North Central London Strategy Plan

2010 - 2014

25 January 2010

Contents

Foreword: Sector Chair and Chief Executive

This Plan brings together the Commissioning Strategy Plans for each of the five PCTs and the overarching strategy for the improvement of health and development of services within NCL. It marks a significant step in developing joint working between all the NHS organisations in North Central London (NCL), which has at its foundation a collegiate approach and strong clinical leadership. As such, this Plan represents the beginning of a process and not all the work is completed. Here we focus on the case for change, key change initiatives to implement care pathways, and a review of care settings.

Our proposals for service improvement are shaped by the London-wide strategy, *A Framework for Action,* published by Healthcare for London (HfL) in 2007 following a review of London's health services by Professor Ara Darzi. It identified that:

> *"Whilst there is excellence in some areas of London and in some specialties, that excellence is not uniform. There are stark inequalities in health and the quality, safety and experience of patient care is not as good as it could and should be."*

A 'Framework for Action' was consulted on in 2008. It provides clinical evidence for delivering improved quality in the NHS. The implementation of the HfL framework in NCL is a key impetus for change and presents a unique opportunity to improve services in a financially constrained context.

Central to this and pivotal to changing the wider healthcare system is the development of polysystems[1]. This requires investment in primary care and a shift of services from secondary care to develop a wider range of services in more accessible locations. This will bring great benefits to many people, for example, those with long term conditions such as diabetes, who regularly have to see a doctor, specialist nurses and other health professionals will receive most of their care closer to home rather than travelling to hospital based services. These local services may be provided by hospital consultants in a primary care setting and they will certainly mean GPs, consultants and other clinicians working together to provide the best possible care for patients.

In the north of the patch, the three PCTs and two Hospital Trusts are working on implementing the BEH the Barnet Enfield and Haringey (BEH) clinical strategy which will be completed by 2013. Any proposals arising from the wider NCL review will build on this work.

This is no doubt that in the NHS we face an unprecedented financial challenge over the next five years. Our financial modelling is based on a prediction of little or no growth against a rising demand for healthcare and a drive to improve quality. All the organisations agree that this means considering more fundamental changes to services rather than a year on year approach to savings by each organisation. Furthermore, as commissioners we will continue to tackle known health inequalities within our communities in NCL.

We fully recognise that health service changes are very important to the public, stakeholders, and to NHS. Our plan is to engage the public stakeholders and staff in our work – indeed this has started and will continue. We will be open and transparent in how we reach decisions and any proposal that we put forward will be supported by our clinical leaders and will demonstrate benefits to patients.

Rachel Tyndall

Paula Kahn

[1] A 'polysystem' comprises: a large primary care centre acting as a hub for services (including GPs, Nursing, Physiotherapy, Out Patients, Diagnostics, Specialist Community Services) and linked to surrounding GP practices and mental health services and hospitals, typically serving a population of 50-100,000

1. Vision for North Central London

1.1 Introduction

In developing the strategy for North Central London, we have maintained a clear focus on improving health and addressing health inequalities. Our vision sets out what we want to achieve for our population and our goals have evolved from our consideration of the following factors:

- Our population challenges
- The drivers for change
- What we plan to address at local (PCT) level
- What we plan to address at Sector level
- How we are going to deliver change

These are described in detail throughout the rest of this Sector plan.

1.2 Our vision and goals

Our vision

To improve the health of our population over the next five years compared with Londoners as a whole. In particular, we will improve health outcomes by addressing health inequalities within our population, focusing on our most deprived communities.

As a world class commissioner of healthcare, our population will have access to more services closer to home and the highest quality hospital services.

Under pinning our vision is realism about what we will deliver by when. Both out goals and our initiatives express this realism and are supported by a strong evidence base. They are achievable within the stated timeframes.

Our goals

Health improvement across North Central London compared to Londoners as a whole (2014)

Improvement in quality and productivity across the entire health system over the next five years

Implementation of 19 polysystems within NCL by 2014

Implementation of changes to hospital care settings by 2015

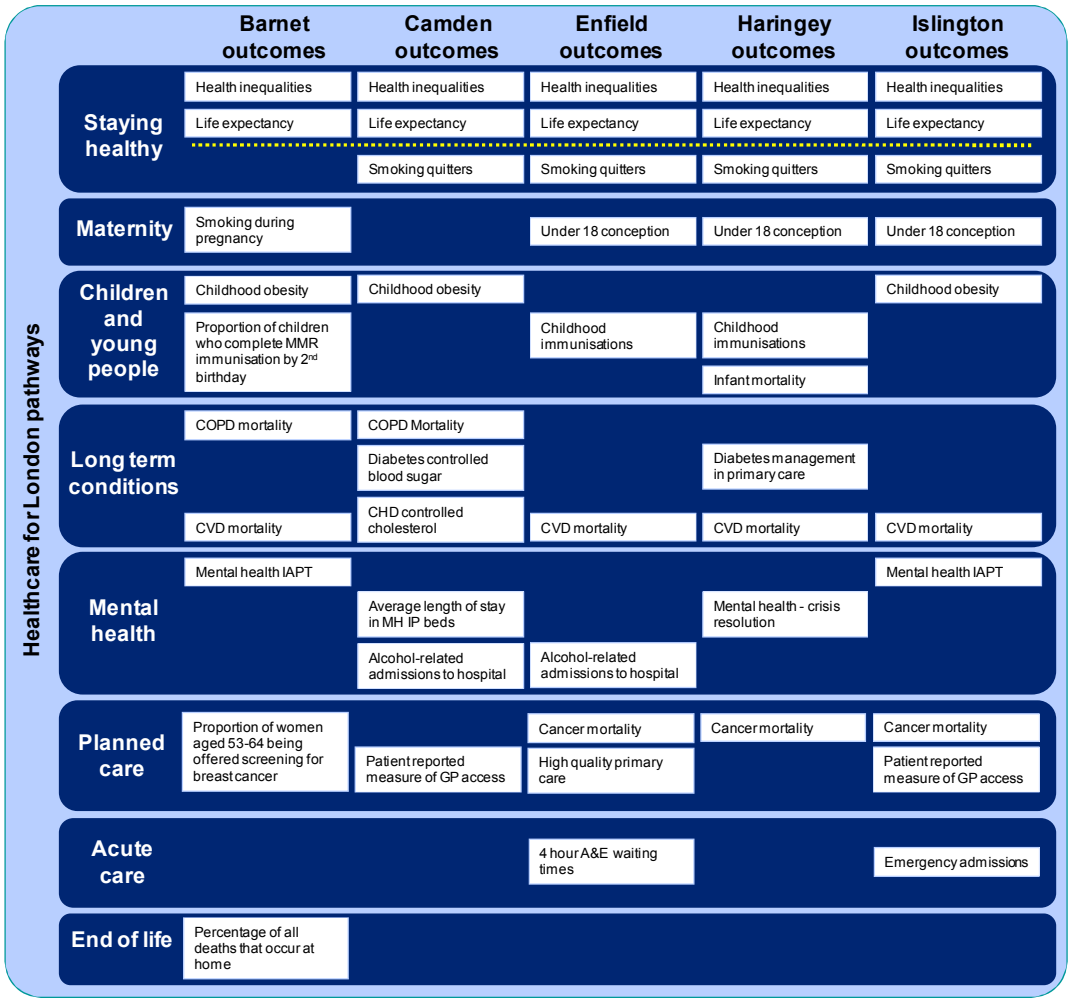
These goals have been determined by the need to implement the best possible care in line with HfL, take account of the current provider landscape and with PCTs' plans to ensure that local needs are met in the most appropriate way. Our goals are closely linked to specific health outcomes and we are clear that they need to be met within a challenging financial climate.

Our health improvement strategy has been built from the bottom up taking into account the differences in health needs amongst and within our five boroughs. The outcome measures selected by each NCL PCT are shown in figure 1 and are tailored to each PCT's unique population. In section 3 under population health needs we highlight our key public health indicators as identified from our NCL public health assessment.[2]

[2] See section 7.2 for full description of public health indicators against this goal

Figure 1: Outcomes adopted by each PCT mapped against HfL pathways

Source: PCT CSPs



1.3 Collaborative working across NCL

The five PCTs have established a Joint Committee of PCTs (JCPCT) and recognise the differences between the PCTs and their populations as well as the similarities. This is particularly important when working to improve the health outcomes and tackling the health inequalities that exist within our population. PCTs working within Joint Strategic Partnerships with Councils retain prime responsibility for improving health and tackling health inequalities. We believe that this local leadership will ensure that investment is targeted at local health needs to deliver the best outcomes.

The JCPCT has prioritised work on the development of the pathways (including LTCs, planned care and urgent care, with related diagnostics,) that are pivotal to the development of polysystems across NCL. . PCTs will deliver the services and infrastructure required to develop primary care and shift secondary care into polysystems. The Sector role is to provide programme leadership, to ensure that minimum standards are achieved, key milestones are met and best practice is shared between PCTs.

The Sector has taken on the leadership role for acute services and has established an Acute Commissioning Agency (ACA) to drive up performance and deliver efficiencies.

We have established a programme of work, the NCL Service and Organisation Review (SOR), led by the JCPCT and supported by the 16 NHS organisations in NCL. Its purpose is to determine how

best to implement HfL in NCL and ensure a sustainable configuration of providers in the context of a challenging financial outlook.

Our Sector has some of the highest mental health needs in the country and therefore improving mental health services is also a joint priority with our PCTs and the three Mental Health Trusts. All are working to deliver improvements across the range of mental health services and wherever possible ensuring integration with polysystems.

We will use the World Class Commissioning Assurance process to improve our commissioning capabilities year on year and to demonstrate the progress we are making in meeting our goals. This will ensure that NCL progresses towards meeting the WCC aspiration of 'commissioning for improved outcomes', moving from a historic process of commissioning for inputs and outputs. In this new commissioning environment PCTs will commission services according to the real impact they are able to make on population health.

The JCPCT will ensure that our goals and related initiatives are implemented and support the delivery of our vision.

1.4 Our values

The Sector has developed the following values which have been deeply imbedded within each of our organisations. They underpin our strategy and have been developed in collaboration with representatives from across NCL:

Values	How these influence our work
Quality	Improving quality through the implementation of the HfL care pathways
Diversity and inclusiveness	Ensuring our interventions are effective by targeting the most needy
Partnership working	Working with all 16 NHS organisations. Strong local partnership with Councils
Delivering value for money	Driving up productivity through contract management and the Service and Organisation Review
Sustainability	Ensuring all our organisations have are robust and sustainable for the long term

2. Case for change

There is a clear case for changing the nature of healthcare services and how they are delivered across NCL. The four main drivers for change are:

1. The need to address the wide range of health requirements that result from the diversity of communities within NCL
2. The need to improve quality and reduce variation through the implementation of the Healthcare for London care pathways
3. The need to deliver care from appropriate and modern settings, supporting the delivery of care closer to home where possible whilst ensuring provider organisations are both clinically and financially sustainable over the long term
4. The need to address the funding gap that will arise as demand for healthcare rises and public spending is squeezed

The combination of these four drivers means that status quo in NCL is not an option. The detail and work undertaken to date in these four areas is described in sections 3 to 6; however, a brief summary is outlined here.

2.1 Health requirements

The population of the five boroughs in North Central London is around 1.24m and this is expected to grow to about 1.34m by 2016 – an increase of some 8% over the 2008 population. There is significant variation in healthcare needs across this population, and age, gender, ethnicity and levels of deprivation all impact on these health needs. In NCL, there is a mix of areas of high affluence and high deprivation, many nestling close together. The diversity of cultures across NCL means a huge variety of health needs exist, and the services provided must match the needs of the local population. Responding appropriately to this range of health needs is paramount for the Sector over the coming five years.

2.2 Improving quality: redesigning pathways

A Framework for Action, published in 2007, demonstrated that current service provision did not meet the needs of the population; there was widespread inequality in provision and outcomes. Since its publication, the focus of HfL has been on developing robust, safe and high quality clinical pathways that, when implemented, will result in improved outcomes and experiences for patients. There are eight main HfL pathways:

1. Staying healthy
2. Maternity and newborn care
3. Children and young people
4. Long term conditions
5. Mental health
6. Planned care
7. Acute care
8. End of life care

Within each of these pathways, there are a cluster of discrete pathways; for example, stroke and trauma pathways are contained within acute care and diabetes and COPD within long term conditions.

Implementation of these high level pathways, and the discrete clinical pathways contained therein, will have the single biggest impact on improving the health of the local population. Consequently, the focus of the five PCTs and Sector over the past year has been on designing approaches to implementation and the main focus of our strategies is on delivering these pathways.

2.3 Strengthening the provider landscape

As part of *A Framework for Action*, Darzi described new care settings that would improve the quality of services and outcomes. For example, consolidation of complex and overnight emergency surgery onto a smaller number of major acute sites has been shown to improve outcomes. The separation of elective and emergency surgery has, likewise, been shown to improve outcomes on both sides through decreased cancellation of lists, increased throughput driving quality and reduced length of stay for patients. In addition, within NCL, there is a high variability in the quality of the estate across the provider landscape, from primary care through to tertiary services. Finally, there are question marks over the long term clinical and financial sustainability of a number of the provider organisations within NCL; of the 11 secondary care providers, only four have achieved foundation status and none of the five PCT provider arms have, as yet, got clear plans for their future. Identifying the future care setting requirements and organisational forms for the Sector is, clearly, therefore a priority.

2.4 Developing a financially sustainable system

Over the past decade, there have been unprecedented levels of investment in the NHS. Funding available to commissioners has increased in real terms and increasing activity and a reduction in waiting times has been achieved by providers. Now, as a result of the global recession and the level of public sector debt that has been incurred to support the UK economy, funding of public services is likely to be significantly impacted over the next one to two comprehensive spending review rounds(3-6 years). It is now widely acknowledged that significant efficiencies will need to be delivered in the NHS with as much as 15 – 20% of the £100bn annual settlement in real terms needing to be saved by 2016/17.

In NCL, this is likely to translate into a funding challenge for the commissioners of over £500m by 2016/17; the impact of this on provider organisations will be significant, with the five acute providers facing a combined deficit of over £350m by 2016/17 with an equivalent challenge in primary and community provision. Working collaboratively across NCL to develop solutions to this financial challenge is therefore essential.

3. Case for change: population health needs

3.1 Introduction

As a result of the diversity of communities within NCL there is a wide range of health needs across NCL. The London Boroughs of Barnet, Camden, Enfield, Haringey and Islington have distinct differences. All have diverse populations with a high proportion of people from black and minority ethnic (BME) groups but the concentration of these groups and their affluence differs. All the boroughs have areas within them of relatively high deprivation and this is particularly concentrated in Islington and east Haringey.

3.2 Population growth

The overall population of NCL is about 1.25m and this is expected to grow to 1.33m by 2016, an 8% increase from 2008. A summary of the forecast NCL population growth by age group (2008 – 2016) and the likely impact on health services is shown in Figure 2:

Figure 2: Population growth by age group

Age group	Forecast changes	Likely impact
0-14 years	Moderate increase 11% growth	Additional resources are likely to be required for children's services both in the community and within local acute trusts. We need to ensure that good service provision is maintained for the youngest children (under fives) e.g. health visiting services, and ensure good childhood immunisation uptake rates.
15-44 years	Slight increase 4% growth	Most of the increase is in the female population of childbearing age. This may have implications for planning contraception and maternity services (particularly in Barnet which has a relatively higher increase). However, taking fertility rates into account, the overall impact on maternity services may be small.
45-64 years	Large increase 16% growth	This increase corresponds with the time when people are most likely to develop long term health conditions related to life-style and/or genetic susceptibility. The risk of developing certain cancers, such as breast and colorectal, increases in this age group. Primary and community services will need to cope with more people requiring lifestyle risk assessments and cancer screening.
65-74 years	Moderate increase 11% growth	This age group will include people with progressive long-term conditions as well as those with degenerative conditions requiring interventions such as major joint replacement or cataract surgery, all of whom will utilise more planned and community-based care.
75+ years	Small increase 2% growth	Overall, there is not much growth forecast in this age group. However, it is important to remember that services for older people who will suffer conditions such as stroke, dementia, falls and fractures, need to be flexible enough to expand in the next 10-15 years to provide for the next age group which will be increasing at a higher rate. That said, there is also likely to be an increased need for the management of degenerative disease, such as major joint replacement, in this age group over the next few years.

