barnet a number of patients have access on line. Barnet CCG is currently targeting all practices to improve on-line booking between now and 31 March 2017 in line with national targets.

DEFINITION / PLAN

Strategic Narrative – CHIN/ QIST development Barnet CCG

North Central London Sustainability and Transformation Plan

- There will be 4 CHINs across Barnet covering a population size of £100k each, operating around the same geography as the existing 4 hubs. In Barnet we will continue to use the term 'Hub' to describe the CHIN.
- A Hub management board will be established and will report to the CCG's Care Closer to Home Board/Health and Wellbeing Board and where appropriate the Governing Body. .
- The Barnet GP Federation, Royal Free London, Central London Community Health Services, Barnet Local Authority and Voluntary Services, Public Health, BEHMHT, CEPN, NELCSU and on occasions NHSE will form the basis of the Hub planning group.
- Integrated networks , or BILT, as they are known in Barnet, are a whole health and social care economy approach which is directly linked to the NCL STP ambition. The ambition in Barnet is for networks to evolve into a capitated, accountable care organisations.
- The new Hub integrated care teams will have primary care leadership with a strong focus on reducing variation at a practice/population level, greater integration of the workforce model across primary, community, secondary and voluntary care to deliver a new offer, personalised outcomes within the funding available - Hub budgets based on population needs.
- Aligned with Hubs/CHINs, a local QIST team made up GPs/Nurses and analysts that will make use of population/benchmarking data to identify trends and variations, supporting a change in service delivery and referral through new ways of working, changing models of practice; clinician to clinician discussions which challenge current practice. There will be 4 QIST teams.
- The QiST team will work closely with the Referral Management Service that already reviews all secondary care referrals and identifies and addresses variation in referral practice.
- It is proposed that the local NHS estate is utilised wherever possible, therefore HUBs will be centred around Edgware Community Hospital in the West, Vale Drive Medical Centre in the North, Finchley Memorial in the East.
- A location for the South has still to be identified, but this is likely to be one of the larger GP practices or potentially the new Health and Wellbeing Hub in Hendon.

DEFINITION / PLAN

Strategic Narrative – Improved Access
Enfield CCG

North Central London Sustainability and Transformation Plan

- Our model for extended access in Enfield CCG will be delivered from three hubs in 2016/17 increasing to four hubs in Q2 of 2017/18 – one in each of our four localities. Each Hub will be aligned to one of our four Locality Based Health & Care Teams (HCTs) and will form the vehicle through which any additional services are commissioned.
- Arrangements for direct booking into our extended access service from NHS 111 were established on 1st December 2016 as part of our IUC Procurement. Patients are warm transferred from 111 to a Single Point of Access for direct booking.
- Our population can access the extended access service in two ways: shared appointment booked via patients own practice or an appointment booked via our Single Point of Access telephone number.
- Patients can book consultations online in 100% of practices
- The North Central London CCGs will be piloting e-consultation functionality for GP practices during 2017/18 and this forms part of our response to the GP Forward View.

DEFINITION / PLAN

Strategic Narrative – CHIN/ QIST development
Enfield CCG

North Central London Sustainability and Transformation Plan

- Enfield CCG is establishing a number of Health & Care Teams (HCTs) that will perform functions that overlap with that of the CHINs. There will be four HCTs (one for each of Enfield's localities) each covering a population of ~80k patients and organised around the existing Primary Care Hubs that are being established (one in each locality).
- Enfield has established Locality Based Health & Care Teams (HCTs) who have established Working Groups focused on operational and clinical issues. This Working Group reports to and is accountable to Enfield CCG's Executive Committee (a formal sub-committee of the Governing Body). Services are intended to be planned and commissioned by the CCG via the Hubs and each HCT will be aligned to one of the Enfield Hubs.
- Enfield's HCTs already comprise representation from the CCG, London Borough of Enfield, Voluntary Sector Partners, Enfield Healthwatch, Enfield Community Services (provided by BEH Mental Health Trust who also represent our patients' Mental Health needs), North Middlesex University Hospital Trust and Royal Free Foundation Trust.
- Enfield CCG will be restructuring existing Integrated Care Services and improving alignment to our existing HCTs. In addition to this we will also be making the following significant changes for 17/18:
    - Funding Locality Based Mental Health Primary Care via our BCF
    - Increasing investment in our Community Specialist Nurses around LTCs and aligning them to our HCTs.
    - Restructuring the services provided by CHAT (Care Home Assessment Teams) and increasing funding for additional activity.
    - Moving toward a single offer for Primary Care utilising enhanced funding to improve care for Patients with LTCs and for Older People.
- Enfield will be building on our existing Quality Improvement Collaborative work and forming 2 QISTs in 17/18 with the intention being to form a further two in 18/19. The QISTs will be aligned to each of our four localities and our four Health & Care Teams

DEFINITION / PLAN

Strategic Narrative – Improved Access
Haringey CCG

North Central London Sustainability and Transformation Plan

- Extended access in Haringey will be delivered through hubs.
- Patients access the service via their practice, through redirections from A&E/UCC and via NHS111.
- There is currently a procurement regarding the hubs and under the service specification access will also be possible through patients directly calling the hubs.
- Across Haringey practices share data through EMIS community and the MIG for Vision practices. There is a data sharing agreement in place between the practices in Haringey.
- Patients are able to book appointments online in 100% of Haringey's practices. The local federation has appointed champions to support those practices who have fewer than 20% of their patients signed up to date.
- As part of wider NCL plans we will implement a pilot next financial year where we will explore approaches to online consultations. We expect to start trialling the different products available in Q2/Q3 2017/18 with a view to procuring a single solution across NCL by Q1 2018/19.

DEFINITION / PLAN

Strategic Narrative – CHIN/ QIST development
Haringey CCG

North Central London Sustainability and Transformation Plan

- Haringey CCG will implement approximately 6 Integrated Networks (CHINs) which will be circa 50,000 in population.
- Our Integrated Networks (CHINs) will be made up of groups of practices, community services, mental health, social care (including both private and council providers) and third sector. It will also have a strong focus on local community engagement.
- CHINs will review evidence and local data to identify priority areas which will support provision of quality care, closer to home for patients. We will identify opportunities to shift activity out of hospital and to focus on prevention.
- Haringey already has weekly MDT teleconferences and multi-professional locality teams. These support holistic case-management for people at risk of admission and those with frequent attendances to A&E. CHINs are more strategic in nature, looking at whole population level performance and outcomes in order to identify areas for improvement and focus. They will be responsible for the whole population and have a focus on prevention and early intervention as well as deployment of resource.
- Haringey's model for quality improvement is through regular provision of quality data to highlight unwarranted variation; prioritising areas for improvement and informing the type of change which is required.
- Local incentive schemes have been developed which will incentivise better case finding and case management of long term conditions at practice level and support CHIN level collaboration across practices.
- Quality Improvement Support Teams will be established that are embedded within each CHIN. These will provide practical help, in the form of continuous quality improvement support and clinical sessions, to develop consistent standards of care to all patients, help identify opportunities for working more productively both independently, as teams and by tapping into local resources and using data to inform the system as a whole.