3.3 Ethnicity

NCL is culturally and ethnically diverse. Black and minority ethnic groups (BME) constitute 30% of the current population and this proportion is likely to increase to about 34% by 2016. Projected changes in the ethnic population proportions in NCL to 2016 can be seen in figure 3:

Figure 3: Projected changes in the ethnic population proportions in NCL to 2016

Source: GLA 2008 Round Ethnic Group Projections (low), published 2009 (figures rounded to nearest 100)

Ethnic group	2001	2006	2016	Increase from 2006 to 2016 (n)	Increase from 2006 to 2016 (%)
White	881,800	856,600	892,800	36,200	4
Black Caribbean	52,400	53,400	57,000	3,600	7
Black African	69,200	76,800	89,400	12,600	16
Black Other	27,500	31,300	38,300	7,000	22
Indian	52,600	56,800	65,900	9,100	16
Pakistani	10,200	11,900	15,200	3,300	28
Bangladeshi	25,300	28,300	34,500	6,200	22
Other Asian	30,400	32,800	39,100	6,300	19
Chinese	17,900	21,900	28,500	6,600	30
Other	36,500	51,400	75,500	24,100	47
Total	1,203,800	1,221,200	1,336,200	115,000	9

BME groups have specific health needs, and tend to have poorer health outcomes for a range of diseases. There are several reasons for this. Some diseases are relatively specific to certain ethnic groups. For example, sickle cell disease occurs mainly in people in Black ethnic groups, whilst thalassaemia mainly occurs in people from Asian and Mediterranean (especially Greek and Turkish) ethnic origin.

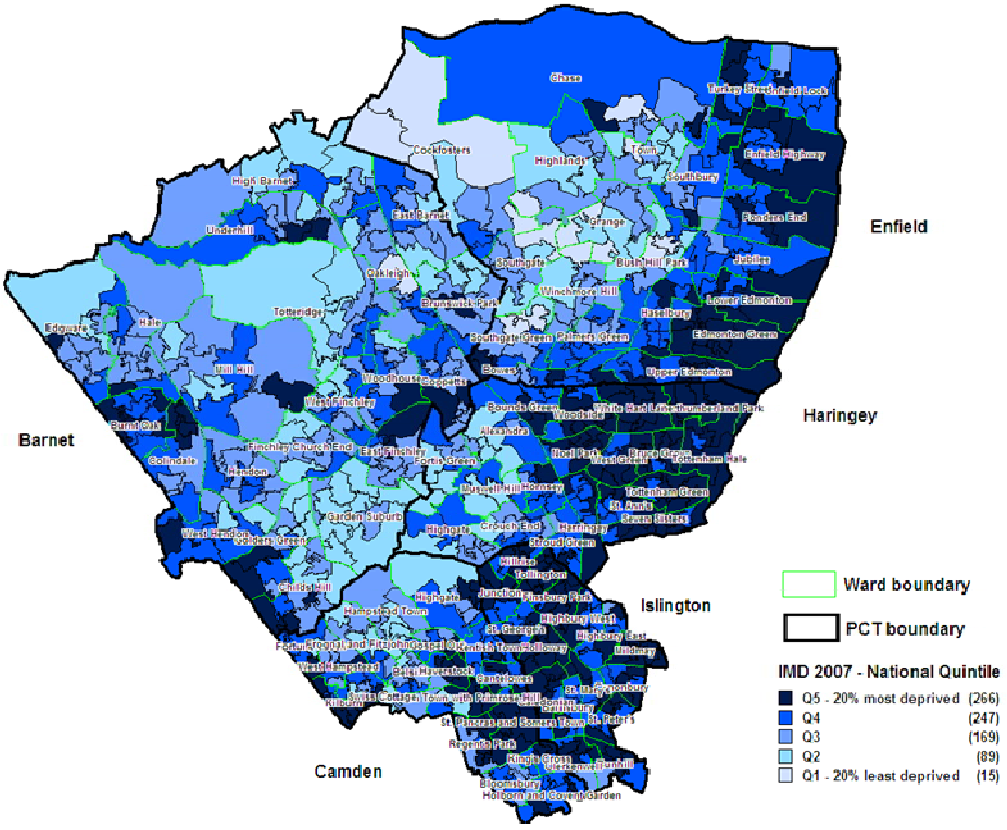
3.4 Deprivation and health inequalities

For most aspects of health, there is a close relationship between deprivation and the need for health and social care services. Within NCL, there are many examples to illustrate this. In Islington, life expectancy for males born in 2005-07 is 75.1 years, compared with the national average of 77.7 years. But there are differences within boroughs too. There is a difference in life expectancy for males at birth of up to seven years for those who live in the most affluent parts of Barnet compared with those who live in the most deprived.Figure 4 indicates deprivation across NCL and illustrates:

- There are areas of moderate and of high deprivation in each of the five NCL boroughs
- The areas of highest deprivation are in the west of Barnet and Camden and, particularly, the east of Enfield and Haringey, with the largest proportion of high levels of deprivation being in Islington
- Even where there are areas of relative affluence, there are pockets of high deprivation - often focused on large estates of social housing

Figure 4: Deprivation in NCL at ward level in 2007

Source: Department for Local Government and Communities, IMD 2007



Cardiovascular disease

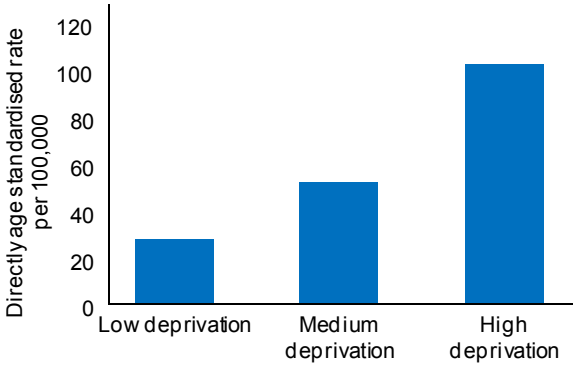
Figure 5 shows death rates from CVD in NCL, standardised for age. It shows the different death rates in NCL by areas of deprivation divided into three groups according to their Index of Multiple Deprivation scores: from those living in the most affluent areas to those in the most deprived. There is a statistically significant difference between death rates amongst people in each of these three groups: those living in the most affluent areas experiencing lower death rates from those living in the medium deprived areas and those in the most deprived areas

There is evidence to suggest that a major causal factor for the difference in death rates by area of deprivation is that people who live in the most deprived areas are more likely to have risk factors for CVD (e.g. smoking, hypercholesterolaemia) that are not identified or managed as well as people from less deprived areas. These inequalities are further evidenced by the variation in outcomes associated with a number of common conditions. We have described some of these below:

- Death rates from cardiovascular disease
- Death rates from chronic obstructive pulmonary disease
- Admission rates for mental health conditions

Figure 5: Age-standardised death rates from cardiovascular disease people aged under 75 years in NCL in 2003-07 by deprivation tertiles

Source: ONS Annual Mortality Files 2003-2007; IMD 2007; ONS LSOA estimates, mid-2007

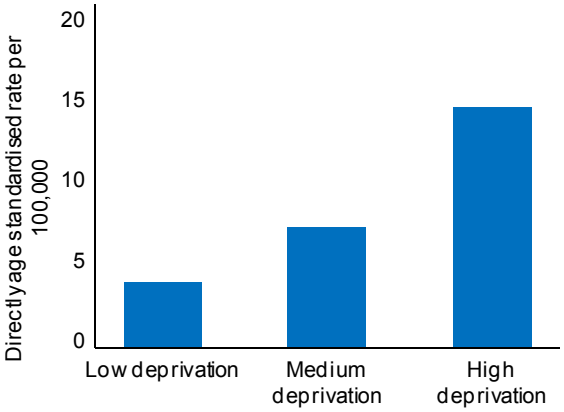


Chronic Obstructive Pulmonary Disease (COPD)

Figure 6 shows that, for COPD, like cardiovascular disease, there are health inequalities: people living in the most deprived areas are more likely to die prematurely from COPD than those living in more affluent areas. This is likely to be related to the higher prevalence of smoking amongst people living in more deprived areas.

Figure 6: Age-standardised death rates from COPD in people aged under 75 years in NCL in 2003-07 by deprivation tertiles

Source: ONS Annual Mortality Files 2003-2007; IMD 2007; ONS LSOA estimates, mid-2007



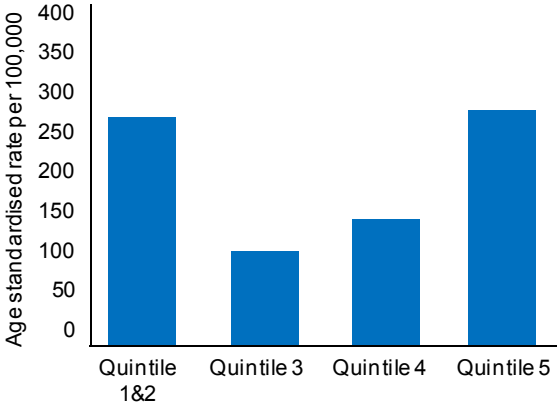
Mental health

Admissions to hospital for mental health can be used as a proxy for the prevalence of mental health in the population although a significant number of people with mental health problems will be seen in the community. Figure 7 shows the hospital admission rates for mental health in NCL by areas of deprivation divided into five groups ranging from the least deprived to the most deprived. The data shows mental health admissions are significantly higher in the most deprived group compared to quintile 3 which is less deprived but are not statistically significantly higher than in quintile 1 and 2 which are the least deprived.

Figure 7: Age-standardised Hospital admission rates for mental health, all ages, North Central London, 2003-07 by deprivation quintiles

Source: ONS Annual Mortality Files 2003-2007; IMD 2007; ONS LSOA estimates, mid-2007

Quintiles 1 and 2 are added together because of very small numbers in quintile 1.



The health needs and prevalence captured in this section form a clear rationale supporting the inclusion of a Sector level goal on health improvement. The health inequalities between the most and least deprived parts of the Sector have significant impacts on the health needs of those populations and all of the PCTs have selected many of their key health outcome measures based on this diversity. Each of the five NCL PCTs has adopted “health inequalities” and “life expectancy” as priority outcomes. They are also targeting smoking as a health indicator in order to address long term conditions and to improve the health of their populations.

3.5 Public health indicators

In order to target our health improvement strategy for NCL the following measures have been agreed on which to track progress over the next five years:

- Increase life expectancy for men to the London average: NCL average - 77.2 years, London average - 77.8 years
- Increase life expectancy for women to above the London average: NCL and London averages 82.4 years
- Increase our smoking cessation success rate to 1,230 per 100,000: current success rate is 1,157 per 100,000
- Increase breastfeeding rates to 90% of women breastfeeding at 8 weeks: current rate 86%
- Reduce smoking in pregnancy to the London average: NCL rate – 8.3%, London rate - 7.1%
- Increase proportion of women having breast cancer screening to the London average: NCL average – 54.7%, London average – 63.8%
- Increase uptake of childhood immunisation to the London average: uptake of MMR by 5th birthday, NCL rate – 49%, London rate - 56.5%; uptake of DTP by 5th birthday, NCL rate – 52%, London rate – 57.4%

3.6 Clinical quality

The need to address the status of provider organisations across NCL can be further articulated through reviewing the range of clinical quality indicators and the differences between Trusts across NCL.

The Doctor Foster results for 2008/09 show a range of performance across our five district general and teaching hospital trusts with University College London Hospitals, Royal Free and Whittington achieving a Green rating against the standardised mortality indicator, indicating that they have a significantly below average rate. The remaining trusts, BCF and North Middlesex, received an amber rating, indicating mortality rates in line with the national average.

In addition to this, against the Doctor Foster patient safety bandings (one to five), only UCLH achieved a five rating with Royal Free and Whittington receiving a four and the remaining trusts receiving a two.

These results indicate that reorganising the way services are provided in NCL must also improve the quality of our services and centralising some service can deliver improvements - this is discussed further in section 5 on care settings.

Care Quality Commission results on clinical quality for all our acute provider organisations are shown in figure 8 with the results for commissioners shown in figure 9.

Figure 8: Care Quality Commission ratings of NCL providers 2008/09

Source: CQC website

Acute and mental health trusts	Overall quality	Financial management
Barnet and Chase Farm Hospitals	Good	Good
North Middlesex University Hospital	Good	Fair
Royal Free Hospital	Excellent	Good
University College London Hospitals	Good	Excellent
Whittington	Excellent	Excellent
Royal National Orthopaedic Hospital	Fair	Fair
Great Ormond Street Hospital	Fair	Good
Moorfields	Good	Excellent

Barnet, Enfield and Haringey MH	Excellent	Good
Camden & Islington MH	Excellent	Excellent
Tavistock & Portman MH	Excellent	Excellent

Figure 9: Care Quality Commission ratings of NCL commissioners 2008/09

Source: CQC website

PCTs	Quality of commissioning	Financial management	Providing services
Barnet	Good	Good	Almost met
Camden	Good	Good	Almost met
Enfield	Fair	Weak	Almost met
Haringey	Fair	Good	Almost met
Islington	Good	Good	Fully met

4. Case for change: improving quality through pathway redesign

4.1 Introduction to the Healthcare for London care pathways

Delivery of the eight HfL care pathways is at the heart of the Sector strategy. Ensuring that we redesign care appropriately in these areas will result in improved health and improved healthcare delivery for the population. Considerable work has been undertaken by the Sector, PCTs and jointly, on planning the implementation of the pathways.

There has been agreement across the five PCTs and the Sector that responsibility for identifying best practice, standards, setting a specification and monitoring performance should only happen once across clinical pathways, although commissioning and delivery responsibilities will be owned more widely. In this context the ownership of pathways has been determined.

The ACA will lead on three of the HfL pathways - acute care, planned care and maternity and new born care. The PCTs will lead on three – staying healthy, children and young people and end of life care. The PCTs have agreed that they will work collaboratively at a Sector level to deliver improvements in inpatient mental healthcare and that for long term conditions, standards and specifications will be developed only once across NCL.

The London Specialised Commissioning Group (SCG) works on behalf of London's PCTs to ensure the people of London have access to the most specialised care pathways, and to improve the quality and value for money of specialised care. The SCG is working to ensure it is aligned with each of the main Sector strategies on service configuration. For specialised services there will need to be some centralisation and also a greater role for networks. The SCG's strategic goals reflect specific local drivers for specialised services in London, as described in the HfL pathways, for example major trauma, tertiary paediatrics, cancer and cardiovascular services.

4.2 Analysis of pathways in NCL

We have been through a process of reviewing the elements of each HfL pathway and identified the component parts of these pathways where the Sector and PCTs' work needs to focus. This has been driven by a thorough review of best practice against each of the pathways.

The following section outlines this process and gives the following information for each of the HfL pathways:

- The scope of the pathway
- Best practice, either nationally or locally
- Current performance in the sector
- The key messages from local clinical discussions including the work undertaken by the Clinical Advisory Group and its sub-groups as part of the Service and Organisation Review
- The identified areas in the pathway which have formed the basis of the Sector and PCT strategic plans. Sector owned components are highlighted in bold
- The specific initiatives for each component of the eight pathways at Sector and PCT level that will be described in more detail in section 7

The second table under each pathway heading identifies the PCT and Sector initiatives. The numbers refer to relevant initiatives in the PCT chapters or Sector initiatives in section 7.3 of this chapter to facilitate referencing.

4.3 Staying healthy

Summary

Staying healthy and the drive towards a more proactive approach to health is at the heart of future NHS service planning and will be led at a PCT level, although the Sector and the Specialist Commissioning Group will support the delivery of screening services to a consistent standard. To date, the focus of activity from PCTs has been to engage with local communities to drive different health behaviours in areas such as smoking, diet and physical activity. This has been complemented by a focus on early identification of certain conditions through community screening programmes and improved chronic disease management.

Staying healthy	Changing health behaviours	Improving protection and prevention	Managing the burden of disease
Scope	Smoking cessation Improving diet Increasing exercise	Screening programmes for example CVD and breast Immunisation	Improved management of long term conditions
Best practice	Targeted programmes for specific population groups Use of social marketing and individual incentives Use of electronic interaction tools Close partnership working with local authorities, community services and voluntary groups	Targeted and tailored interventions by population groups and service delivery Early detection and intervention approaches Call and recall systems TIA pathway implementation Robust quality assurance and failsafe mechanisms	Secondary prevention for individuals with long term conditions
Local discussions	DPHs have agreed that they are all working to promote healthy behaviour (smoking cessations, healthy eating and exercise) and implementing local vascular checks. They will review the impact of the local approaches, learn, and develop best practice	Directors of Public Health auditing local approaches to vascular risk assessment to allow standardised approach across NCL	Asthma, COPD, CHD and mental health identified as key areas for sector wide pathway work
Local priorities	1. Wider determinants of staying healthy – smoking, diet, exercise, alcohol	**2. Screening pathways including chlamydia** 3. Vascular risk assessment 4. Immunisations	**5. Secondary prevention of long term conditions**

Staying healthy	Changing health behaviours	Improving protection and prevention	Managing the burden of disease
Sector		1. Coordination of NCL polysystems implementation	1. Coordination of NCL polysystems implementation
Barnet	1(a). Finding the 5000: 2(b). Reducing the prevalence of obesity in adults & Children 1(c). Reducing prevalence of smoking	1(d). Increase childhood Immunisation rates 1(e). Increasing rate of breast screening	3. Development of LTC care pathways
Camden	1(a). Health checks , cardiovascular risk management	3(b). Dental services 1(b). Support for Healthier Lifestyles (smoking cessation, exercise, minimise alcohol misuse, sensible eating)	3(c). Improving access and capacity in primary care - GP led Health Centre 3(d). Strategic development of primary care - Fortune Green development

Staying healthy	Changing health behaviours	Improving protection and prevention	Managing the burden of disease
Enfield	1. Implementing Teenage pregnancy interventions	1. Roll out NHS Health Checks linked to smoking cessation & health trainers 1. Increasing immunisation uptake 1. Use social marketing techniques to maximise uptake	4. High Quality Primary Care Polysystems development
Haringey	15. Healthier communities Smoking cessation- tobacco control Health trainer programme Newly arrived people Life channel	15. Healthier communities Cervical screening, access to breast screening Pilot vascular checks programme	15. Healthier communities Exercise referral, obesity management Alcohol strategy implementation
Islington	1. Lifestyle Improvement Programme for Adults 3. Tobacco Control Programme 9. Improving oral health promotion and access to oral health 11. Sensible and Safe Drinking	5. Cancer – extend screening programmes 6. Vascular Risk Assessment Programme	

4.4 Maternity and newborn care

Summary

The Sector maternity commissioners' group was established in 2009 and has prioritised a set of activities to improve the outcomes for pregnant women and is providing the leadership for this care pathway in NCL. Delivery of the NICE antenatal pathway is of primary importance.

Maternity and newborn	Pre-conception	Antenatal care	Birth	Postnatal and neonatal care
Scope	Sex education and family planning Advice for women with pre-existing conditions Genetic testing	Risk stratification ensuring appropriate care Full assessment by 12 weeks and 6 days	Maternity services including choice of delivery location and one to one midwifery care in established labour	Routine postnatal care Breast feeding support Specialist postnatal care

Maternity and newborn	Pre-conception	Antenatal care	Birth	Postnatal and neonatal care
Best practice	Integrated programmes of sex education and family planning advice via targeted interventions, polysystems and schools Referral for women with recurrent miscarriages Pre-conception advice for prospective parents	Adoption of NICE guidance for antenatal care Early identification of women with medical risks and social complexity Rigorous ongoing risk assessment Adoption of midwife led care model including continuity of care through to postnatal period Deliver services in accessible locations, e.g., polysystems, children's centres Address late presentation Establish and utilise formal clinical networks	Choice of birthing location with processes for rapid transfer if required Obstetric units to have a minimum of 98 hours per week consultant presence rising to 168 hours Continuity of care through labour, including as much one-to-one care as possible Manage risk and complexity through appropriate specialisation Improve the patient experience Reduce level of interventions and incentivise normal deliveries Reduce number of obstetric units to maximise efficiency of workforce and ensure safe services	Increased numbers of women breastfeeding to at least six months High quality post-natal care based on risk and clinical need High quality neonatal care Offer appointments in local centres as well as at home
Local discussions	Most of this work is focussed in PCTs	Discussion has been focused on role of GP in antenatal pathway	Given 24,000 births in the future, 4 obstetrician led birthing units with co-located midwifery led units recommended; a minimum of level 2 NICU at each location No further stand-alone midwifery units until cost effectiveness reviewed	Peri – and post-natal mental health services need to be improved; core part of mental health offering via polysystems
Local priorities		**1. Implementation of NICE antenatal care pathway** **2. Establishment of clinical network**	**3. Consolidation of services to fewer units to improve safety and maximise workforce availability** **4. Review viability (clinical and financial) of stand-alone midwifery led units**	**5. Improvement of perinatal mental health services**

Maternity and newborn	Pre-conception	Antenatal care	Birth	Postnatal and neonatal care
Sector	1. Coordination of NCL polysystems implementation	1. Coordination of NCL polysystems implementation 4. Implementation of maternity improvement programme - 12+6 and choice	1. Coordination of NCL polysystems implementation 2. Acute care reconfiguration – maternity services moved from Chase farm 4. Implementation of maternity improvement programme - 1:1 care in labour	1. Coordination of NCL polysystems implementation 4. Implementation of maternity improvement programme - review of specialist services including perinatal mental health
Barnet	3(e). Implement Sector Initiatives detailed care pathway mapping and whole system approach to service redesign	2(b). Implement BEH strategy including agreeing a minimum data set for performance which ties investment to outcomes 3(e). Implement Sector Initiatives detailed care pathway mapping and whole system approach to service redesign	2(b). Implement BEH strategy including agreeing a minimum data set for performance which ties investment to outcomes 3(e). Implement Sector Initiatives detailed care pathway mapping and whole system approach to service redesign	3(e). Implement Sector Initiatives detailed care pathway mapping and whole system approach to service redesign

Maternity and newborn	Pre-conception	Antenatal care	Birth	Postnatal and neonatal care
Camden	2(a). Local initiatives to support 90% seen by maternity professional by 12 weeks Reducing under 18 conceptions through LA partnership	2(a). Integrate antenatal into polysystems Implement NICE antenatal care schedule Implement NCL maternity improvement programme locally Implement local initiatives to support early access to maternity services.	2(a). Implement NCL maternity improvement programme locally- HfL maternity and newborn pathways Implement local initiatives to support early access to maternity services.	2(a). Children's recommissioning - Local initiatives to support increased breastfeeding prevalence Postnatal clinics in children's centres
Enfield	1. Reducing under age conceptions	3(c). Implement BEH maternity strategy through polysystems antenatal and shared care	3(c). BEH Clinical strategy: Women & Children's services Implement Sector initiatives and pathway redesign	5. Perinatal MH service development
Haringey		1. Maternity Routine community antenatal care in polysystems – shared care model	1. Maternity - Community midwife outreach	1. Maternity - Postnatal care in children's centres
Islington	4. Reducing under 18 conceptions	13. Community Planned Care Services 15. Transforming Primary Care	13. Community Planned Care Services 15. Transforming Primary Care	

4.5 Children and young people

Summary

PCT focus to date on this pathway has been ensuring that there is effective integration with local Children's Trusts to set local priorities and deliver better services with improved outcomes for children and young people. As part of the SOR, the children's clinical working group looked at the appropriate delivery of services in the acute setting for both paediatric medicine and surgery; in addition, the workforce implications – how acute and community paediatrics work more collaboratively – were reviewed.

Children and young people	Prevention	Protection and care for vulnerable children	Primary care	Community care / therapies	Specialist / acute care	Tertiary care
Scope	Improving health behaviours Immunisation Routine screening	Children in care / at risk Care for children with disabilities Care for children at risk of social exclusion	Urgent or unscheduled care services Planned or routine care services	Speech and language therapy Community paediatrics Care for children with long term health needs	Specialist outpatient care Emergency care Planned care	Tertiary and quaternary care for children

Children and young people	Prevention	Protection and care for vulnerable children	Primary care	Community care / therapies	Specialist / acute care	Tertiary care
Best practice	Increased numbers of women breastfeeding to at least six months Targeted action to address health behaviours Increased uptake of immunisation programmes	Increased information sharing with local authorities	Ensure urgent care services for children available and integrated with primary care Link urgent care provision with the universal offer in children's centres	Community based MDTs provide care for children Increased coordination and knowledge sharing between secondary and community based paediatric services Shift of up to 40% OPD to community settings Consolidation and co-location of services from a community hub (polysystem or children's centre)	Paediatric assessment units (PAU) at every A&E dept staffed by specialist paediatric staff Consolidation of inpatient medical and surgical units to ensure safety and consolidate expertise	Ensure tertiary services are at clinical scale Develop and implement clear transfer protocols to and from tertiary providers
Local discussions	Reflected in borough Children and Young People Plans			Integration of community and hospital based paediatrics to ensure appropriate skill levels	18 hour PAUs at each hospital Inpatient paeds at 2 or 3 locations plus GOSH Inpatient paed surgery consolidated to maximum of 2 sites plus GOSH	Improve protocols with GOSH to ensure appropriate transfer of tertiary patients
Local priorities	1. Working with schools and LAs to drive healthy behaviours 2. Encourage immunisation uptake		3. Clarify role of children's centres and polysystems	**4. Develop tier three and tier four services in CAMHS** **5. Shift of OPD** **6. Improve coordination between community and secondary care**	**7. PAU at each acute hospital** **8. Consolidation of inpatient paediatric services**	

Children and young people	Prevention	Protection and care for vulnerable children	Primary care	Community care / therapies	Specialist / acute care	Tertiary care
Sector			1. Coordination of NCL polysystems implementation	1. Coordination of NCL polysystems implementation	2. Acute care reconfiguration – Implementation of BEH including PAU at Chase farm Consolidation of inpatient paediatrics onto fewer sites	2. Acute care reconfiguration – rationalisation of specialist services across Royal Free and UCLH
Barnet	3(d). Development of Children and Young people care pathway	3(d). Development of Children and Young People care pathway including: - Development of integrated care pathways with Local Authority for delivery of complex care	3(d). Development of Children and Young People care pathway including: - Development of integrated care pathways with Local Authority for delivery of complex care	2(b). Implement BEH strategy 3(d). Development of Children and Young People care pathway including: - Development of integrated care pathways with Local Authority for delivery of complex care	2(b). Implement BEH strategy 3(d). Development of Children and Young People care pathway including: - Recommission complex care and children's team	2(b). Implement BEH strategy 3(d). Development of Children and Young People care pathway including: - Recommission complex care and children's team

Children and young people	Prevention	Protection and care for vulnerable children	Primary care	Community care / therapies	Specialist / acute care	Tertiary care
Camden	2(a). Recommission services to children's trust model 1(b). Support for healthier lifestyles Increased breastfeeding and immunisations Support healthy eating and reduce obesity Strengthen liaison with schools and other partners	2(a). Strengthen safeguarding	2(a). Integrate children's services into polysystems	2(a). Fully integrate paediatric therapies into polysystems	2(a). Integrate CAMHS and services for disabled children into polysystems	2(a). Strengthen children's whole system pathways and improve flows to/from primary care
Enfield	1. Improving immunisation uptake through polysystems development and management 1. Reduce teenage pregnancy – outreach nurses	1. Partnership working with local authorities and commissioners and other providers	4. High Quality Primary Care / through Poly systems development and management	1. Outreach nurses to target difficult to reach groups	3(c).Implement BEH Clinical strategy: Women & Children's services	
Haringey	2. C&YP who are ill - Reduce health inequalities between families east and west 8.1. Early years 8.5. Sexual health	8.2. School aged C&YP 8.3. Aiming High for Disabled Children 8.6. Safeguarding 9. C&YP's mental health and well-being	2. C&YP who are ill 8.5. Sexual health	2. C&YP who are ill – community based pathways for common childhood conditions 8.4. Improving early access & choice in the community 8.2. Childhood obesity – Healthy schools Keys to well being – Infant psychology service	2. C&YP who are ill - Reduce hospital admissions for children with LTC 2. Paediatric assessment as part of urgent care pathway	
Islington	2. Lifestyle Improvement Programme for Children – reduce obesity	2. Lifestyle Improvement Programme for Children	2. Lifestyle Improvement Programme for Children	2. Lifestyle Improvement Programme for Children – Aiming High for Disabled Children		

4.6 Long term conditions

Summary

Work on long term conditions has been a key focus of the polysystems working group over the past six months looking at a set of conditions including diabetes, hypertension, heart failure, asthma, COPD and dementia. Changing how individuals with multiple co-morbidities are managed – facilitated by the development of polysystems – is a key priority for both the Sector and all PCTs. Rather than individuals being seen by multiple specialists in different care settings about discrete problems, they will be managed in a more coordinated manner closer to home. At the Sector level, agreeing common principles for these pathways is a key priority.

Long term conditions	Prevention and early diagnosis	Integrated primary and community care	Ambulatory specialist input	Inpatient / acute care	End of life care
Scope	Prevention of the onset of long term conditions Early identification of at risk patients to allow targeted interventions Early diagnosis	Ongoing case management of patients with LTCs outside of hospital Linkages with social care	Specialist team input and outpatient care locally Management of complications and exacerbations	Inpatient management including A&E, emergency and planned admission	End of life care for patients with LTCs
Best practice	Risk stratification to identify at risk population Establishment of risk registers Targeted interventions for at risk groups	100% people with LTC on disease registry with personalised care plan and lead professional (consideration of personal budget) Single point of access 24/7 Standardised care pathways across health economy for key LTCs Reduction in A&E attendances and emergency admissions via appropriate MDT / case management working Access to specialist advice and support Telehealth / monitoring Self help and expert patient programmes Clear governance	Reduction in A&E attendances and emergency admissions via appropriate MDT / case management working Standardised care pathways across health economy for key LTCs Provision of training and skills transfer for primary and community providers	Standardised assessment of emergency attendances; admission avoidance team review Facilitated discharge and reduced length of stay through MDT working (specialist teams working across community and secondary care) Single care record for MDT	Implementation of gold standard framework
Local discussions	4 pathways to be developed and signed off by the Sector implementation board Require consistent core approach to ensure appropriate treatment across NCL				
Local priorities	1. Risk stratification and risk register	2. Case management **3. Design and implement agreed pathways** 4. Single point of access 5. Clarify role of community services 6. Payment and incentive mechanisms	**3. Design and implement agreed pathways** 7. Skills transfer for primary and community teams	**3. Design and implement agreed pathways**	

Long term conditions	Prevention and early diagnosis	Integrated primary and community care	Ambulatory specialist input	Inpatient / acute care	End of life care
Sector	1. Coordination of NCL polysystems implementation - new LTC best practice	1. Coordination of NCL polysystems implementation - new LTC best practice ation	1. Coordination of NCL polysystems implementation - new LTC best practice	1. Coordination of NCL polysystems implementation - new LTC best practice	1. Coordination of NCL polysystems implementation - new LTC best practice
Barnet	3(b). Development of following Care Pathways: COPD Stroke Diabetes	2(a). Development of Polysystems 3(b). Development of following Care Pathways: COPD Stroke Diabetes	3(b). Development of following Care Pathways: COPD Stroke Diabetes	3(b). Development of following Care Pathways: COPD Stroke Diabetes	3(d). Development of end of life care pathway

Long term conditions	Prevention and early diagnosis	Integrated primary and community care	Ambulatory specialist input	Inpatient / acute care	End of life care
Camden	1(a). Health checks to identify concerns early 1(b). Promote healthy behaviours 2(d). Long term conditions	2(d). Long term conditions 2(f). Transforming adult community nursing 2(g). New care pathways - MSk, dermatology, COPD, diabetes 3(c). Improving access and capacity in primary care - GP led Health Centre 3(d). Strategic development of primary care - Fortune Green development	2(g). New care pathways - MSk, dermatology, COPD, diabetes	2(g). New care pathways - MSk, dermatology, COPD, diabetes 3(a). Urgent care centres	2(g). New care pathways - MSk, dermatology, COPD, diabetes
Enfield	2. Development of pathways in polysystems for: COPD, Stroke, Cardiac. Development of Diabetes pathway in poly systems via Better Value Programme	2. Development of pathways in polysystems for: COPD, Stroke, Cardiac. Development of Diabetes pathway in poly systems via Better Value Programme			2. End of life care pathway development and planning – link to dementia
Haringey	5. Prevention of long term conditions - Implement NHS Checks programme Work with British heart foundation 12. Preventing long term conditions	13. Care of long term conditions Community matron programme EOLC – gold standard framework 17. Liverpool model project		16. Delayed transfers of care	14. Rehabilitation and intermediate care 13. Care of long term conditions Community matron programme EOLC – gold standard framework
Islington	7. Experience, Engagement and Empowerment 16. Data Driving Improvement in Quality	14. Improving Long Term Conditions - Reduce the directly standardised rate of emergency admissions 15. Transforming Primary Care	14. Improving Long Term Conditions - Reduce the directly standardised rate of emergency admissions	14. Improving Long Term Conditions - Reduce the directly standardised rate of emergency admissions	

4.7 Mental health

Summary

The shape and future of mental health services is one of the three main clinical workstream in the NCL service and organisation review. The key redesign component identified by the working group was the need to develop pathways that have a much stronger community basis to them and, thus, pull individuals through the system, requiring lower intensity interventions. In addition, diagnosing patients earlier was identified as a clinical requirement. Key to the success of both of these is defining the core mental health offering that will be delivered in polysystems. In line with the prominence that dementia care has in this year's Operating Framework, memory services will be a core offering.