DEFINITION / PLAN

Strategic Narrative – Improved Access
Camden CCG

North Central London Sustainability and Transformation Plan

- In Camden the extended access services model is based on 3 hubs.
- The current service features on the Directory of Services and NHS 111 can book appointments into the hub via telephone. Camden's extended access service is currently out to procurement with a new service available from April 2017, this will also feature booking via NHS 111.
- Patients in Camden currently access the service via local practices or NHS 111. Following the procurement it is anticipated multiple access points will be available, including, A&E re-direction and a single point of access telephone number,
- Across Camden GP practices have a data sharing agreement which allows access to a shared appointment booking on EMIS Community.
- Online booking functionality is already in place in all practices in Camden. A dedicated team are working with practices to increase the number of patients using this facility

DEFINITION / PLAN

Strategic Narrative – CHIN/ QIST development Camden CCG

- Camden CCG are in the process of implementing Neighbourhood Care Groups (CHINs) as part of the Camden Local Care Strategy. There is expected to be approximately 4 Neighbourhood Care Groups across the borough based around a population of 50-80,000. This may vary as groups formalise over the next 2 months.
- A Primary Care Transformation Group which forms part of the overall governance for the Local Care Strategy is now in place. This group meets monthly and has representation from each of our Neighbourhood Care Groups (CHINS). This forum will oversee the development and delivery of our local plans, with other relevant activities led through adult's, children's and mental health 'partnership boards'. This group will report to the Local Care Delivery Board which has representation from every key provider organisation in Camden.
- The relevant health and social care providers are represented on each partnership board, and the primary care transformation group has representation from each neighbourhood and integrated commissioning team Collectively all health and social care providers and commissioners are involved in the development of our Neighbourhood Care Groups.
- Our local acute providers are members of the relevant partnership boards and Local Care Delivery Board. The mechanisms for agreeing what activity will shift and how this will managed is therefore in place through these existing forums.
- Our plans will build on existing MDT arrangements already embedded across Camden. the key change will be the primary care leadership role and the accountability for population health improvement, with incentives in place to support this way of working built into contracts with each key partner organisations.
- During 17/18 we will pilot the QIST model initially to support the delivery of the Universal Offer outcomes for each neighbourhood. (Outcomes align with STP expectations). A business case will be development in March 2017 with a view to enhance this model within 17/18 and 18/19.
- Each of the Neighbourhood Care Teams is expected to have a QIST team.

DEFINITION / PLAN

Strategic Narrative – Improved Access
Islington CCG

North Central London Sustainability and Transformation Plan

- Islington CCG intend to offer extended access services via HUBs
- The service features on the Directory of Services and NHS 111 can book appointments into the hub via telephone. Islington's extended access service is currently out to procurement with a new service available from April 2017
- Islington patients can access extended hours appointments through their own GP practice – either via reception directly booking them into the service, or as all practice phones divert to I-Hub outside of opening hours.
- EMIS community enables records to be accessed from the extended access hubs and the provider is currently piloting EMIS Enterprise which will enable direct recording into patient notes.
- Across the GP practices in Islington the facility for booking appointments online is available in all practices. However, take-up is variable, and use is limited with wide variation across practices in numbers of patients with online accounts (variation from 0.1% to 27.0%). We are currently working with our GP Federation to support practices to make improvements in this area following national investment.

DEFINITION / PLAN

Strategic Narrative – CHIN/ QIST development Islington CCG

North Central London Sustainability and Transformation Plan

- There is likely to be between 3-4 CHINs in Islington covering a population of 80,000 each
- It is envisaged that a memorandum of understanding will be put in place between partners of the CHIN planning groups.
- Within these planning groups we foresee the following partners; GP's, local authority, community providers eg mental health trust, acute partners. These will have clinical leadership with a strong emphasis on local community engagement (so voluntary sector and local people).
- CHINs will review evidence and local data to identify pathways within which to focus . This work will link into work across elective care pathways already being led by the STP programme. The purpose of this work will be to identify opportunities for closer collaboration with hospital specialists plus opportunities to shift activity out of hospital. This work has already led to a new model being developed within diabetes care where more activity will be managed within primary care.
- Through its integrated care programme Islington has already rolled out integrated networks that have developed multi-disciplinary teams, wrapped around primary care. Integrated care teams deliver person centred co-ordinated care to those most at risk. This is generally the top 5% of population. CHINs are more strategic in nature, looking at population level performance and outcomes in order to identify areas for improvement and focus. They will be responsible for the whole population and have a focus on prevention and early intervention as well as deployment of resource.
- Islington's model for QIST delivery is to employ additional clinician and analyst support to: review data, identify variation and bring additional clinical capacity into general practice to support continuous quality improvement.
- Islington will endeavour to have one QIST per 50,000 population as recommended in the design brief but this is dependent upon resource so as a minimum we shall look to having one QIST per 80,000/CHIN level (3-4 across the CCG).

DEFINITION / PLAN

Constraints & links to other programmes

North Central London Sustainability and Transformation Plan

Constraints	➢ **Time:** Lead time to realise reductions in activity and finance. Establishing effective teams to provide care closer to home and address unwarranted clinical variation takes time. ➢ **Cost:** A significant level of investment will be required in order to realise the savings targets set out in this plan ➢ **Quality:** According to information provided by the GP outcome standards reporting portal, the quality of primary care in NCL is variable. ➢ **Legal:** The programme will need to work within competition rules when procuring services
Links to other work-streams	➢ **Urgent and Emergency care –** particularly links to CHIN working for supporting discharge to community setting, delivering more end of life care in community settings and rapid response aligned with the CHIN ➢ **Planned care** – linking to establish an appropriate model of specialist support to GPs to enable them to manage more planned care in community settings with CHINs providing an integrated local delivery vehicle ➢ **Prevention –** through the delivery of prevention at practice level within the CHIN and agreed outcomes for CHINs and QISTs reflecting local health and wellbeing priorities ➢ **Mental Health** – as part of plans for primary care mental health and its role within the CHIN system of care ➢ **Wellbeing partnership –** links particularly to CHIN development in Haringey and Islington ➢ **Digital workstream-** in particular for enhanced access and online consultations/ GP online/ patient online ➢ **Workforce workstream**– to address the requirements for additional capacity, different skills and organisational development/culture change with new ways of working ➢ **GP Forward view –** forms a major part of the programme, features within workstreams