Mental health	Public awareness and health promotion	Primary care	Community specialist input	Inpatient / acute care	Suicide prevention	Rehabilitation	End of life care
Scope	Mental wellbeing Address inequalities Prevention	Early intervention GP provision Talking therapies / IAPT CAMHS	CMHTs Crisis resolution Assertive outreach Early intervention teams CAMHS IAPT	Local hospital medical treatment ICPs for patients with severe and enduring mental illness Liaison services in secondary care including A&E Specialist provision	Suicide prevention strategy	Low secure intensive rehabilitation	End of life care for patients with mental health problems
Best practice	Social marketing across London to increase awareness of mental health issues Joint activities to promote social inclusion Action to reduce stigma Supporting improved mental wellbeing in the workplace Use of NHS Direct for first level advice and entry to system	Proactive identification and assessment of MH needs Improved local access to effective treatments including psychological therapies Implement NICE guidance for Anxiety and Depression Register of individuals with severe and enduring mental illness Improve level of knowledge in primary care	Crisis resolution teams in every borough CMHTs working to protocols Memory assessment services available to all dementia patients Improved transition from CAMHS to adult services	Protocols and improved access for patients with mental health issues admitted with physical illnesses Care planning for patients with severe and enduring MI Implement pathways to avoid admission Ensure estate is of appropriate quality	Implement NSF standards and NICE guidance on self harm Joint approach with alcohol and drug services to combat young male suicides	Resourced step down care Improved integration with social care to allow alternative care pathways	Implementation of dementia strategy End of life care pathways
Local discussions	Develop mental health offering for polysystems including early detection of MH issues	Develop mental health services in polysystems including perinatal services, memory services, talking therapies, early detection of MH issues; provision of support and training for primary care	Develop mental health offering for polysystems including perinatal services, memory services, early detection of MH issues	Care pathways for inpatient / community adult care being developed and options for future configuration shaped		Need to improve intensive rehabilitation and reduce out of area placements	
Local priorities	**1. Polysystem MH offering**	**2. Implementation of dementia care pathway** **1. Polysystem MH offering**	**1. Polysystem MH offering**	**3. Develop best practice clinical model for inpatient services; develop options for delivery**		4. Roll out successful Islington approach across NCL	

Mental health	Public awareness and health promotion	Primary care	Community specialist input	Inpatient / acute care	Suicide prevention	Rehabilitation	End of life care
Sector		1. Coordination of NCL polysystems implementation	1. Coordination of NCL polysystems implementation 2. Development of MH care pathways -polysystems	2. Development of MH care pathways – acute inpatient services	2. Development of MH care pathways - polysystems	1. Coordination of NCL polysystems implementation 2. Development of MH care pathways – intensive rehab	
Barnet	3(c). Implement Mental Health care pathway including: Implement local dementia strategies.	3(c). Implement Mental Health care pathway including: Implement local dementia strategies.	3(c). Implement Mental Health care pathway including: - Delivery of IAPT initiative	3(c). Implement Mental Health care pathway including: - Acceleration of implementation of planned reduction in acute beds	3(c). Implement Mental Health care pathway	3(c). Implement Mental Health care pathway including: Mental Health in polysytems Further development of recovery model in line with new horizons	
Camden	2(c). Transforming MH services	2(c). Transforming MH services 2(c). Integrate into polysystems	2(c). Integrate community health into polysystems	2(c). Reduce length of stay and bed numbers Improve flows to primary care	2(c). Transforming MH services	2(b). Building the recovery model in mental health 2(c). Review rehab model with Sector	2(c). Fully implement dementia strategy
Enfield	5. Implement local MH priorities including MH wellbeing	4. Mental health wellbeing, dementia pathway and reduction in Acute MH beds by developing local capacity in polysystems	4. Delivering care in the community via poly systems Access to Psychological therapies Community development workers shaping development of local services	5. Accelerate pace of change if MH strategy to reduce inpatient beds			
Haringey	3. Mental health & well-being in polysystems 9. C&YP's mental health and well-being	3. Mental health & well-being in polysystems - Reducing use of acute inpatient beds and investing in mental health assessment and treatment in polysystems 4. Dementia support	3. Mental health & well-being in polysystems - Reducing use of acute inpatient beds and investing in mental health assessment and treatment in polysystems 9. C&YP's mental health and well-being – CAMHS single access point 10. IAPT – phase two 11. Developing an effective model of care 4. Memory clinic in polysystem			3. Mental health & well-being in polysystems - Rehabilitation and recovery pathways aligned to Sector reconfiguration	4. Priority group for EOLC
Islington	10. Improving mental health and well being - IAPT	10. Improving mental health and well being - IAPT	10. Improving mental health and well being - IAPT				

4.8 Planned care

Summary

The future delivery of planned care services was reviewed by the NCL SOR clinical working groups over the last six months. Much of the focus has been on which services can safely and effectively be provided in an out of hospital setting, thus delivering localised care closer to home. In addition, consideration has been given to consolidating elective surgery onto a smaller number of locations to drive better patient outcomes (for example, hip and knee replacements). The ACA has been, and will continue to be, actively involved in this work since it will play a crucial role in performance management.

Planned care	Self assessment and self care	Primary and community care	Acute and specialist services	Rehabilitation and continuing care
Scope	Support and information to allow patients to address simple, self limiting conditions	Diagnosis and management of broad range of conditions requiring clinical input but not specialist expertise	Management of common conditions requiring specialist expertise	Step down care for patients post hospital admission or treatment
Best practice	Provision of information to patients and public on simple conditions and appropriate management Promote direct access to therapy services	Redesign pathways to support management of conditions in the community Improve access to diagnostics from primary care Provide outpatients, diagnostics and therapy services from polysystems Provide some minor procedures from polysystems Build capability and capacity in primary care	Consolidate routine elective services to elective centres to improve productivity and quality of outcomes Improve pre-operative assessment Move to top quartile day case rates (Better Care Better Value indicators) Decommission low priority procedures and interventions Consolidate and rationalise specialist and tertiary services to improve throughputs and outcomes Reduce consultant to consultant referrals	Ensure planned discharge date is set on pre-assessment Risk assess for discharge support Develop appropriate residential and home based intermediate care to meet demand
Local discussions		Polysystem delivery of OPDs, diagnostics and some routine treatments	Endorsement of the elective care model with potential for one or two “cold sites” in NCL	
Local priorities		**1. Increase polysystem capacity to deliver planned care services (both hubs and spokes)** **2. Prevention and early detection of cancer**	**3. Deliver elective care from Elective Centres as described in the BEH clinical strategy** **4. Increase day case rates** **5. Rationalisation of tertiary services to improve quality and sustainable workforce** **6. Decrease consultant to consultant referrals** **7. Decommissioning**	

Planned care	Self assessment and self care	Primary and community care	Acute and specialist services	Rehabilitation and continuing care
Sector	6. Development of cardiac care pathway 7. Delivery of national cancer reform strategy	1. Coordination of NCL polysystems implementation – redesign of chosen care pathways to enable shift of activity from hospital setting 6. Development of cardiac care pathway 7. Delivery of national cancer reform strategy	2. Acute care reconfiguration – movement of outpatient services to community. BEH clinical strategy implementation 6. Development of cardiac care pathway 7. Delivery of national cancer reform strategy 9. Definition of core list of procedures for decommissioning 9. Driving productivity	6. Development of cardiac care pathway 7. Delivery of national cancer reform strategy
Barnet	3. Development of LTC care pathways	2(a). Development of Polysystems 3. Development of LTC care pathways	2(b). Implement BEH clinical Strategy 4. Improve Contracting and Commissioning processes to improve quality, safety and the patient experience.	3. Development of LTC care pathways
Camden	1(a). Health checks/cardiovascular risk management 1(b). Support for healthier lifestyles 2(d). Long term conditions	3(b). Dental services 3(c). Improving access and capacity in primary care - GP led Health Centre 3(d). Strategic development of primary care - Fortune Green development	4. Decommission ineffective procedures 2(d) and 2(g). Transfer outpatients to polysystem	1(b). Support for Healthier Lifestyles
Enfield		3(b). BEH Clinical strategy: Planned care 4. High Quality Primary Care Polysystems development	3(b). BEH Clinical strategy: Planned care 4. High Quality Primary Care	
Haringey		7. Outpatient care (based on seven polysystem pathways): See 'acute and specialised services for list of pathways 17. Liverpool model project 16. Implement World Class Primary Care Strategy – quality and access 3 neighbourhood Health Centres providing diagnostics and LTC, intermediate care, access to unscheduled care	7. Outpatient care (based on seven polysystem pathways): 7.1 Women's health 7.2 Unscheduled care 7.3 T&O & Rheumatology 7.4 Ophthalmology 7.5 Dermatology 7.6 ENT/ MaxFax/ Audiology 7.7 Managing long term conditions 16. Delayed transfers of care	7. Outpatient care (based on seven polysystem pathways): See 'acute and specialised services for list of pathways
Islington		5. Cancer – extend screening programmes 7. Experience, Engagement and Empowerment 9. Improving access to oral health 13. Community Planned Care Services 15. Transforming Primary Care		

4.9 Acute care

Summary

This care pathway – the delivery of urgent and emergency care – was the focus of both the acute clinical working group and the polysystem working group in the NCL SOR. The main priority of both groups was to develop an improved model for urgent care delivery to reduce the volumes of patients attending A&E. The key initiative will be the implementation of polysystems and closer working with primary care. Local modelling has identified that over 200,000 of the current 500,000 attendances could be effectively treated in an alternative, lower cost setting – either in urgent care centres based at hospital sites, in polysystems or as unscheduled appointments in general practice.

In addition, the care pathway for emergency admissions in hospitals has been reviewed; models for admission avoidance and alternative management of long term conditions are being developed that will see the shift of over 2000 admissions per annum. The pathway for patients following admission has also been identified as crucial; for example, an agreed priority area is ensuring that all admitted patients are reviewed daily by a consultant.

Acute care	Self care, support and advice	Primary care and community services	Ambulance services	Accident and emergency	Non-elective admissions	Specialist and tertiary services
Scope	Provision of advice, information and support	Provision of first line care for patients with urgent / unscheduled care needs	Initial assessment, treatment and transfer to appropriate location (A&E / urgent care)	Provision of acute care - interface between primary and secondary care	Inpatient emergency treatment, in particular, medicine, surgery and ITU	Provision of specialist care for specific acute needs, e.g., stroke, myocardial infarcts and trauma
Best practice	Ensuring availability of information Improved coordination across NHS and local authorities	Provision of 12 hourly primary care allowing unscheduled needs to be met Provision of 12 hourly urgent care service including diagnostics for each local community Improved capability and capacity in primary care Case management approach ensuring early detection of acute exacerbations in patients with LTCs	Increase treatment at scene Develop protocols to ensure patients transferred to appropriate locations (urgent care, A&E, major acute centre, HASU etc)	24 hourly availability of senior clinical decision makers allow early diagnosis and treatment institution Primary care led urgent care centre at each hospital site (main urgent care hub) Access to admission avoidance team / social care etc	24 hourly availability of senior clinical decision makers All admissions reviewed by consultant within 6 hours of admission Daily review by consultants Consolidation of emergency surgery to fewer sites; limiting locations for overnight emergency surgery	Centralise services to fewer sites Maximise use of supporting infrastructure
Local discussions		Shift of around 40% of A&E attendances (majority of minors) to urgent care centres or primary care unscheduled appts	Need to ensure treat and transfer policies in place for new care settings	Shift of around 40% of A&E attendances (majority of minors) to urgent care centres or primary care unscheduled appts	Strong clinical preference for emergency medicine and surgery to be co-located	Strong clinical support for rationalisation of services across RF and UCLH Networked service to NCL and beyond
Local priorities		**1. Development of urgent care services in polysystems including improving access to GPs**	**2. Transformation of ambulance services**	**3. Continue with planned closure of A&E at Chase Farm** **4. Provision of urgent care at front door of all hospital sites reducing A&E attendances by ~ 40%**	**5. Consolidate complex emergency surgery to 3 sites** **6. Decrease admissions with improved LTC management**	**7. Implementation of HASU at UCLH and stroke units at designated centres** **8. Implementation of pan-London cardiac, vascular and cancer work**

Acute care	Self care, support and advice	Primary care and community services	Ambulance services	Accident and emergency	Non-elective admissions	Specialist and tertiary services
Sector		1. Coordination of NCL polysystems implementation including support for UCC	8. Sector wide implementation of LAS initiatives	1. Coordination of NCL polysystems implementation including support for UCC 2. Acute reconfiguration – reorganisation of A&E provision at Chase Farm with UCC at front door of each hospital	2. Acute reconfiguration including consolidation of emergency surgery 2. Implementation of BEH clinical strategy	2. Acute reconfiguration – consolidation of specialist services 5. Implementation of stroke strategy.
Barnet	3. Development of LTC care pathways	2(a). Development of Polysystems including: - development of urgent and unscheduled care pathway - Recommission GP OOHs and urgent care services as an integrated whole - Commission to achieve maximum integration between GPs within a poly-system and the polyclinic urgent care service Review diagnostics commissioning across the PCT and commission key diagnostics for each polysystem.		2(a). Development of Polysystems including: - development of urgent and unscheduled care pathway - Recommission GP OOHs and urgent care services as an integrated whole. - Commission to achieve maximum integration between GPs within a poly-system and the polyclinic urgent care service 2b. Implement BEH clinical Strategy including: -HfL specification for an urgent care service at the front of Barnet A&E	2(b). Implement BEH clinical Strategy 2(a). Development of Polysystems including: - development of urgent and unscheduled care pathway	2(b). Implement BEH clinical Strategy
Camden	1(a). Cardiovascular risk management	3(b). Dental services 3(c). Improving access and capacity in primary care - GP led Health Centre 3(d). Strategic development of primary care - Fortune Green development		3(a). Urgent care centres 4. Investment Prioritisation and disinvestment	2(d). Long term conditions - Reduce outpatients and admissions and return patients to polysystem management	
Enfield		4. High Quality Primary Care Polysystems development		3(a). BEH Clinical strategy: Urgent care services	3(a). BEH Clinical strategy: Urgent care services	

Acute care	Self care, support and advice	Primary care and community services	Ambulance services	Accident and emergency	Non-elective admissions	Specialist and tertiary services
Haringey		16. Implement World Class Primary Care Strategy – quality and access 3 neighbourhood Health Centres providing diagnostics and LTC, intermediate care, access to unscheduled care (BEH clinical strategy) PMS review 8-8 and WiC		16. 3 neighbourhood Health Centres providing diagnostics and LTC, intermediate care, access to unscheduled care		
Islington		12. Urgent care redesign - Deliver an urgent care centre at the Whittington hospital site by the end of spring 2011. - Commission a rapid response team in the community to commence by the end of spring 2011.		12. Urgent care redesign - Deliver an urgent care centre at the Whittington hospital site by the end of spring 2011.		

4.10 End of life care

Summary

Initiatives for end of life care are predominantly led at a local PCT level. All five PCts meet together regularly in the EoLC collaborative commissioning group, where the work common priorities for EoLC. A key priority within end of life care has been the facilitation of improved access to the Gold Standard Framework (GSF) across primary care.

End of life care	Identification of patients / early discussions	Assessment and care planning	Coordination of individual patient care	Delivering high quality care in different settings	Care in the last days of life	Care after death
Scope	Discussions regarding prognosis Awareness raising with patient and carers	Advanced care planning Support for individuals	Ongoing management / coordination of care	Delivering care to high standards in all settings	Pain relief, support to carers	Care and support for carer / family
Best practice	Increase public and practitioner awareness Incorporation of EoLC planning into LTC management Early involvement of carers	Implement GSF Agree individual care plans Regular review of care plans Assess carer needs	Clarity about responsibility for all aspects of care Single point of contact Shared records 24 hour rapid response services Case management Improve coordination with social care	Improve end of life care in acute settings – use of CQUIN as incentive in acute contract Implement GSF and LCP Education and support for workforce	Review of needs and preference for place of death Support for carer Recognise wishes regarding resuscitation Protocols to allow dedicated carer to administer morphine Acute trust implementation and monitoring of GSF / LCP	Care and support to carer / family

End of life care	Identification of patients / early discussions	Assessment and care planning	Coordination of individual patient care	Delivering high quality care in different settings	Care in the last days of life	Care after death
Local discussions		Need to ensure rapid roll out of GSF; currently inconsistent		Improve consistency of EoLC across hospital, nursing and residential homes	Hospice tariff	
Local priorities	1. Increasing public awareness 2. Support to carers	2. Support to carers 3. Roll out of Gold Standard Framework 4. Ensure common records		3. Roll out of GSF, including nursing and residential care settings **5. Implementation of hospital standards** 6. Training for care homes **7. Tariff for hospice care**	2. Support to carers 3. Roll out of GSF, including nursing and residential care settings **5. Implementation of hospital standards**	2. Support to carers

End of life care	Identification of patients / early discussions	Assessment and care planning	Coordination of individual patient care	Delivering high quality care in different settings	Care in the last days of life	Care after death
Sector		1. Coordination of NCL polysystems implementation	1. Coordination of NCL polysystems implementation	1. Coordination of NCL polysystems implementation	1. Coordination of NCL polysystems implementation	
Barnet	3(a). Implement EOLC care pathway	3(a). Implement EOLC care pathway	3(a). Implement EOLC care pathway	3(a). Implement EOLC care pathway	3(a). Implement EOLC care pathway	3(a). Implement EOLC care pathway
Camden	2(e). End of Life care	2(e). End of Life care – implement Liverpool pathway and gold standard framework	2(e). Strengthen care management	2(e). Strengthen education and training programmes	2(e). End of Life care – increase % of people supported to die outside hospital	2(e). End of Life care
Enfield		4. High Quality Primary Care	4. High Quality Primary Care	2. Acute Home Care and End of Life services to support patients at home rather than hospital	2. Acute Home Care and End of Life services to support patients at home rather than hospital	
Haringey	6. End of life care Implement Gold Standard Framework	6. End of life care Implement Gold Standard Framework	6. End of life care Develop community service for people with dementia modelled on best practice outcomes	6. End of life care Develop community service for people with dementia modelled on best practice outcomes Implement Gold Standard Framework 14. Rehabilitation and intermediate care	6. End of life care Implement Gold Standard Framework	13. Care of long term conditions Community matron programme EOLC – gold standard framework
Islington	Islington has completed its key actions on EoL care from last year and does not have current initiatives in the CSP.					

4.11 Development of NCL priorities

Having identified the gaps in the eight HfL pathways outlined in previous tables, we have further prioritised a core group of priority areas that require additional effort and resources to deliver. These were identified through a series of workshops with clinicians and managers where the gaps were assessed against a group of criteria, outlined below:

- Strategic fit with Healthcare for London
- Impact on quality
- Impact on performance including access and patient experience
- Value for money

These discussions have culminated in agreement of thirteen NCL priorities which we believe are pivotal to delivering service transformation in NCL:

Diabetes	COPD
Coronary heart disease	Dementia
Maternity	Cancer
Cardio-vascular pathway	Urgent care
Paediatric services	Acute mental health inpatient care
CAMHS	Planned care
Screening	

Although all of the identified gaps in the pathways are addressed in our initiatives, which are detailed in section 7, the thirteen priorities will form the basis of the Sector's early work.

4.12 Summary

The previous sections outlined how the Sector has identified its priorities for this strategic plan and how these map to gaps in the HfL care pathways that the Sector needs to focus on. The mapping of our thirteen priorities to the HfL component parts can be seen in the following table. Delivery against our priorities, therefore, should allow the Sector to comprehensively redesign the eight pathways and deliver a stepped change in the quality of care delivered to our population. The next section of the strategy looks at the care settings across NCL and reviews how these pathways are currently delivered and how improvements to care settings will allow us to deliver better outcomes for the population.

Figure 10 demonstrates how the 13 priority groups will deliver each of the Sector sub-component priorities identified in the pathway analysis shown above.

Figure 10: The sub-components which link to the 13 Sector priorities

13 NCL sector priorities	Map to the following sub-components of each HfL pathway
Diabetes (LTC3, A6)	**Long term conditions:** Design and implement agreed pathways **Acute care:** Decrease admissions with improved LTC management
COPD (LTC3, A6)	**Long term conditions:** Design and implement agreed pathways **Acute care:** Decrease admissions with improved LTC management
CHD (LTC3, A6)	**Long term conditions:** Design and implement agreed pathways **Acute care:** Decrease admissions with improved LTC management
Dementia (LTC3, MH1, MH2)	**Long term conditions:** Design and implement agreed pathways **Mental health:** Polysystem MH offering **Mental health:** Implementation of dementia care pathway
Maternity (M1, M2, M3, M4, M5)	**Maternity:** Implementation of NICE antenatal care pathway **Maternity:** Establishment of clinical network **Maternity:** Consolidation of services to fewer units to improve safety and maximise workforce availability **Maternity:** Review viability (clinical and financial) of stand-alone midwifery led units **Maternity:** Improvement of perinatal mental health services
Cancer (P2)	**Planned care:** Prevention and early detection of cancer
Cardio-vascular (A8)	**Acute care:** Implementation of pan-London cardiac, vascular and cancer work
Urgent care (A1, A2, A3, A4, A7)	**Acute care:** Development of urgent care services in polysystems including improving access to GPs **Acute care:** Transformation of ambulance services **Acute care:** Continue with planned closure of A&E at Chase Farm **Acute care:** Provision of urgent care at front door of all hospital sites reducing A&E attendances by ~ 40% **Acute care:** Implementation of HASU at UCLH and stroke units at designated centres
Paediatric services (C6, C7, C8)	**Children and young people:** Improve coordination between community and secondary care **Children and young people:** PAU at each acute hospital **Children and young people:** Consolidation of inpatient paediatric services
Acute mental health inpatient care (MH3)	**Mental health:** Develop best practice clinical model for inpatient services; develop options for delivery
CAMHS (C4)	**Children and young people:** Develop tier three and tier four services in CAMHS
Planned care (SH5, C5, P1, P3, P4, P5, P6, P7, A5, EOLC 5, EOLC 7)	**Staying healthy:** Secondary prevention of long term conditions **Children and young people:** Shift of OPD **Planned care:** Increase polysystem capacity to deliver planned care services (both hubs and spokes) **Planned care:** Deliver elective care from elective centres as described in the BEH clinical strategy **Planned care:** Increase day case rates **Planned care:** Rationalisation of tertiary services to improve quality and sustainable workforce **Planned care:** Decrease consultant to consultant referrals **Planned care:** Decommissioning **End of life care:** Implementation of hospital standards **End of life care:** Tariff for hospice care
Screening (SH2)	**Staying healthy:** Screening pathways including chlamydia

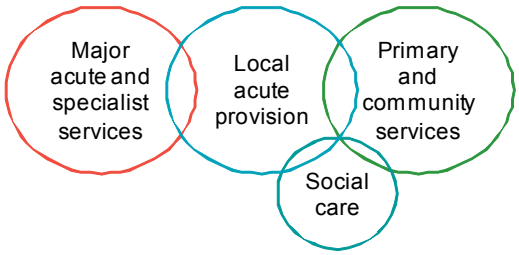
5. Case for change: strengthening the provider landscape

5.1 Introduction to the Healthcare for London care settings

The implementation of the eight HfL pathways and 13 NCL priorities described in the previous section will be facilitated by the development of distinct models of provision that have also emerged from the HfL work. These models support the maxim of "localising where possible and centralising where necessary" to enhance both quality and patient experience. There is also benefit to be had from the separation emergency and planned care into appropriate and clinically safe locations for provision of care. Figure 11 summarises these new care settings, while figure 12 summarises which core functions would be provided from within these care settings, specifically capturing those services provided in a local hospital, a care setting which enables optimal working between all parts of the health care system.

Figure 11: A local hospital model for London

Source: adapted from A Framework for Action



Primary and community services, including significant aspects of urgent and planned care, will be delivered from polysystems. Local acute provision provides the linkage between major acute and specialist services and polysystems. Ensuring integration and cohesion between primary care, secondary care and social care will be increasingly important in delivering high quality services to all.

Figure 12: HfL models of care

Source: adapted from A Framework for Action

Core functions	Specialist Hospital	Elective Centre	Major Acute Hospital	Local Hospital	Polysystem
Inpatient beds	✓	✓	✓	✓	
24 hour emergency surgery			✓		
In-hours non-complex emergency surgery			✓	✓	
24 hour emergency medicine			✓	✓	
A&E			✓	✓	
ITU	✓		✓	+/-	
Obstetrics + level 2/3 NICU			✓		
Interventional radiology	✓		✓		
HDU			✓	✓	
Maternity + level 1 NICU				✓	
Elective surgery	✓	✓	✓	+/-	
Outpatient	✓	✓	✓	✓	✓
Paediatric assessment unit				✓	
Urgent care			✓	✓	✓
Inpatient rehabilitation	✓		✓	✓	
Specialist palliative care services				✓	✓
Community services				✓	✓
Satellite x-Ray and diagnostics		✓		✓	✓
Minor procedures				✓	✓
Regular attendees, e.g. renal dialysis				✓	✓
General practice					✓
Pharmacy					✓

Implementing HfL will deliver a step change in service delivery to improve outcomes for patients. It is, in effect, NHS London's quality strategy for London. HfL not only provides the scope to secure better quality services, but a framework within which NHS London can meet the productivity and affordability challenges ahead and position London to deliver the other aspects of the Quality, Innovation, Productivity and Prevention Programme currently being developed by the Department of Health. Whilst NCL already has some world leading health services, we want to ensure that all our residents have access to the best health care in every setting.

5.2 Polysystems

5.2.1 Introduction

Polysystems are at the centre of our vision for healthcare in North Central London. They will enable the shift of care to local settings and will both strengthen and improve access to primary care services. The development of polysystems is essential for the delivery of the eight HfL care pathways and will support the integrated provision of physical, social and mental health services.

Given this importance, the Sector has prioritised the implementation of polysystems as one of its four goals in this strategic plan.

5.2.2 The Healthcare for London model

A **polysystem** is a clinically-led network of care, based on a population of 50,000 – 80,000, involving a range of community partners and supported by a primary care led polyclinic at its heart.

Polysystems will be the setting where the majority of the population's routine healthcare needs will be met. These community-based delivery models will include a broad range of key service areas including:

- Urgent Care
- Diagnostics
- Primary and community care
- Planned care – including some outpatients and minor procedures
- Long term condition and case management

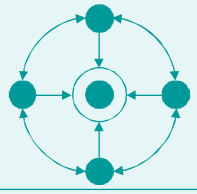
The scale of polysystems and their associated polyclinic hubs will support extended opening hours and improved access

These settings will also provide a platform for further integration of health and social care, primary, acute and mental health services in a patient-centric manner which is closer to the user's home

There are 3 possible polyclinic physical structures which can be utilised in delivering the polyclinic service model:

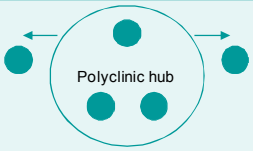
Networked polyclinic

A hub and spoke model with various GP practices linking to the hub for more specialist services. There are a variety of options for a hub building to be either an existing GP practice, another provider, a new build or a new existing building.



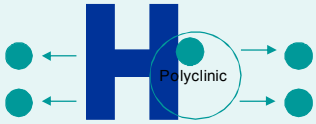
Same site polyclinic

The majority of services including GP practices can be provided from the same building. The GP practices could run independently or merge.



Hospital based polyclinic

The polyclinic would be based at the front of the hospital, with a network of primary and community care operating from community locations.



5.2.3 Current primary and community provision in NCL

Primary provision

The primary care landscape in NCL is characterised by a significant variation in general practice size. There are a significant number of single handed GPs and many are in old buildings and estate that is not fit for purpose. The Sector needs to address this situation, with the main solution being the development and implementation of polysystems to deliver a linked up model of general practice within the hub and spoke system described above. This will contribute towards a more sustainable provider landscape with a more consistent care offering being provided across NCL, including, for example, extended hours and increased level of unscheduled appointments. Figure 13 shows the variation in GP practice sizes across NCL.

Figure 13: Number of GP practices by list size in NCL

List size	Barnet	Camden	Enfield	Haringey	Islington
< 2,000	10	4	6	7	4
2,000 - 5,000	29	19	36	31	15
5,000 - 10,000	21	13	16	14	15
10,000 - 20,000	9	5	5	6	4
Number of practices	69	41	63	58	38
Total registered population	**366,367**	**235,187**	**292,819**	**280,887**	**198,993**

Community provision

There are currently five community service providers in NCL. All five met the NHSL deadline of April 2009 for reaching Autonomous Provider Organisation (APO) status requiring arms length separation from their host PCTs. Whilst this achievement was significant there is a further requirement to define the “end state” of each provider organisation. There are various end states currently available to provider arms, for example Community Foundation Trusts or Social Enterprises, however each state requires the organisation to meet certain conditions and must be acceptable to their host PCTs. Each APO has been looking at options including the possibility of integration with a mental health foundation trust, secondary care provider or with neighbouring provider arms. None of the five NCL provider arms has yet specified its final end state and this will be agreed by March 2010.

Community providers will be key to ensuring that there is a joined-up approach to delivering services in polysystems but face challenges around how they will fit into and integrate with this new model. The PCTs need to work to ensure the organisational forms chosen are the most appropriate given the need to implement HfL. There is considerable interest in the vertical integration option and we are actively exploring vertical integration as an option.

5.2.4 Local work and future plans

Polysystem development is pivotal to service transformation within NCL and will underpin and support the improved outcomes and productivity requirements which NCL must achieve. As one of the Sector goals, it will enable the delivery of the HfL care pathways and provide further leadership in integrating physical and mental health. Polysystem development underpins the Barnet, Enfield and Haringey clinical strategy, described in section 5.3.4, and will ensure local access for a range of services in primary care settings.

The five PCTs have already undertaken significant work in identifying locations for their polysystems and have begun to clarify the services that will be delivered both from the hubs and the general practice spokes. Each polysystem will have a primary hub, some of which will be formed from existing estates and some of which are yet to be identified and developed. Plans are subject to further specification as strategies develop over the coming months.

There are 19 planned polysystems across NCL; the catchment area and estimated population coverage, based on current PCT primary care strategies, can be seen in the following figure. The total population represented is 1.35m.

Figure 14: Sector plans for polysystems

Source: PCT primary care plans

This map only shows the proposed 19 primary hubs. As outlined in the HfL explanation, depending on the location of the primary hub, each polysystem will include other estate such as Urgent Care Centres and GP practices operating within a hub and spoke model. Of the planned hubs five are open and delivering services: three in Haringey, one in Camden and one in Enfield. Establishing the hubs is the first step in developing fully functioning polysystems. Figure 15 demonstrates the timeline for the 19 hubs to be operational; a further three will open during 2010 and by 2014, all polysystems will be fully established.

Figure 15: Polysystem hub delivery timeline

Source: PCT primary care plans

The Sector and five PCTs have begun to work collaboratively to ensure polysystem development is achieved in a coordinated fashion. A NCL-based polysystems working group was established as part of the NCL SOR, comprising clinicians and commissioners from across the five PCTs and including members from primary, community and secondary care, mental health and LMCs.

The working group concentrated its early efforts on defining which clinical pathways should be coordinated from a Sector level to avoid duplication of effort or differences in clinical practice. Through a process of clinical prioritisation and data analysis – looking at forecast volumes of activity and spend - the working group identified the following core pathway groups for further work at Sector level.

- Urgent care
- Long term conditions – diabetes, COPD, coronary heart disease and dementia
- Women's health
- Mental health services
- Planned care

Although the PCTs have ownership and responsibility for the delivery of their polysystems, there is clear acknowledgement from all five PCTs and the Sector that there needs to be a Sector-owned stream of work that defines the core offering for this group of pathways to be delivered through the polysystems. The pathways, ratified through the prioritisation exercise described previously, need to be delivered consistently so that both patients and healthcare professionals have clarity around how treatment will be delivered, regardless of where an individual lives in NCL. Part of the pathway definition will involve developing clear clinical indicators and thresholds for how individuals step through the pathway. The details of this polysystem initiative can be found in section 7.3, whilst the detail for the individual PCT polysystem strategies can be found in the relevant PCT chapters.

5.3 Acute healthcare provision

5.3.1 Introduction

Defining how and where secondary and tertiary services are delivered in North Central London is essential in driving up the quality of healthcare and ensuring that we have a sustainable provider landscape – both clinically and financially. NCL is privileged to be home to a number of world class hospitals and last year, University College London, University College London Hospital, The Royal

Free Hospital, Great Ormond Street and Moorfields Eye Hospital were successful in their bid, as UCL Partners, to become one of the five Academic Health Science Centres in England. UCL Partners is committed to improving the quality of all providers throughout NCL and has made clinical research across the primary/secondary/tertiary interface a focus of its work.

Ensuring that acute care provision across NCL is of an equivalently high standard is one of the drivers behind this strategy. The recently established ACA will be crucial in delivering this consistency.

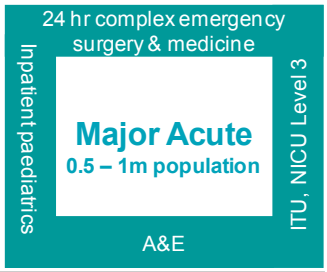
5.3.2 The Healthcare for London model

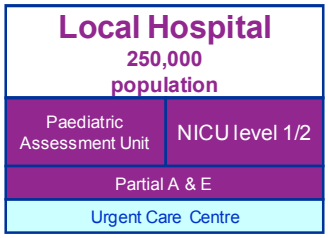
A Framework for Action defined a range of different settings for hospital care: major acute hospitals, local hospitals, specialist hospitals and elective centres. Further work has been undertaken since the publication of this document which has further nuanced these models. For example, there is a clear recommendation from HfL that inpatient paediatrics should be delivered only on major acute sites. In a further example, the review of stroke services designated eight sites across London as hyper-acute stroke units where rapid treatment of strokes will be undertaken – in North Central London, the designated location is UCLH.