DEFINITION / PLAN

Initiatives & deliverables to 2020/21(1/1)

North Central London Sustainability and Transformation Plan

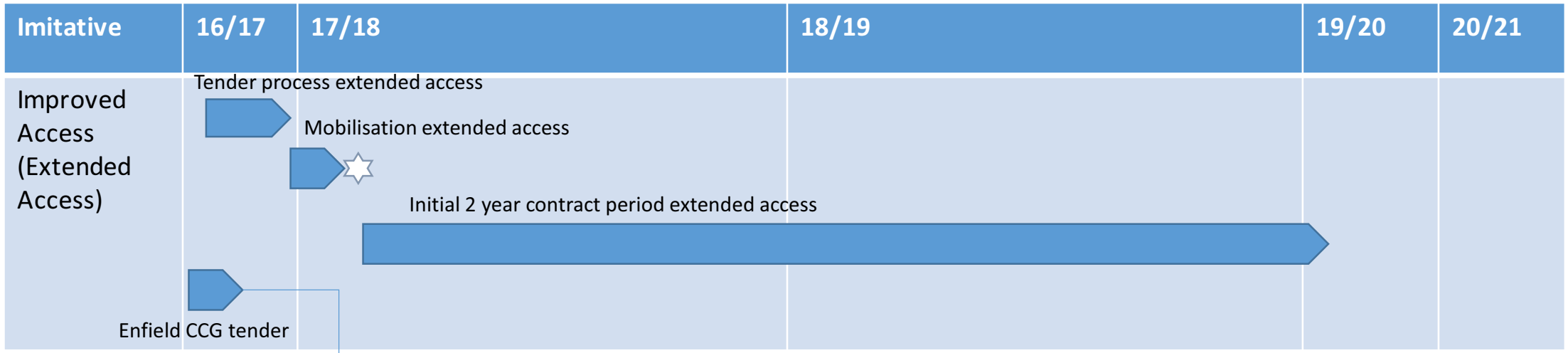
Working with GP and public health colleagues a complete set of KPIs is being developed to measure progress on improvement of health, patient experience and system efficiency outcomes. CCGs will agree with their CHINs and QISTs the relevant KPIs to direct their action plans from this set depending on local needs and priorities. The KPIs will measure a range of deliverables including those below.

Work package	Initiative	Description	Deliverable	Target Delivery Date
Health and Care Closer to Home	**Improved access**	Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.	• Improved patient satisfaction with access to primary care • Reduced number of patients with a primary care appropriate problem seen in A&E or Urgent Care • A health and care system that is more resilient	April 2017
Health and Care Closer to Home	**QISTs**	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.	• Reduction in clinical variation • Reduction in activity and cost of secondary care services • Preventing people from dying prematurely • Enhancing quality of life for people with long-term conditions • Ensuring people have a positive experience of care	All CCGs by Mar 19
Health and Care Closer to Home	**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	• Reduction in clinical variation • Reduction in activity and cost of secondary care services • Preventing people from dying prematurely • Enhancing quality of life for people with long-term conditions • Ensuring people have a positive experience of care	All CCGsby Mar 19