Major acute hospitals will be where the most complex, specialist care is delivered. 100% of complex emergency surgery, and >85% of complex emergency and elective medicine should be delivered in major acute settings. Only major acute hospitals will deliver overnight emergency surgery to ensure patient safety and outcomes. Specialist support services, such as 24 hour interventional radiology and other diagnostics, will be provided from major acutes with a networked service to the other hospitals in the sector.

Almost all inpatient paediatrics should be consolidated onto major acute sites. Specialist services such as hyper –acute stroke treatment, vascular surgery, primary angioplasty and transplant surgery will be delivered at some major acute centres.

Source: "A Framework for Action"; Technical Paper





Local Hospitals will provide non-complex inpatient and day case services, and expert inpatient rehabilitation. 24 hour urgent care centres will act as a "front door" to A&E. Complex cases arriving at a local hospital will be transferred, if clinical safety allows, to a major acute.

A 16 hour paediatric assessment unit will be included alongside an obstetric unit with an MLU and level 1/2 NICU (24hr).

Specialist and support services, such as neurosurgery and 24 hour interventional radiology will be provided in a networked arrangement from major acute centres

Specialist hospitals retain established infrastructure, expertise and focus to deliver leading-edge complex services in a specific area. Such specialisation allows hospitals to concentrate on what they are good at.

There are six single specialty hospitals in London already, three of which are in the North Central sector (Moorfields Eye Hospital, Great Ormond Street and RNOH).

Activities	Hours open per day
Related outpatient services	12
Complex surgery	12
Complex medicine	12
Specialist diagnostics eg. CT/PET for cancer centres	12
Some will be or form part of Academic Health Science Centres	

Elective centres focus on specific types of activity and exclude emergency work to be more productive and produce better clinical outcomes. HfL predicts 40% of complex elective surgery and 85% of high throughput elective surgery could be provided in an elective centre.

They have successfully been implemented in the UK (Central Middlesex's ACAD in London, SWLEOC in Southwest London and Netcare in Manchester) and overseas.

Activities	Hours open per day
High throughput elective surgery, some centres may sub-specialise in specific areas, e.g., ophthalmology	12
Simple day case medical interventions (such as endoscopy)	12
Outpatient consultations	12
Pre-admission clinic and facility for pre-op workups	12
Diagnostics	12

5.3.3 Current acute provision in North Central London

There are eight acute hospital providers NCL delivering a wide range of secondary (general hospital) and tertiary (specialist hospital) care from a mix of single specialty and multi-specialty sites. World class organisations exist within NCL and the Sector is particularly proud to be the home of UCL Partners.

Figure 16 shows a breakdown of key financial information for the eight acute providers in North Central London.

Figure 16: Financial information for acute providers

Source: 2008/09 Annual Reports of acute trusts supplemented by bed numbers taken from Service and Organisation Review. Bed numbers are current before BEH implementation and the North Middlesex PFI

Acute trust	Revenue (£m)	Surplus before interest (£m)	Employees	Beds
Barnet and Chase Farm	302.2	12.6	4,285	953
Great Ormond Street Hospital	291.5	5.9	3,368	368
Moorfields Eye Hospital	112.5	2.7	1,383	11
North Middlesex	155.6	9.6	2,037	410
Royal Free	479.1	14.4	5,536	947
Royal National Orthopaedic Hospital	85.1	2.4	1,036	185
University College Hospitals	631.8	6.9	6,199	963
The Whittington	166.0	5.5	2,800	428

All acute providers need to achieve foundation trust status by December 2010; currently, only UCLH and Moorfields of the eight providers have achieved this status. Longstanding concerns exist around the ability of some the remaining providers to achieve FT status, particularly in the face of the financial challenges posed by the worsening economic climate in combination with income reduction due to activity shifts to the community. None of the remaining six organisations have definite dates for achieving FT status with both Royal Free and the Whittington withdrawing from the process in the acknowledgement that, in their current forms, FT status is not achievable.

Figure 17: FT status for NCL organisations

Acute trust	Foundation Trust Status
North Middlesex	In pipeline – date not known
Great Ormond Street	In pipeline – date not known
The Whittington	Withdrawn from process
Royal Free	Withdrawn from process
Barnet and Chase Farm	Undecided
Royal National Orthopaedic Hospital	Undecided

The Sector's strategy must address the need to ensure the long term clinical and financial viability of providers within NCL; this is increasingly a priority for both commissioners and providers. Initial dialogue between the various providers has begun around the potential options to secure this viability.

The Sector wants to see a sustainable provider landscape. We recognise that attainment of FT status is a good indicator of future financial stability, and expect each of our acute providers to agree a clear and realistic plan for their future by March 2010.

The Acute Commissioning Agency

The ACA was established in 2009 and has responsibility for commissioning services from the eight acute providers in NCL on behalf of the five PCTs. In addition, it has responsibility for the performance management of these contracts. By consolidation this commissioning activity, the agency will be able to improve the quality of services that the Sector purchases on behalf of its population through improved data management and improved contracting and performance management.

A key role of the agency is to manage choice and plurality – albeit in the context of the NHS as preferred provider – in NCL. The agency will consider the impact of the SOR on Choice and potential monopolies. In the coming year the agency will jointly agreeing a rolling work programme of market segments to be reviewed, identifying monopolies and unmet need, as well as acting as part of a co-ordinated response to addressing gaps in life expectancy across NCL.

As part of the review of the market national comparative measures will be used to identify areas of poor performance on productivity or quality. In the first instance these will be managed through contract levers with a potential market management solution being identified if there is no improvement in performance.

5.3.4 Local work and future plans

The Barnet Enfield and Haringey (BEH) Clinical Strategy

The BEH clinical strategy developed from a need to improve clinical safety and quality, improve the condition of the estates, and strengthen financial viability across the three boroughs. It includes plans developed in response to Professor Sir George Alberti's review of emergency services, which concluded that full A&E services could not be maintained safely on all three sites.

The strategy has taken many years to develop and has gone through extensive consultation. In addition, it has been reviewed by the Independent Reconfiguration Panel (IRP) and has been approved by the Secretary of State for Health. Although the strategy was developed prior to the publication of *A Framework for Action*, its implementation is an important first step for the sector in delivering the Healthcare for London vision – it will deliver safer, higher quality services for the population in these boroughs.

A pre-requisite for the BEH clinical strategy is the development and implementation of the 12 planned polysystems across the three boroughs. Without the strengthening of primary and community services, allowing the shift of care closer to home, the reconfiguration of acute services between the Barnet, Chase Farm and North Middlesex sites is not achievable.

The first phase of implementation – moving women's and children's services from Chase Farm providing a stand alone midwifery unit and PAU on Chase Farm – has begun and will be completed by July 2011; the second phase - involving changes to urgent care, emergency inpatient and planned care services – is due to be completed by 2013. This second phase requires the re-provision of some of Chase Farm beds on the North Middlesex site along with a small number of additional beds at the Barnet sites. Business cases for the phase two capital build requirements are currently being developed.

The Sector must build on the progress made so far by this programme when reviewing its acute strategy in order to support the delivery of the HfL pathways and care settings.

North Central London Service and Organisational Review

The NCL SOR, which has been underway since the middle of 2009, has focused on how to deliver the HfL care pathways across the whole health economy and, thus, what care settings are required. One of the three main workstreams focused on the future of acute provision in NCL. Clinical recommendations from this group, which have been signed off by the Sector clinical advisory group, included:

- Successful polysystem implementation is a pre-requisite for any significant changes to the acute sector
- Up to 40% of A&E attendances can be shifted to urgent care settings: each polysystem should offer access to urgent care both at the hubs and through unscheduled emergency appointments with general practice; each hospital site should have an urgent care centre co-

located to ensure the successful diversion of patients to the appropriate setting; in addition, each site should have a paediatric assessment unit for the rapid assessment and treatment of children

- Long term conditions should be managed across the care pathway to reduce the number of emergency attendances and admissions and to maintain the health of individuals
- Productivity in the acute sector should be improved through a number of evidence based targeted interventions such as review by a consultant within 6 hours of admission and daily review of patients by a consultant
- Complex emergencies should be managed in a major acute setting where specialist opinion and support services such as 24 hour interventional radiology can be rapidly sought
- Specialist services, such as neurosurgery and specialist cardiac services, should provide a network of support to the other providers in NCL and beyond, including a presence in polysystems if appropriate

Given these clinical recommendations, the CAG proposals to the JCPCT for care settings in NCL were as follows:

- Two major acute sites, one in the north of the sector and one in the south
- A multi-specialist acute provider from where highly specialist and tertiary services that require a major acute type infrastructure will be delivered
- Rationalisation of specialist services, such as cardiac, neurosurgery and ENT across the Royal Free and UCLH; in addition the development of world class networked services from these sites to the rest of the sector and surrounding areas
- A maximum of two local hospitals, of which three variants have been described:
  - A medical and surgical emergency hospital
  - A medical emergency hospital[3]
  - An elective care hospital with an associated urgent care centre
- A maximum of three inpatient paediatric sites, which should be co-located with a major acute site or multi-specialist acute
- Four obstetric units each catering for 6,000 births with level 2 NICU either co-located with a major acute, a medical and surgical emergency hospital or a multi-specialist acute
- Further consideration should be given as to the viability in workforce and financial terms of stand alone midwifery led birthing units

Options development is ongoing, with a significant modelling exercise being undertaken to understand the impact on capacity, capital investment, productivity and required cost improvements for each acute provider organisation. The JCPCT has approved a shortlist of seven options to proceed to a formal option appraisal process. This will be carried out against agreed criteria using an independent panel of experts in 2010. The details of these seven options can be found in Appendix 1.

In the meantime, the Sector has begun pre-consultation activities with the public through a deliberative event with a group of 100 people recruited using quota targets to broadly represent the populations of Enfield, Barnet, Islington, Camden and Haringey in terms of age, ethnicity, gender and employment status. This event was used to understand what was important to the public in relation to the delivery of healthcare and to begin to explain the potential configuration of services. In addition, the relative importance of the groups of criteria was explored. Clinical safety and accessibility were perceived by the group to be somewhat more important than financial or deliverability criteria. Further events with this group and a wider group of stakeholders will continue over the next nine months until the anticipated start of formal consultation in September 2010.

[3] The CAG has expressed some reservations about the clinical safety of this local hospital variant; this is yet to be considered by the JCPCT

Following this process, implementation of the finalised option will begin in 2011/12.

The delivery of this reconfiguration process is one of the Sector's initiatives and is described in detail in section 7.3.

Single specialty sites

Given the number of sites in NCL delivering single specialty services, the Sector has considered its position on these. The current position is as follows:

- No changes are proposed to GOSH, Moorfields or Queen Square
- The future of the RNTNE and the Heart Hospital will be determined by the outcome of HfL reviews that are ongoing
- RNOH has submitted a business case to rebuild on the Stanmore site. Should the business case be unsuccessful, then NCL would work with the RHOH to consider alternative options.

5.4 Mental health provision

5.4.1 Introduction

Improving the provision of mental health across NCL has been a focus of the SOR over the past six months. Delivering mental health services in polysystems and improving the pathways to allow earlier interventions and more joined up care, including in the inpatient setting, will deliver wide ranging benefits to both individuals and the health economy.

5.4.2 The Healthcare for London model

A Framework for Action does not specifically identify models for mental health care settings; however, HfL has been undertaking work over recent months that has started to define the mental health offering in polysystems.

5.4.3 Current mental health provision in North Central London

There are three mental health providers in NCL: The Tavistock and Portman NHS Foundation Trust, and Camden and Islington NHS Foundation Trust and Barnet Enfield and Haringey Mental Health Trust. Barnet Enfield and Haringey has not yet achieved foundation trust status; however, it has a date in the foundation trust pipeline. The key financial metrics for the three organisations can be seen in the following figure.

Figure 18: Financial information for mental health trusts

Source: Taken from Trust Annual Plans with bed numbers taken from SOR

Mental health trust	Revenue (£m)	Surplus before interest (£m)	Employees	Beds
Barnet, Enfield & Haringey	175.8	4.3	2219	548
Tavistock and Portman	26.8	0.6	356	0
Camden & Islington	149.6	5.4	1720	408

Foundation Trust Status

As can be seen, only BEH and Camden and Islington provide inpatient services. These services are currently delivered from a total of nine sites of very variable estate quality, including the St Pancras site in Camden and the St Ann's site in Haringey.

5.4.4 Local work and future plans

The main area of focus for the mental health workstream in the SOR was improving adult and elderly inpatient care through:

- An improved clinical model reducing the reliance on inpatient care
- A consolidation of inpatient beds to reach a size that is both clinically safe and effective from a workforce perspective

- Delivery of inpatient services from improved estate to the current provision

The working group is currently modelling the impact of the clinical model and is developing a set of options for site configuration that will then be appraised through an option appraisal process. It is important to note that the Sector acknowledges the need to consider estates solutions holistically across primary, community, acute and mental health provision rather than by and individual workstream. The Sector mental health initiative is fully described in section 7.3.

5.5 Summary

This section has outlined how changes to care settings will allow us to better deliver both the HfL care pathways and our thirteen priorities. The next section of the strategy introduces our goals and initiatives and details how the delivery of these will allow us to meet the identified priorities in appropriate settings.

6. Case for change: developing a financially sustainable system

6.1 The funding challenge

The five PCTs in NCL currently commission approximately £2.27bn of activity annually from a range of different providers. The breakdown of this activity is shown in the following figures:

Figure 19: Commissioned spend by provider group

Source: SOR

Type of care	£m
In sector acute care	927.0
Out of sector acute care	131.1
Maternity	76.6
Accident and emergency	42.6
Mental health	255.8
Primary	366.0
Community	269.5
Other[4]	200.3
Total	**2,269.0**

Figure 20: NCL Sector commissioning spend by care type

Source: SOR

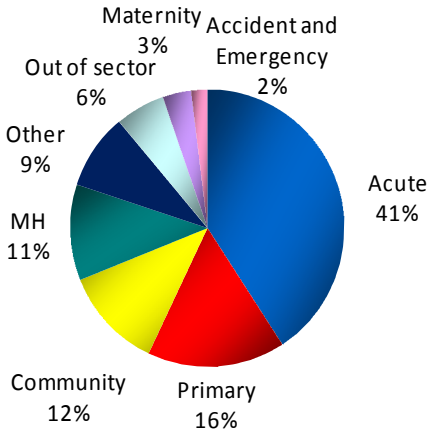
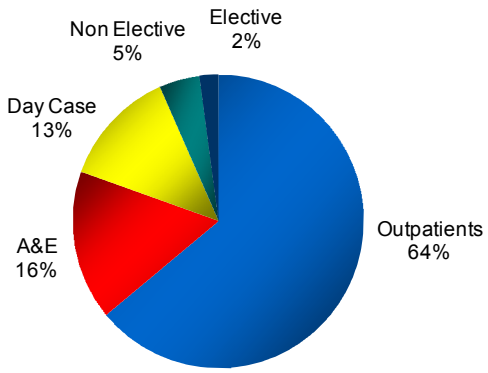


Figure 21: Volume of acute activity by point of delivery

Source: SOR



The significant deficit in the UK's public finances, arising from the global recession, has resulted in uncertainty around the future funding of public services, including the NHS. Although both of the main political parties have promised to protect health funding, the reality is that, following a decade of unprecedented growth, funding will be, at best, flat in real terms over the next one to two comprehensive spending review rounds. It is now widely acknowledged that significant efficiencies will need to be delivered in the NHS with as much as 15 – 20% of the £100bn annual settlement in real terms needing to be saved by 2016/17.

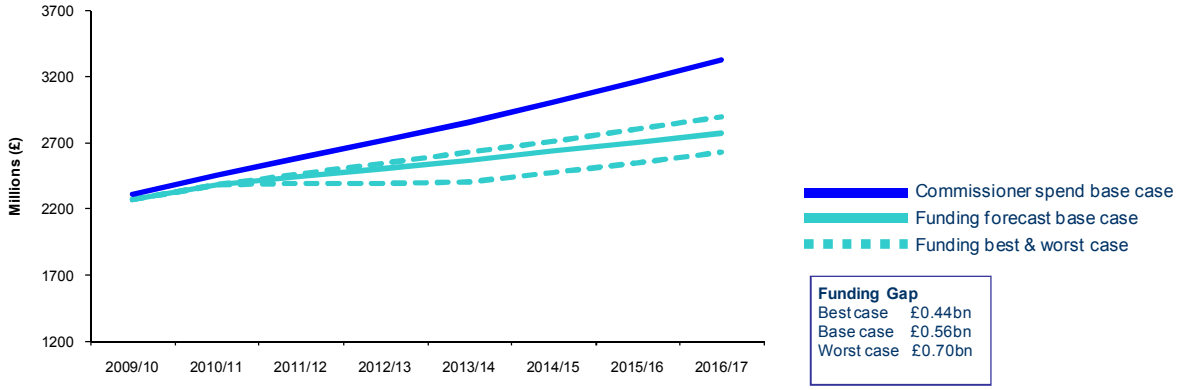
[4] "Other" includes a range of commissioned activity including social care, some mental health provision, some drug commissioning, the implementation of the HfL stroke and trauma pathways and PCT carry-over.

This position forms the backdrop for the five PCTs' and Sector's strategies. Although the health needs of NCL's population, along with the need to improve quality through the implementation of the HfL care pathways and settings are the main drivers of change in NCL, the need to ensure that the healthcare landscape is financially viable and sustainable is also essential.

NCL has undertaken local analysis to better understand the financial challenge its organisations face. From the commissioners' perspective, this has involved taking current activity levels, applying annual activity growth and inflation impacts and quantifying the funding gap in 2016/17. Using the assumptions outlined below, the affordability challenge for the Sector is forecast to be £560m per annum. This can be seen in the following diagram.

Figure 22: The commissioner funding gap

Source: 09/10 Commissioning plans; SOR analysis



In this modelling, the following assumptions have been used:

- Base case PCT funding increase of 5% in 2010/11 and 2.5% (RPI) per annum thereafter (base case)
- Worst case PCT funding increase of 5% in 2010/11, 0.2% per annum 2011/12 – 2013/14 and 3% per annum thereafter
- Best case PCT funding increase of 5% in 2010/11, 3.25% per annum thereafter
- Cost of delivering activity increasing at 3.5% per annum (2.5% RPI and 1% NHS cost inflation)
- Growth of 2% per annum for acute activity
- Growth of 1.5% per annum for mental health, community and primary care activity

The funding and cost assumptions have been taken from the NHS London guidance. The base case funding assumption was confirmed by the Chancellor in the Pre-Budget Report in December 2009.

The only variance from the NHS London guidance relates to activity growth assumptions. These were agreed by the five PCTs to be the appropriate growth rates, given historic trends. There is an acknowledgement, at both Sector and PCT level, that the development of polysystems has the potential to uncover latent demand for primary care services; this would have the impact of increasing the growth rates in primary and community care in the future and will increase the requirement for improved productivity and cost efficiency in services. This risk will be monitored actively as polysystems come on line over the next three to four years.

Reconciliation of the Sector and PCT modelling

The starting inputs for the Sector modelling were the DH funding allocation and contract values for the five PCTs. It was agreed that allocations, rather than current position, was the appropriate starting point for the Sector modelling as the main output from this work was a strategic overview of the size of the funding gap rather than a bottom up tactical view. The Sector modelling has therefore not taken into account the starting financial positions of the five PCTs. The full details of each PCTs starting position, proposed handling strategies (including, where necessary, variances

from the agreed assumptions outlined above) and the year on year income and expenditure position is detailed in each PCT's financial return.

The key differences in the PCT and Sector modelling are outlined in the following table.

Area	Sector modelling approach	PCTs' modelling approach
Starting position 2009/10	DH funding allocations 2009/10	Actual positions as of January 2010
Treatment of surplus / deficits	Assumption that each PCT in balance at start point; no specific treatment of surplus or deficit across the modelled time period	Deficit and surplus positions in 2009/10 and the impact going forwards modelled bottom up
Growth assumptions	Assumptions for growth in activity: 2% per annum for acute activity 1.5% per annum for all other activity	Some local variations on growth assumptions modelled driven by local nuances
Operating plan assumptions	Operating plan assumptions not incorporated	Operating plan assumptions incorporated

6.2 Tackling the funding challenge

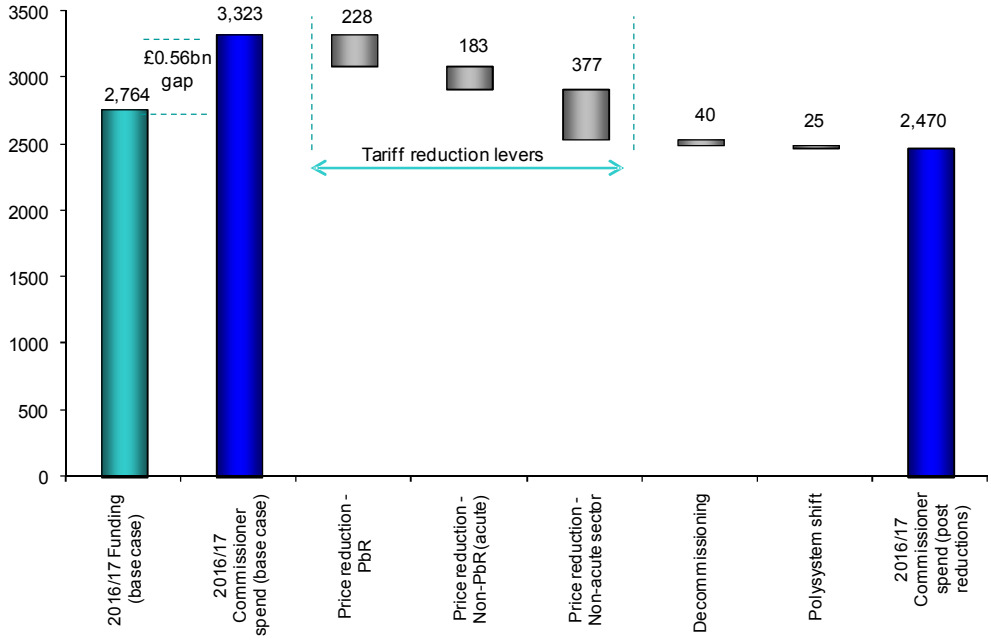
The purpose of the Sector top down modelling has been to quantify the size of the problem facing commissioners and providers in North Central London. Although the potential funding gap facing the five commissioning organisations is in the region of £560m, as demonstrated in figure 22, there are a number of levers either directly available to commissioners or available via policy changes that support them in addressing this challenge, including:

- Changes to tariff payments including annual reduction, the introduction of normative tariffs and marginal pricing for over-performance. These changes, although not directly within the gift of commissioners, have a significant positive impact on the funding position for commissioners. We have, to date, only modelled the impact of the first of these changes
- Price negotiation for non-PbR activity in the acute sector
- Improved productivity and price negotiation in community and primary care through polysystems delivery
- Decommissioning of services
- Shift of services into polysystems
- Management of long term conditions

The impact of implementing these levers can be seen in figure 23. As detailed in the strategy section, the Sector has several initiatives that, as well as improving quality and ensuring delivery of HfL, also have the financial benefit demonstrated below. In particular, there are key initiatives around decommissioning of services, the promotion of polysystems and the redesign of long term condition pathways.

Figure 23: Tackling the commissioning funding gap

Source: SOR



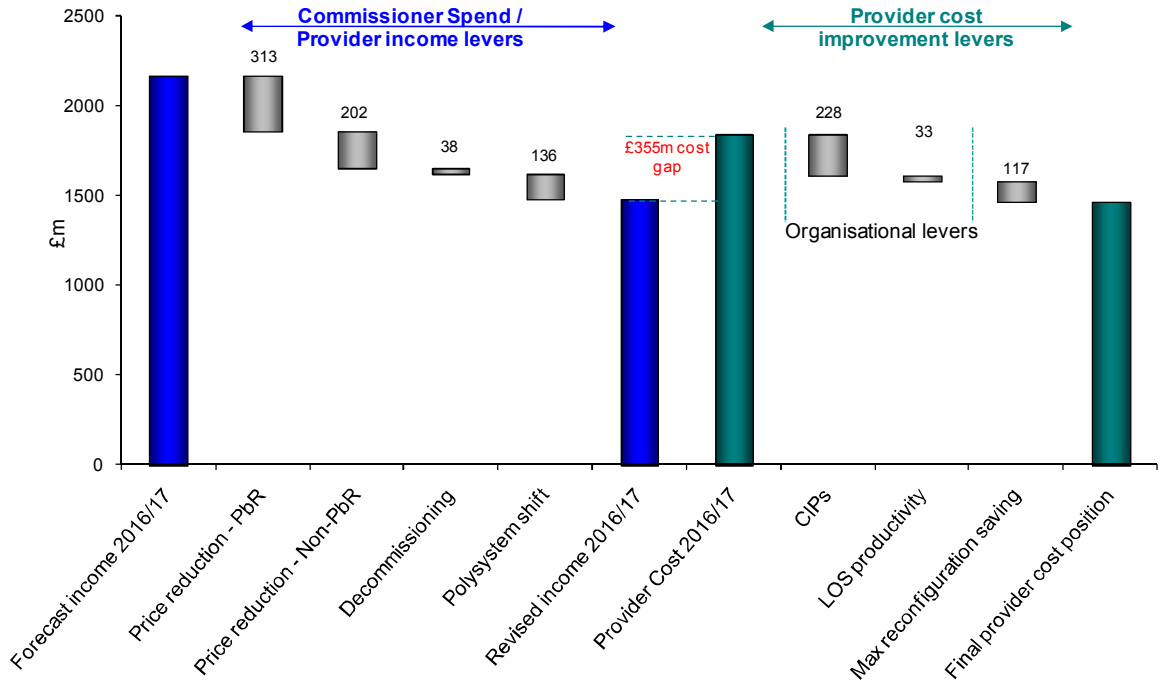
Implementing these levers transfers a significant proportion of the affordability challenge to the acute providers within NCL. Assuming that PCTs from outside NCL apply the same levers, by 2016/17 the five district general and teaching hospitals in NCL[5] will be in deficit by £355m. There are a number of cost drivers available to providers to close this gap:

- Intra-organisation levers - traditional cost improvement (CIPs) and productivity programmes, for example length of stay reductions, lean initiatives and theatre productivity
- Inter-organisation levers – reconfiguration of services resulting in a reduction in fixed costs and economies of scale
- Merger levers – the reduction of back office costs and overheads associated with merging organisations

The local NCL modelling has shown that CIPs and productivity are important drivers for providers but also that, without reconfiguration, the cost gap cannot be closed, given the reduction in income that the providers are facing. The impact of the various levers can be seen in figure 24. It is important to note that, while acute reconfiguration offers no direct financial benefits to commissioners, it is an important enabler in delivering Healthcare for London. So, although managing the financial challenge is not a direct goal of the Sector, achieving the goal of delivering the HfL care settings will ensure both quality provision and the sustainability of the provider landscape in NCL.

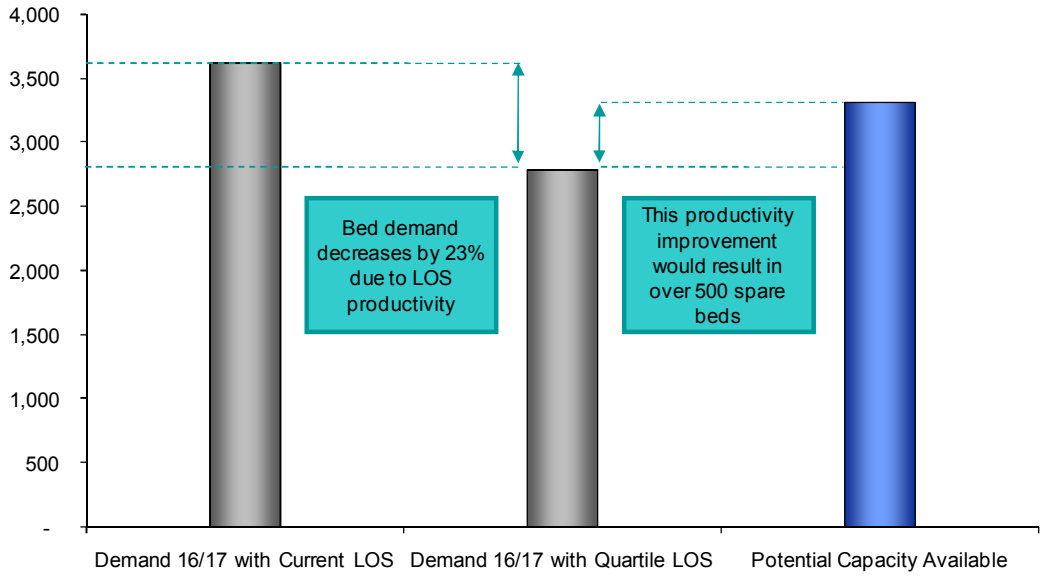
[5] UCLH, The Royal Free, The Whittington, North Middlesex and Barnet and Chase Farm Hospitals

Figure 24: The impact of commissioner levers on provider income and cost



Moving to top quartile performance in length of stay provides significant cost benefits to providers, as seen in the previous figure. More importantly, however, what this benchmarking reveals is that the overall future demand for beds in NCL is reduced by almost 25%. Given available capacity in NCL (assuming the re-provision of Chase Farm services to North Middlesex and Barnet goes ahead with the requisite capital builds), this will result in around 500 excess beds in acute settings in North Central London. This is demonstrated in the following diagram. Even a move to median performance would release around 250 beds.

Figure 25: Bed requirements with productivity improvements



Given this, reconfiguration solutions in NCL need to:

1. Minimise any required capital build as there is spare capacity that could be used
2. Have a whole system perspective so that primary, community, mental health and acute care collaborate to drive the most efficient estate solution for the system in its totality
3. Potentially be bolder than initial proposals have been

Achieving financial balance at PCT level

The five PCTs are committed to NCL-wide working, and to achieving a balanced monthly run rate for each PCT by March 2011 at the latest, acknowledging that historic deficits will necessarily be separate to this. All PCTs are also committed to achieving the necessary reduction in management costs over the medium term, as defined by the Operating Framework.

A number of initiatives support this aim:

- A contingency fund to manage acute sector commissioning risk
- A wider pool of non recurrent funding to support transitional change with clear rules on incentives and penalties around accessing this fund
- A core programme of common demand management and decommissioning areas for all PCTs. In addition, all PCTs will work to a common set of contractual levers through the Acute Agency
- Identification of priority programmes for sector-wide working

Each PCT CSP will be supported by these sector-wide initiatives and we are committed to working with PCTs during January to ensure that we deliver a realistic financial plan for North Central London. The compilation of operating plans for year 1 of the CSP is the starting point, and we will ensure a degree of consistency between these.

However, given the scale of challenge facing some of the individual organisations within NCL, achieving overall financial balance at a Sector level by 2010/11 will be extremely challenging without a pan-London strategy.

7. Sector strategy: goals and initiatives

As outlined in section 4.11, the Sector has identified 13 priority pathways, along with how these might be best provided in care settings. These priorities have shaped our goals and informed the development of nine delivery initiatives that will be the focus of the Sector work plan. The following sections set out:

1. The Sector goals, how these goals map to our priorities and how the goals have formed a framework for PCT goals
2. An introduction to the Sector initiatives and how these will deliver our priorities

7.1 Sector goals

The Sector has developed four goals which it will achieve over the period of this plan, 2010 - 2014. Delivering these goals will allow the Sector to respond to the case for change and support the PCTs in delivering their prioritised outcomes. The four NCL goals are as follows:

Health improvement across North Central London compared to Londoners as a whole (2014)

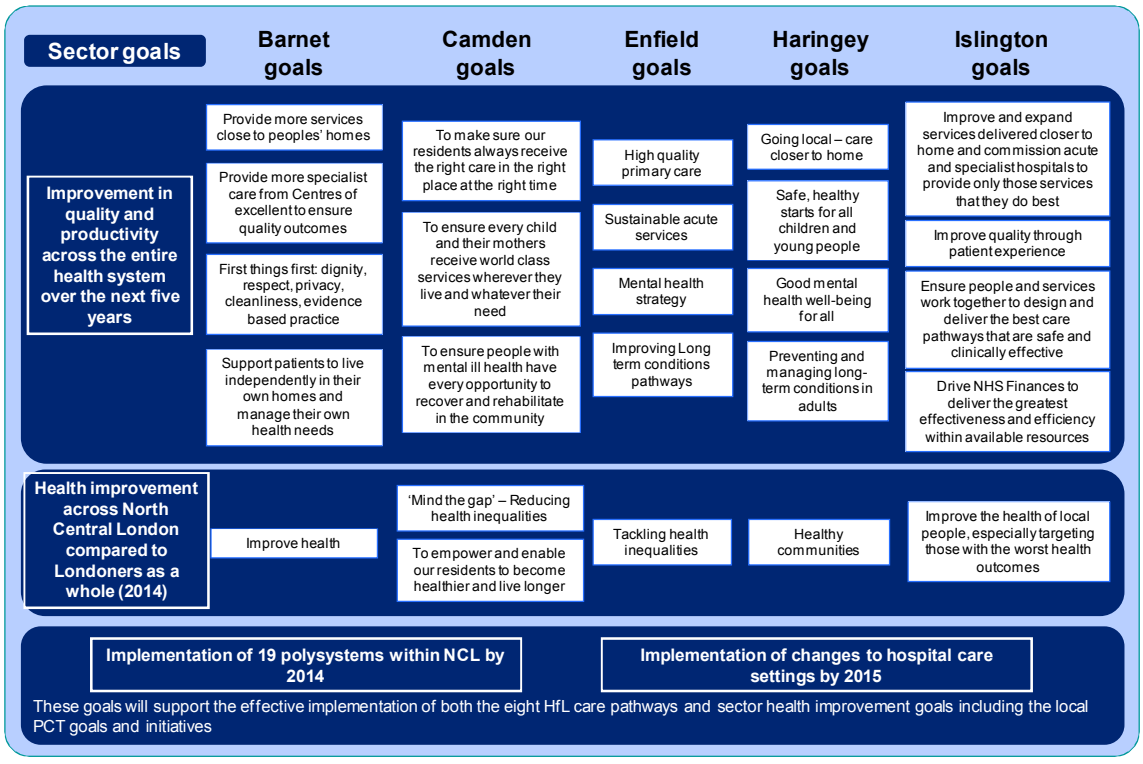
Improvement in quality and productivity across the entire health system over the next five years

Implementation of 19 polysystems within NCL by 2014

Implementation of changes to hospital care settings by 2015

These goals have been shaped by the priorities that we have identified. Two of the goals – health improvement and improving quality and productivity – are focused on delivery. The other two – implementation of polysystems and the care settings – are enabling goals, supporting the implementation of both the Sector delivery goals and PCT goals. Figure 26 outlines how our Sector goals act as a framework within which the PCT goals will be achieved.