DEFINITION / PLAN

Delivery schedule to 2020/21
Extended Access

North Central London Sustainability and Transformation Plan



Nb. Enfield CCG have already procured an extended access service

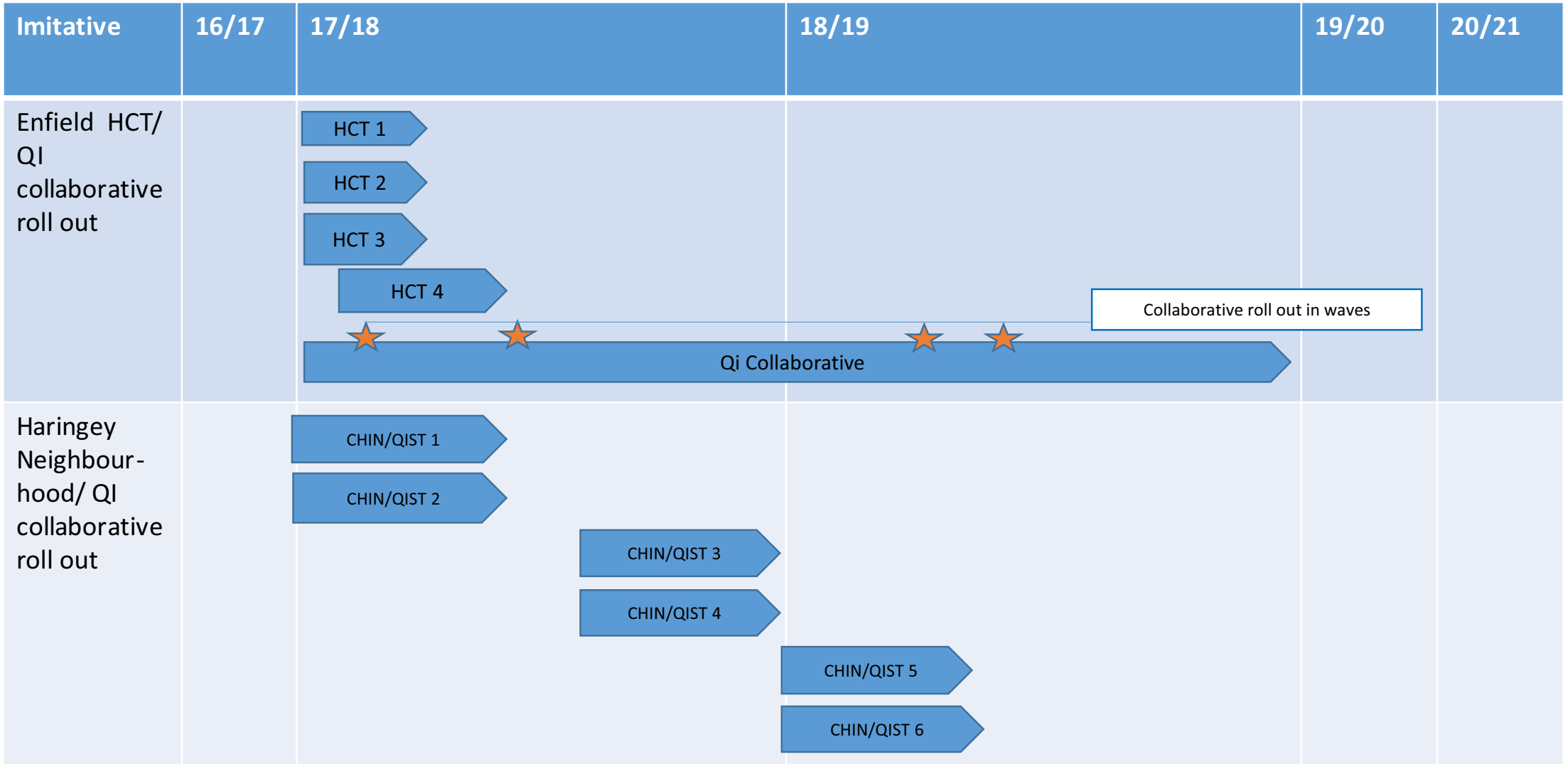
Delivery schedule to 2020/21
CHIN/ QIST

North Central London Sustainability and Transformation Plan

Imitative	16/17	17/18	18/19	19/20	20/21
Camden Neighbour-hood Care Team/QIST roll out		Neighbourhood Care Team/QIST 1 Neighbourhood Care Team/QIST 2 Neighbourhood Care Team/QIST 3 Neighbourhood Care Team/QIST 4			
Islington CHIN/QIST roll out		CHIN/QIST 1 CHIN/QIST 2 CHIN/QIST 3 CHIN/QIST 4			
Barnet Integrated Locality Team/QIST roll out		Integrated Team/QIST 1 Integrated Team/QIST 2	Integrated Team/QIST 3 Integrated Team/QIST 4		

Delivery schedule to 2020/21
CHIN/ QIST

North Central London Sustainability and Transformation Plan



DEFINITION / PLAN

2017/18detailed Work Breakdown Structure (1/1)

Work package	Initiative	Activity / Deliverable	Owner / Lead	Target delivery date
Improved Access	Extended Access to Primary Care	Extended Access Service in Barnet CCG	Beverley Wilding	Q1/ 2017/18
		Extended Access Service in Haringey CCG	Cassie Wilding	Q1/ 2017/18
		Extended Access Service in Islington CCG	Clare Henderson	Q1/ 2017/18
		Extended Access Service in Camden CCG	Gordon Houliston	Q1/ 2017/18
CHIN/ QIST	CHIN/ QIST roll out	Barnet Hub 1/ QIST 1	Beverley Wilding	Q2/ 2017/18
		Barnet Hub 2/ QIST 2		Q4/ 2017/18
		Barnet Hub 3/ QIST 3		Q2/ 2018/19
		Barnet Hub 4/ QIST 4		Q4/ 2018/19
		Enfield HCT 1	Jenny Mazarelo	Q1/ 2017/18
		Enfield HCT 2		Q1/ 2017/18
		Enfield HCT 3		Q1/ 2017/18
		Enfield HCT 4		Q2/ 2017/18
		Enfield QI Collaborative (in waves 2 x 17/18 and 2x18/19)		Q1/ 2017/18
		Haringey CHIN 1/ QIST	Cassie Williams	Q1/ 2017/18
		Haringey CHIN 2/ QIST		Q1/ 2017/18
		Haringey CHIN 3/ QIST		Q4/ 2017/18
		Haringey CHIN 4/ QIST		Q4/ 2017/18
		Haringey CHIN 5/ QIST		Q1/ 2018/19
		Haringey CHIN 6/ QIST		Q1/ 2018/19
		Camden Neighbourhood 1/ QIST	Gordon Houliston	Q1/ 2017/18
		Camden Neighbourhood 2/ QIST		Q2/ 2017/18
		Camden Neighbourhood 3/ QIST		Q3/ 2017/18
		Camden Neighbourhood 4/ QIST		Q1/ 2018/19
		Islington CHN 1/ QIST	Clare Henderson	Q1/ 2017/18
		Islington CHIN 2/ QIST		Q2/ 2017/18
		Islington CHIN 3/ QIST		Q3/ 2017/18
		Islington CHIN 4/ QIST		Q4/ 2017/18

DEFINITION / PLAN

2017/18 Programme Management Capacity

North Central London Sustainability and Transformation Plan

Rationale	Resources required	Capacity requirements
Central team		
Senior leadership to each work programme delivering the strategic goals.	Programme Lead	1 wte Band 9
Coordinate delivery and report against the STP and the GPFV. Initiate the direction and pace of progress, review and reset progress as necessary, identify and manage risks and manage relationships with external partners across NCL.	Programme Manager (in post) Programme Officer	1 wte Band 8c 1 wte Band 7
Analytics support to the programme – public health analytics	Programme analyst	£50,000 per annum
Senior leadership to each work programme delivering the strategic goals.	Clinical lead (in post)	£31,200 per annum
Local delivery team		
Initiate the direction and pace of progress to work with the existing local landscape and partners within the strategic framework set by the STP. Review and reset progress as necessary, identify and manage risks and manage relationships with external partners, securing local ownership.	Head/ Assistant Director of Primary Care Delivery and commissioning CCG Primary Care Clinical Lead	1 wte x 5 2 sessions per week
Deliver and report against the STP and the GPFV. Co-ordinate CHINs and QIST set up locally CCG level clinical leadership <u>Other resources to be locally determined</u>	CCG Project manager CCG Clinical Lead	5 wte Band 8a £50,000 per annum

DEFINITION / PLAN

Proposed recruitment plan (1/1)

North Central London Sustainability and Transformation Plan

Resources required (specify required roles)	AfC Grade	Estimated Cost (based on midpoint AfC for higher band plus 20%)	Start date	End date	How the post will be filled
Programme Lead	9	£108,644	31/3/2017	31/3/2018	TBC – Director of Strategy to determine
Programme Manager	8C	£74,876	In post		
Programme Officer	7	£43,500	31/3/2017	31/3/2018	Fixed term contract/ secondment
Programme Analyst	N/A	£50,000	31/3/2017	31/3/2018	Commissioned via Public Health Islington and Camden
Head of/ Assistant Director of Programme Delivery – Barnet	8C/8D	£89,790	In post		
Head of/ Assistant Director of Programme Delivery – Camden	8C/8D	£89,790	In post		
Head of/ Assistant Director of Programme Delivery – Enfield	8C/8D	£89,790	In post		
Head of/ Assistant Director of Programme Delivery – Islington	8C/8D	£89,790	In post		
Head of/ Assistant Director of Programme Delivery – Haringey	8C/8D	£89,790	In post		
Programme Clinical lead		£31,200	In post		
CCG Clinical leadership		£50,000	31/3/2017	31/3/2018	Sessional opportunityto GPs

BENEFITS REALISATION

Workstream finance and activity impact - 2017/18 (if applicable)

North Central London Sustainability and Transformation Plan

Work Package	Initiative	Recurrent	Non Recurrent	Savings (gross)*	Net savings	Activitychange +/-

See Finance Appendix

BENEFITS REALISATION

Investment plan (where applicable)

North Central London Sustainability and Transformation Plan

Month	CCG / Borough / Trust	Rationale
Apr 2017		
May 2017		
Nov 2017		
Dec 2017		
Jan 2018		
Feb 2018		
Mar 2018		

See Finance Appendix

BENEFITS REALISATION

Initiative impact trajectory to 2020/21

North Central London Sustainability and Transformation Plan

Initiative impact trajectory - Activity

Initiative	POD	ACTIVITY - Impact (gross savings achieved by year)				
		16/17	17/18	18/19	19/20	20/21

See Finance Appendix

BENEFITS REALISATION

Benefits realisation and KPIs (1/3)

North Central London Sustainability and Transformation Plan

Initiative	Impact	Key Performance Indicator Influenced	Target	Validation date
Extended Access	Improve patient experience	% Patient satisfaction	CCG specific target	Q1 2018/19
Extended Access	Achieving an enhanced level of access with standardisation of methods and speed as appropriate	30 minutes per thousand population of wrap around extended access	CCG specific target	Q1 2018/19

BENEFITS REALISATION

Benefits realisation and KPIs (2/3)

North Central London Sustainability and Transformation Plan

Initiative	Impact	Key Performance Indicator Influenced	Target	Validation date
CHINs/ QISTs	Identifying unmet need through enhanced case finding and review	Reduced gap between identified and expected prevalence rates for key chronic diseases	CCG specific target	Q1 2018/19
CHINs/ QISTs	Reduced premature mortality in key areas (heart disease, COPD, severe mental illness, hypertension, learning disability, alcohol misuse)	Deaths under 75	CCG specific target	Q1 2018/19
CHINs/ QISTs	Reduction of mortality rate from all cancers considered preventable	Morbidity and mortality by social class	CCG specific target	Q1 2018/19
CHINs/ QISTs	Reduction in complications from diabetes	Increase in Diabetes prevalence	CCG specific target	Q1 2018/19
CHINs/ QISTs	Reduced inequalities in health	Percent of patients on the practice mental health register with cholesterol check in preceding 12 months	CCG specific target	Q1 2018/19
CHINs/ QISTs	Increase in cancer survival at one year	Increase in cancer detection rates	CCG specific target	Q1 2018/19

BENEFITS REALISATION

Benefits realisation and KPIs (3/3)

North Central London Sustainability and Transformation Plan

Initiative	Impact	Key Performance Indicator Influenced	Target	Validation date
CHINs/ QISTs	Increase in proportion of people feeling supported to manage their condition per year	A&E attendances and emergency admissions	CCG specific target	Q1 2018/19
CHINs/ QISTs	Increase in proportion of people who feel they are more in control of their health	Proportion of vulnerable patient groups receiving flu immunisation	CCG specific target	Q1 2018/19
CHINs/ QISTs	Increased range of support for people to people to improve their health where a need is identified	Percentage of people with diabetes who have received the nine care processes	CCG specific target	Q1 2018/19
CHINs/ QISTs	Increase in proportion of patients dying in the place of their choice	Numbers of those eligible living within the most deprived quintile receiving an NHS Health Check	CCG specific target	Q1 2018/19
CHINs/ QISTs	Improved quality of life for carers	Number of alcohol brief interventions per year	CCG specific target	Q1 2018/19

BENEFITS REALISATION

Equalities impact assessment

North Central London Sustainability and Transformation Plan

Equalities Impact Assessment

GOVERNANCE

Linkages to other workstreams

- Prevention
- Urgent Care
- Mental health
- Workforce, IT and Estates
- Finance and Activity modelling

North Central London STP Transformation Board

Programme Delivery Group

CCG Primary Care leads working with others to deliver the agreed programme

Health and Care Closer to Home Programme Board

Drives development and delivery of the HCC2H component of the STP. Membership: Commissioners, Providers, LAs, NHS E, Healthwatch

Clinical Reference Group (CRG)

Chaired by NCL Primary Care Clinical lead. Membership CCG Primary Care leads and other clinicians

NHS E/ CCGs

Primary Care Joint Committee

- Defined Terms of Reference to deal with contractual matters
- Established since October 2015

TRANSFORMATIONAL

ENABLER

SUSTAINABILITY/ ENABLER

Implementing the Primary Care Model

- Delivery of the primary care vision in each borough
- Delivering accessible, co-ordinated and proactive care in each borough
- Developing the hub/practice model
- Workforce model, IT, Estates implications

Clinical Lead – Islington CCG supported by Camden CCG
Management lead - Islington CCG supported by Camden CCG

Commissioning

- Developing the commissioning approach for NCL (Commissioning intentions, LCS alignment, new types of contracts)
- Overseeing the development of delegated commissioning
- Reporting progress on PMS review
- Developing arrangements for NHS E primary care contracting via the OD review

Clinical Lead –Enfield CCG supported by Haringey CCG
Management lead - Enfield CCG

Provider development and sustainability

- Development of sustainability plans for practices
- Support to the development of 'at scale' primary care providers.

Clinical Lead – Haringey CCG supported by Barnet CCG
Management lead - Barnet CCG supported by Haringey CCG

Improving quality and addressing variation

- Improving quality/ patient experience
- Developing an improvement package for practices
- Addressing and supporting poorer performing practices
- Consideration of common standards
- Link to provider development

Clinical Lead – Camden CCG
Management lead - Haringey CCG

Patient and public involvement

- Overseeing the programme for Health and Care Closer to Home to ensure that patient/ public voice is captured, heard and influences the programme

Clinical Lead – Barnet CCG
Management lead - Programme Director

GOVERNANCE

Programme Board - Governance group core membership

Role	Name	Organisation
SRO	Alison Blair	NHS Islington CCG
Local authority sponsor	Sanjay Mackintosh	LB Haringey
Adult Social Care Lead	Sean McLaughlin	LB Islington
Children's Social Care Rep	Collette McCarthy	LB Barnet
NCL STP Clinical Lead	Dr Katie Coleman	Islington CCG
Mental Health representative	Dr Alex Warner	Camden CCG
Mental Health representative	Pippa Wady	Camden CCG
UEC representative	Liz McAndrew	Enfield CCG
UEC representative	Dr Sam Shah	NHS England
Prevention representative	Will Marmaris	LB Haringey
Finance lead	Ahmet Koray	Islington CCG
NHS England representative	Liz Wise	NHS England
End of Life Care representative	Caroline Stirling	UCLH
LMC representative	Greg Cairns	LMC
Federation representative	Anita Patel	CEPN Barnet
Acute trust representatives	Fiona Jackson	RFH
Acute trust representatives	Catherine Pollard	UCLH
Acute/Community trust representatives	Siobhan Harrington	Whittington
Community trust representatives	TBC	TBC
Mental health provider/s	Dr Vincent Kerchner	C&I
Healthwatch	Patricia Mecinska	Healthwatch Enfield

GOVERNANCE

Programme Board - Governance group non-core membership

Role	Name	Job Tile	Organisation
Director of Commissioning Rep	Graham MacDougal	Director of Commissioning	Enfield CCG
Director of Commissioning Rep	Rachel Lissauer	Director of Commissioning	Haringey CCG
Programme Director	Programme Director	Interim NCL Primary Care STP Programme Director	Islington CCG
Programme Manager	Daniel Morgan	NCL Primary Care STP Programme Manager	Islington CCG

GOVERNANCE

How CCGs/providers/LAs are being engaged in the period to 31 March

Summary

CCGs:

- Each of the work stream groups is led by one of the CCG primary care leads from each of the CCGs in NCL and engages various parties through events organised
- The SRO has met with CCG Chief Officers and their teams in NCL during January/February 2017 to discuss progress and any barriers
- CCGs are establishing CHIN delivery groups which involve commissioners from each of the CCGs commissioning portfolio areas as well as key partners

Providers:

- Dr Katie Coleman has been meeting with them during February/March 2017
- We have met with GP groups and federations to discuss the plans
- NHS Trusts and other providers are represented on the Health and Care Closer to Home Board
- The Health and Care Cabinet has reviewed the delivery plan on 8th March

Local Authority:

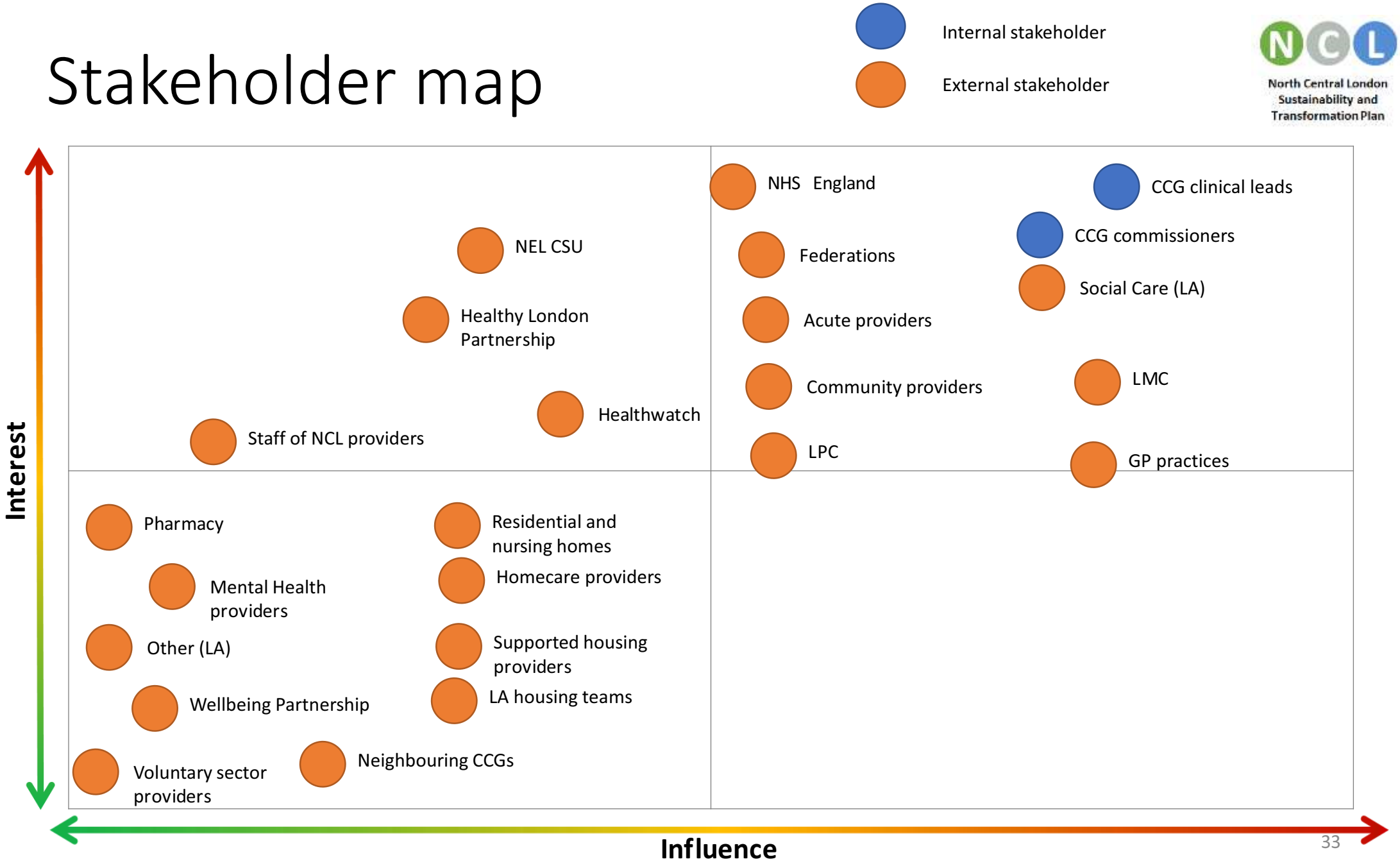
- We have met with the Directors of Adult Social Services in Enfield, Islington and Haringey, the Director of Strategic and Joint Commissioning for Camden and the Commissioning Director Adults and Health for Barnet to discuss proposals
- The DASS in Islington will be part of the board and has helped to develop the CHIN design principles and other programme documentation.
- We have a named link, Sanjay Mackintosh, who is working with us on behalf of all five local authorities
- Local Authorities are represented on the Health and Care Closer to Home Board

Wider engagement:

- Wider proactive engagement of the local community, ensuring that the complete marketplace is engaged.
- In particular, the voluntary and community sector
- Healthwatch and other community groups

COMMS/ENGAGEMENT

Stakeholder map



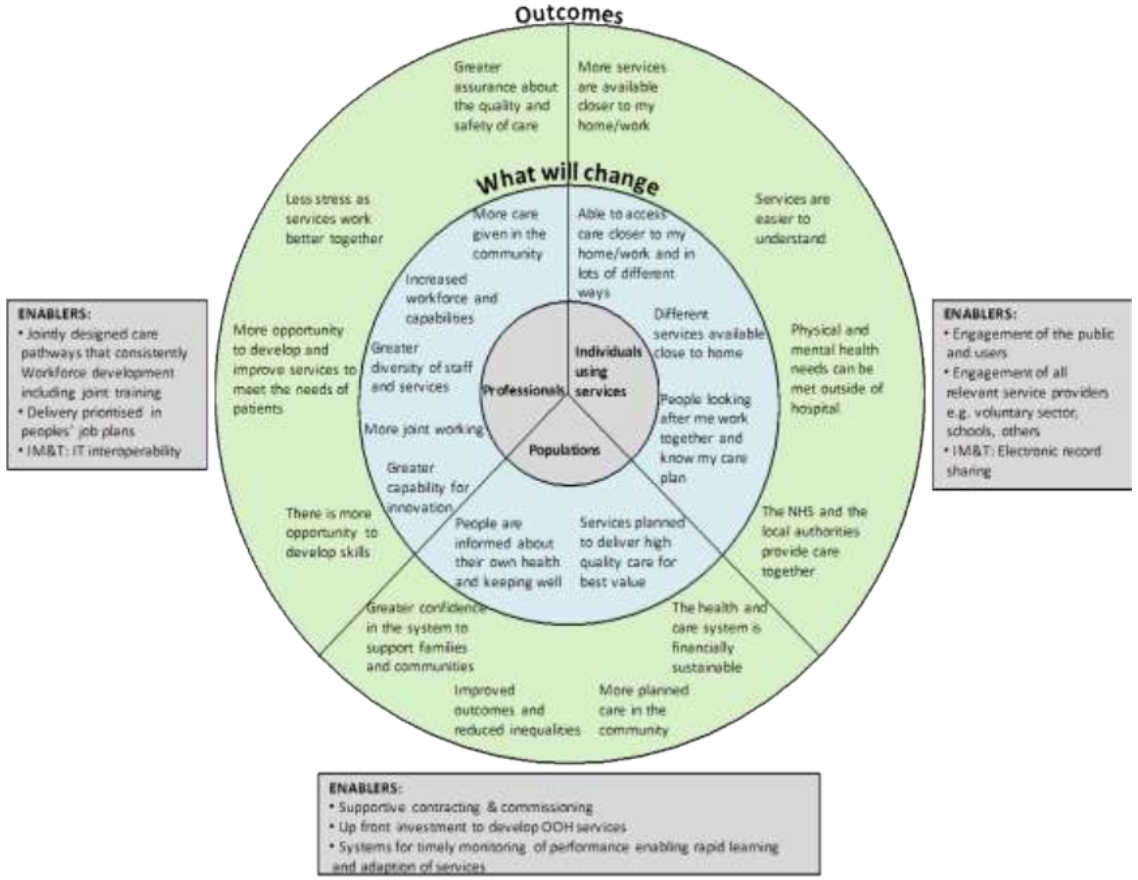
COMMS/ENGAGEMENT

Key messages

North Central London Sustainability and Transformation Plan

Overarchingmessage

- Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability.
- NCL has good services, the health and care closer to home model will focus on scaling these services up, reducing variation and making this the CHIN model the default approach to care and place based commissioning of services. Ensuring services are focused on the care of people within neighbourhoods.
- Social care and the voluntary sector will play a key role in the design, development and expansion of the future model.
- 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 which draws together social, community, primary and specialist services underpinned by a systematic focus on prevention and supported self-care



COMMS/ENGAGEMENT

Key messages – CHINs and Extended Primary Care

North Central London Sustainability and Transformation Plan

Overarchingmessage
CHINs/ QISTs • CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. • Interventions focused on the strengths of residents, families and communities; • 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 which will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes. **Extended Access** • Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. • telephone triage, virtual consultations and online booking systems will be available for all patients.

COMMS/ENGAGEMENT

Key messages – Social prescribing, patient education and supporting healthier choices

North Central London Sustainability and Transformation Plan

Overarchingmessage
• In line with our prevention agenda, the care closer to home model will include upscaling 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; • reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception. • the care closer to home model will include a greater emphasis on social prescribing and patient education. • Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.

COMMS/ENGAGEMENT

Outline Stakeholder Engagement Plan

North Central London Sustainability and Transformation Plan

Plan to 31 March 2017
Proposed engagement activity by stakeholder **GP Practice engagement events –** being led by each CCG primary care lead introducing the concepts within the plan **Provider engagement –** being led by Dr Katie Coleman. Visits to trusts to introduce the concepts within the plan **Market engagement (bidders) regarding extended access –** led by Islington AD for Primary Care and lead for CHIN delivery **HCC2H Board –** established to involve all key stakeholders in the development and delivery of the plan. Chaired by the SRO Alison Blair **Local Authority engagement and links –** Sanjay Mackintosh of Haringey LA providing link in to ADASSs and input to plans

Plan for 2017/18
Proposed engagement activity by stakeholder Detailed communications and engagement plan being developed with the input of Genevieve Ileris. Key messages to be refined and targeted at specific stakeholder groups. Lines of communication to be defined along with the method of communication. The programme intends to establish ongoing internal communications about the progress of the programme.

Lead for Comms and Engagement
Named lead: - **Engagement with external stakeholders:** Dr Katie Coleman (NCL GP Clinical Lead for PC) - **Engagement with internal stakeholders::** Programme Director with support from Dr Katie Coleman - **Programme Communications and Engagement lead**: Genevieve Ileris

RISKS

Key workstream risks

North Central London Sustainability and Transformation Plan

Risk	Likelihood x impact	Score	Mitigation	Revised score
Ability of GP Federations and other providers to deliver the necessary outcomes particularly the reduced activity beyond 2017/18.	4 x 4	**16**	Commissioners to ensure ongoing support, including OD support and develop strong strategic partnerships with clear and robust governance, accountability, monitoring and review for delivery. Ongoing system wide monitoring and review to adjust for variance and to support consistently high performance against plan.	**3 x 4 12 Escalation potential*: High**
CCGs take a cautious approach to investing in QISTs and GPs in particular, leading to failure to realise the scale of savings needed from unwarranted variation.	4 x 4	**16**	CCGs supported through the STP process to develop a common transformational approach. Promotion of evidence base and potential.	**3 x 4 12 Escalation potential: High**
Difficulty recruiting the GPs and nurses needed to deliver the CHINs and QISTs.	4 x 4	**16**	Providers to be supported to develop highly attractive terms based on research (see design templates), to be bold and creative.	**2 x 4 8 Escalation potential: High**
Failure to win hearts and minds across the system leads to lack of support and drive leading to ineffective implementation	4 x 4	**16**	Step up communications and engagement throughout the whole system and closely monitor to ensure success	**2 x 4 8 Escalation potential: High**

*Escalation potential = if not addressed promptly how much greater will the impact be later on

RISKS

Key workstream risks

North Central London Sustainability and Transformation Plan

Risk	Likelihood x impact	Score	Mitigation	Revised score
Failure to realise and invest in the scale of cultural change, organisational development, training and systematic change required to deliver the outcomes	3 x 4	**12**	OD plan to be developed and approved by Health and Care Closer to Home Board and submitted to STP Programme Delivery Board for approval	**3 x 3 9 Escalation potential: High**
Insufficient capacity and capability in care homes and social care system to provide non clinical support needed to achieve the outcomes	4 x 3	**12**	System wide planning with local authority involvement. CCG support to social and voluntary sector services	**3 x 3 9 Escalation potential: High**
Lack of consistent approach across NCL affects potential to fully realise the planned benefits including system efficiency	3 x 4	**12**	Clarity provided through agreed Design Templates setting out the core standards and capacity needed to deliver the planned savings across the system. Local variation agreed where justifiable. Process for developing and delivering STP to hold all commissioners and providers to account for establishing and supporting the agreed structures and delivery vehicles such as CHINs and QISTs	**2 x 4 8 Escalation potential: Medium**

RISKS

Key workstream risks

North Central London Sustainability and Transformation Plan

Risk	Likelihood x impact	Score	Mitigation	Revised score
GPs fail to engage in CHIN/QIST work	3 x 4	**12**	CCGs to align LCS and PMS* funding to pay for GP involvement. Commissioners to work with GPs to understand the benefits to them of delivering CHINs and QISTs and working at scale. Pioneers to be supported and to share the learning/benefits	**2 x 3 6 Escalation potential: Medium**
Failure to coproduce with local patients/citizens	3 x 3	**9**	Commissioners to support and ensure through mobilisation plans and communications with practical support.	**2 x 2 4 Escalation potential: Medium**
Failure by NHS trusts especially acute to engage with CHINs and QISTs and to help transform across the system	2 x 4	**8**	Commissioners to ensure all actively engaged and acute leaders in particular supported to use opportunities for alignment	**1 x 3 4 EP: Low**
Delays in implementing shared records digitally and developing robust population health analytics	2 x 3	**6**	STP and CCGs to prioritise digital roadmap delivery	**2 x 2 4 EP: Low**

*Locally Commissioned Services and Personal Medical Services

Quality impact

Patient experience/quality outcomes

North Central London Sustainability and Transformation Plan

Quality monitoring

- Commissioners will need to support CHINs and QISTs to agree clear outcomes for improved system efficiency, health and patient experience outcomes to reflect local priorities
- Strong governance of CHINs and QISTs with clear accountability for delivery will need to be established
- A quality dashboard is being developed for NCL with public health support from which priority outcomes can be selected and monitored
- Regular progress reports for all CHINs and QISTs will need to be published to ensure transparency

Quality benefits

These include:

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

For successful delivery

What's different (1/2)?

North Central London Sustainability and Transformation Plan

- The whole of NCL will have a consistent approach to delivering care closer to home with robust and reliable delivery vehicles to maximise care in the community: CHINs and QISTs.
- For the first time there will be teams working directly with and in general practices to address variation whether as a result of clinical practice or organisational systems.
- QISTs will systematically review information on variation and use quality improvement methodology including peer support and challenge and transparency on progress to help drive up standards and develop consistent approaches to managing patient care.
- QISTs will enable faster roll out of new technology, new care pathways, best practice and anything else that requires systematic and reliable change across all general practices
- As is happening across England, GPs will be working "at scale" to a degree never seen before, providing local leadership and ownership of the agreed outcomes and empowered to make changes happen within their local area to deliver these outcomes.

For successful delivery

What's different (2/2)?

North Central London Sustainability and Transformation Plan

- CHINs will build on existing multi-disciplinary teams but will now have:
  - Clear outcome objectives to achieve greater system efficiency, improved health and patient experience – with all organisations signed up and aligned to achieving these same goals.
  - Stronger governance with clear accountability for progress.
  - Transparent reporting and publishing of progress with comparative data.
  - A greater level of patient/citizen/community coproduction of service redesign and monitoring.
  - A much greater level of organisational support from commissioners and providers working in partnership to provide strategic leadership, clarify priorities and give practical support to remove barriers to progress.
  - Budgets and the ability to commission packages of care quickly to prevent admission.
  - Faster access to specialist advice as well as more specialist nurses and therapists in the teams.
  - Shared operating model including shared assessments and budgets for health/social care.
  - Integration of voluntary sector services in the team.
  - Utilisation of the "strength based" approaches being adopted by local authorities to maximise self care and build resilience of individuals, families and communities.

For successful delivery

Next steps

North Central London Sustainability and Transformation Plan

Lead	Action	Timescale
CCG finance/planning leads	Provide detail of whole time equivalent staffing in place and being deployed in CHINs and QISTs. Confirm investment and planned wte establishment in each CCG. Provide any outstanding information on QIPP schemes aligning with CHINs and QISTs. Where relevant provide answers to the questions on the previous slide.	March 9 2017
CCG primary care leads	Confirm mobilisation dates of CHINs and QISTs.	March 9 2017
CCG finance/planning leads	CCGs to provide analysis of activity/finance impact at point of delivery and HRG level to the STP finance team.	March 17 – 31 2017
STP Programme Delivery Board	Consider how CCGs can be supported to invest in additional staff for CHINs and QISTs to enable mobilisation more closely aligned to the STP proposals.	March 17 2017
CCG and Local Authority executive teams	Commissioners to work together with local providers to agree: • The shape of their CHINs/QISTS and breadth/responsibilities of partnerships • Their governance structure with MOUs or similar agreements between organisations • Practical support that will be provided to CHINs/QISTs and who will provide it • Patient/citizen engagement processes and structures • How CHIN/QIST progress will be monitored and published to ensure transparency.	April 2017 Prior to CHIN/QIST mobilisation
STP HCC2H team	Develop an evidence library of international, national and local evidence to provide guidance on the best ways to design and implement new ways of working. Appoint a QI clinical lead to network and assure QISTs and to maintain/review/promote evidence base.	Prior to CHIN/QIST mobilisation

For successful delivery

Next steps

North Central London Sustainability and Transformation Plan

Lead	Action	Timescale
CCG and local authority CHIN/QIST commissioner leads	Develop and agree outcome objectives (system efficiency, health and patient experience outcomes) with CHIN/QIST leads involving all relevant parties. Develop and agree process for agreeing CHIN/QIST action plans.	Prior to CHIN/QIST mobilisation
CHIN/QIST leads with commissioner support	Develop action plans with all partners including local patients/communities. Ensure urgent care, mental health, planned care and prevention work is fully integrated/aligned.	Prior to CHIN/QIST mobilisation period
CCG and local authority CHIN/QIST commissioner leads	Support CHIN/QIST pioneer leads to draft and agree mobilisation plans.	Prior to CHIN/QIST mobilisation
CCG and local authority CHIN/QIST commissioner and workforce leads	Support providers to recruit/redeploy staff into the CHINs/QIST and to offer sufficiently attractive terms and conditions to draw high calibre clinicians into NCL.	During CHIN/QIST mobilisation
CHIN/QIST leads supported by commissioners	Implement mobilisation and action plans	As agreed with commissioners
CCG and local authority CHIN/QIST commissioner leads	Work with local providers to ensure CHINs and QISTs are effectively supported to deliver. Monitor and publish progress Review and develop as necessary	As per mobilisation plans