Figure 26: How Sector goals provide a framework for PCT goals



7.2 Introduction to Sector initiatives

There are nine Sector delivery initiatives which support the delivery of the goals and priorities. Our initiatives will ensure that we deliver a step change in the healthcare we provide to our local population. The following two diagrams demonstrate how our initiatives map firstly to our goals and then our priorities.

Figure 27: Sector goals and initiatives

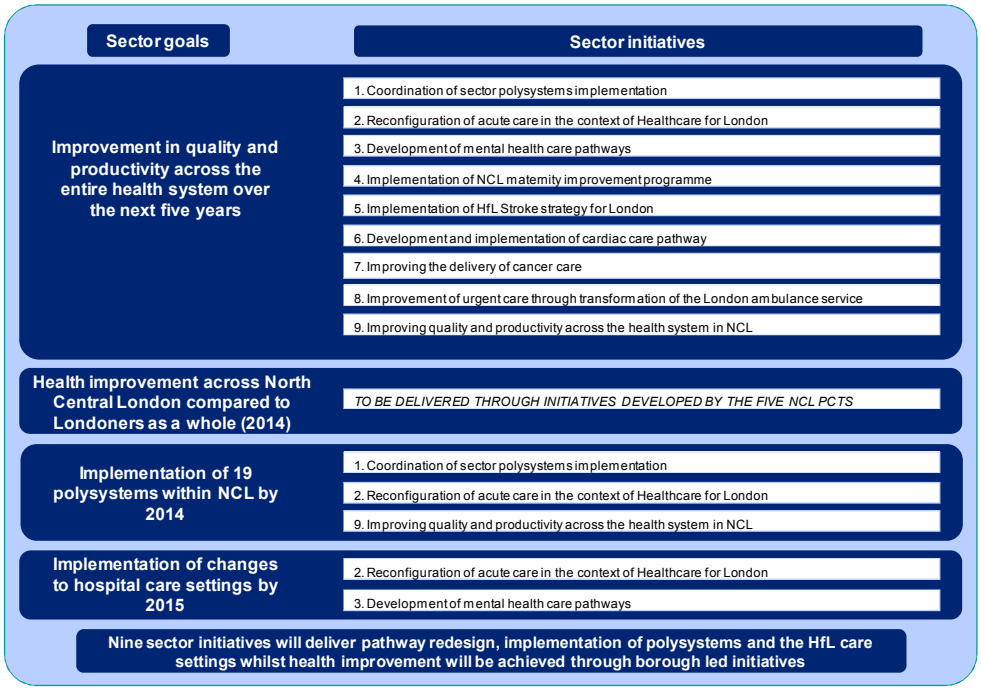


Figure 28: Sector priorities mapped against our nine initiatives

9 sector initiatives

13 NCL sector priorities	Polysystems	Acute care	Mental health	Maternity	Stroke strategy	Cardiac care pathway	Cancer	London ambulance service	Quality productivity
Diabetes	✓								
COPD	✓								
CHD	✓								
Dementia	✓								
Maternity		✓		✓					
Cancer							✓		
Cardio-vascular						✓			
Urgent care	✓	✓			✓			✓	
Paediatric services		✓							
Acute mental health inpatient care			✓						
CAMHS			✓						
Planned care	✓	✓							✓
Screening									✓

The following section details each of our initiatives, discussing the key work being performed, the rationale for inclusion of the initiative, the investment associated with the initiative, the impact the initiative will have on health outcomes and productivity and how they will be delivered.

7.3 Delivering our initiatives

Here, we give an **overview** and **rationale** for each of our initiatives, summarise the **investment** required and state the anticipated **impact**. Each initiative is clearly linked to one or more goals and to one or more HfL pathways.

7.3.1 Coordination of NCL polysystems implementation

Overview

The Sector is leading on the design and development of a group of prioritised clinical pathways that will be delivered through the polysystems:

- Long term conditions: diabetes, COPD, coronary heart disease and dementia
- The delivery of urgent care in polysystems
- The delivery of planned care in polysystems including gynaecology, ENT and musculoskeletal
- The delivery of mental health services in polysystems

Working groups will be established to develop the Sector approach to these pathways, containing clinical leads alongside commissioning and finance leads. Key activities will include:

- Collation of best practice
- Development of pathway specifications
- Development of metrics to assess success of implementation

The Sector polysystems programme board will also have responsibility for developing a consistent operating model for polysystems across NCL. This will involve analysis of the affordability of the proposed model, taking inputs from the pathways groups, and the development of a business case.

A programme lead will be appointed to lead the Sector work to ensure congruence between the development of the clinical pathways, organisational form and the delivery of efficiency savings.

Rationale

The Sector has prioritised polysystems as an initiative for the following reasons:

- Growing middle aged population and increasing incidence of LTCs
- The need to improve primary care services
- Transform healthcare services through the rapid implementation of HfL pathways providing care closer to home
- To improve value for money by providing more effective local services, for example, urgent care
- The need to ensure a consistent offer both for patients and providers
- Avoidance of duplication, given that resource is scarce across the NHS; rather than developing common pathways 19 times in 19 different ways, working at a Sector level means they will be developed once

Investment

- PCTs are leading on the implementation of polysystems and have local plans for the infrastructure investment required. Details can be found in the relevant PCT chapters
- The investment required from a Sector perspective will be in project resource; details are in the delivery section

Impact

The implementation of polysystems will drive significant savings through delivering services in a lower cost setting and by supporting efficiency and productivity in primary and community services. The potential savings from these prioritised areas can be seen in figure 29.

The impact will be measured through agreeing a small number of indicators and by monitoring progress against these. These will include:

- Percentage of agreed volumes of prioritised services shifted to polysystems
- Captured savings
- Patient satisfaction
- Level of acute admissions and emergency attendances of identified patients with long term conditions

Figure 29: Pathway savings from polysystem delivery

Pathway	Savings (£m)
Urgent Care	2.2
Women's health	4.3
Planned care	5.7
Long term conditions	4.6
Other	3.8
Total	**20.7**

Delivery

The programme board will drive delivery and ensure consistency across the patch.

The timeline for polysystem implementation can be seen in figure 30. The Sector is establishing working groups to drive the prioritised pathways; the five PCTs have agreed to commit some of their best resources to these groups to ensure rapid and successful development of the consistent pathways models. These groups will consist of:

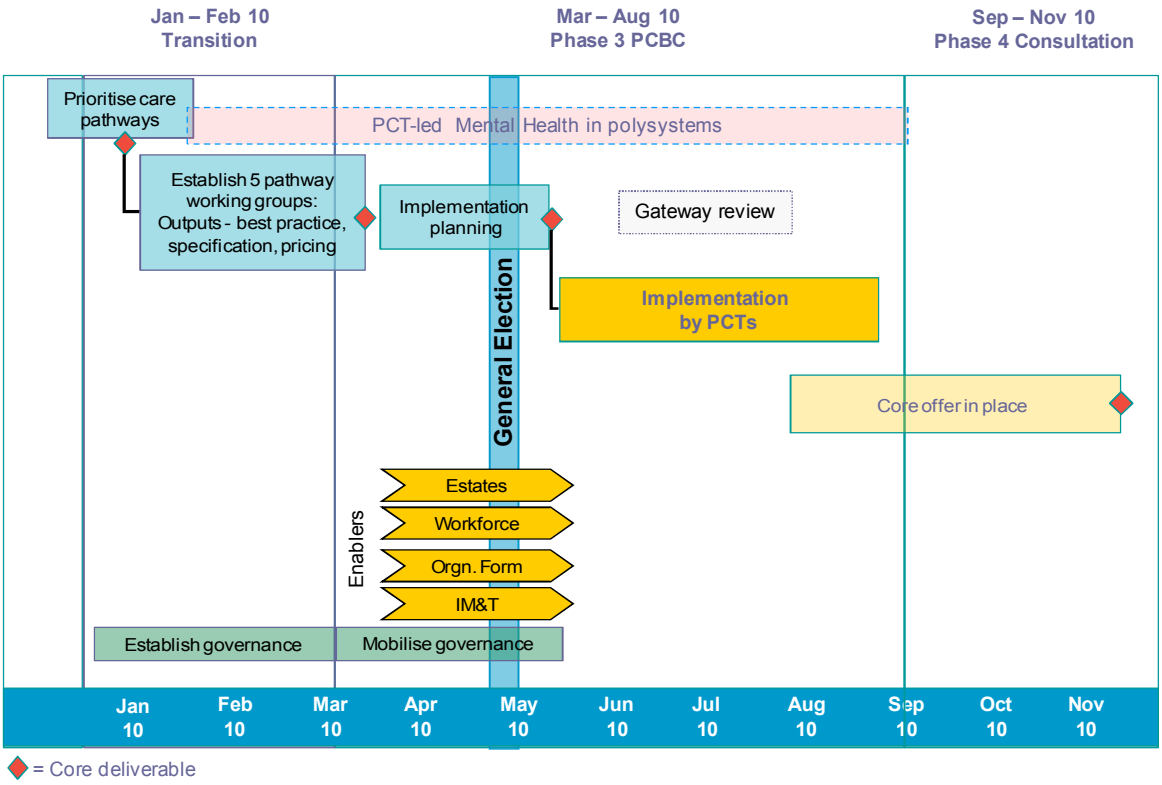
- A director-level SRO
- A clinical lead
- A workforce lead
- A pricing and activity lead
- A project manager

Four working groups will be established in the first instance to develop the approach for diabetes, COPD, CHD and dementia. Urgent care already has an established working group and this will continue to develop the polysystem urgent care offering.

Each SRO will ensure that appropriate patient and public involvement is sought during the development of these pathways.

In addition, a full time programme leader will be required for at least the next 12 months to coordinate the pathway development and operating model work.

Figure 30: Timeline for NCL polysystem implementation



7.3.2 Reconfiguration of acute care in the context of Healthcare for London

Overview

There are two main components to this initiative: implementation of the Barnet, Enfield and Haringey clinical strategy and delivery of the Healthcare for London acute care settings.

Implementation of the BEH clinical strategy

Phase 1 - Women's and children's services

- Obstetric, neonatal, inpatient emergency paediatric, emergency gynaecology services will move from Chase Farm Hospital and be provided at Barnet Hospital and North Middlesex Hospital
- A paediatric assessment unit will be developed at the Chase Farm site
- There are plans for stand-alone midwifery-led unit at the Chase Farm site

Phase 2 - Urgent Care, emergency inpatients and planned care developments

- Accident and emergency services and the associated emergency inpatient beds will be re-provided at the Barnet and North Middlesex sites and close at the Chase Farm site
- A day time urgent care centre will be developed at Chase Farm with an integrated 24-hour doctor-led Primary Care Service
- Elective inpatients will be consolidated on the Chase Farm site
- A range of other services including outpatients, diagnostics, rehabilitation, intermediate care will be maintained or developed at Chase Farm

Delivery of the HfL acute care settings

Delivery of HfL care settings and ensuring a financially viable provider landscape are two of the main drivers in the NCL case for change. Work and decisions made to date are detailed in section 5.3; in summary, these include:

- Urgent care centres at each hospital site
- Centralisation of non-elective inpatient services to a smaller number of sites to improve safety and outcomes
- Consolidation of obstetric services onto four sites with 6,000 births at each
- Consolidation of routine elective surgery into an elective centre
- Centralisation and removal of duplication of specialist and tertiary services, for example, cancer and cardiovascular services
- Consolidation of inpatient paediatrics to maximum of three locations with a paediatric assessment unit at each acute hospital site

Ongoing and future work includes:

- An options appraisal process: development of a set of clinically acceptable options for future configuration; quantification of the impact of each option on capacity and capital investment for each acute provider; formal option appraisal process by an independent panel using agreed criteria
- Business case development: development of a detailed pre-consultation business case following the identification of a preferred option
- Public engagement: deliberative events with a group of randomly selected members of the NCL population to ensure compliance with process and to understand the importance of various criteria and service models to a sample group of the population. Formal consultation is anticipated to start in September 2010
- Implementation: following business case development and consultation, implementation of the finalised option will begin in 2011/12

Rationale

There are a number of drivers for implementing the BEH strategy and HfL acute care settings.

- **Increased quality:** Quality and outcomes for some pathways will be improved by centralisation which will deliver comprehensive and safe services, for example, complex emergency surgery, interventional radiology and neurosurgery. The shift of services closer to home will improve patient experience
- **Sustainable workforce:** more effective use of the workforce and ability to recruit to all specialties and maintain quality
- **Contribution to the sustainability of provider organisation:** As outlined in the affordability section, acute providers will face a deficit of over £350m by 2016/17. Reconfiguration will reduce the size of the overall deficit by between one quarter and one third, reducing the reliance on traditional cost improvement programmes. In addition, the consolidation and rationalisation of services will support organisations in their attempts to achieve foundation status

Investment

BEH clinical strategy

Phase 1: Business cases from BCF and NM have been approved by the three PCTs and NHS London has approved the NMUH business case. The BCF business case is awaiting approval. The capital investment required is:

- BCF: £9.4m
- NM: £23.8m

Phase 2: Business cases from BCF and NM are currently being developed

Delivery of HfL acute care settings

Reconfiguration of services across the NCL acute sector will incur transition costs with some capital requirement.

- **Transition costs:**
  - Double running of services while new models of care become established
  - Workforce costs – both retraining and potential redundancy costs
  - Infrastructure requirements such as IT
- **Capital expenditure:** The option appraisal process will prioritise options that require a lower level of capital expenditure, especially given that there will be spare capacity within NCL. However, it is likely that there will need to be some refurbishment of wards or clinical areas

The formal costing of the required investment has not yet been undertaken since, without a preferred option, this would not be accurate. Following the option appraisal, due to take place in February 2010, work on the pre-consultation business case will rapidly commence which will accurately quantify the investment required. This will be completed by July 2010.

Impact

BEH clinical strategy

- Delivery of high quality, safe clinical services via the consolidation of emergency services, including A&E, onto two sites due to critical mass
- Delivery of services closer to home via the development of community provision in local polysystems
- Two thirds of patients previously seen at the Chase Farm site will either continue to be treated there or closer to home; one third of patients will have to travel to the next nearest hospital site. The percentage flows are demonstrated in the following table.

Patient flows (%age)	To Barnet site	To North Middlesex site	To other locations
Elective admissions	27%	53%	20%
A&E majors	25%	56%	19%
Emergency admissions	23%	48%	29%

Delivery of HfL acute care settings

Reconfiguring acute provision will support provider organisations to be sustainable:

- Consolidation of specialist and major acute activity onto a smaller number of sites will result in a reduction in fixed and variable costs
- Consolidation will also facilitate the delivery of length of stay productivity improvements which in turn releases potential physical capacity and estates

Preliminary findings from finance and activity modelling undertaken to date suggest the potential for savings are in the range of £90m to £130m. This will be in addition to the quality and outcome benefits associated with delivering HfL.

Delivery

BEH clinical strategy

Timescales:

- Phase 1 – women's and children's services: Implementation underway and due to complete by July 2011
- Phase 2 – emergency and planned care: Implementation to be completed by 2013

Resources:

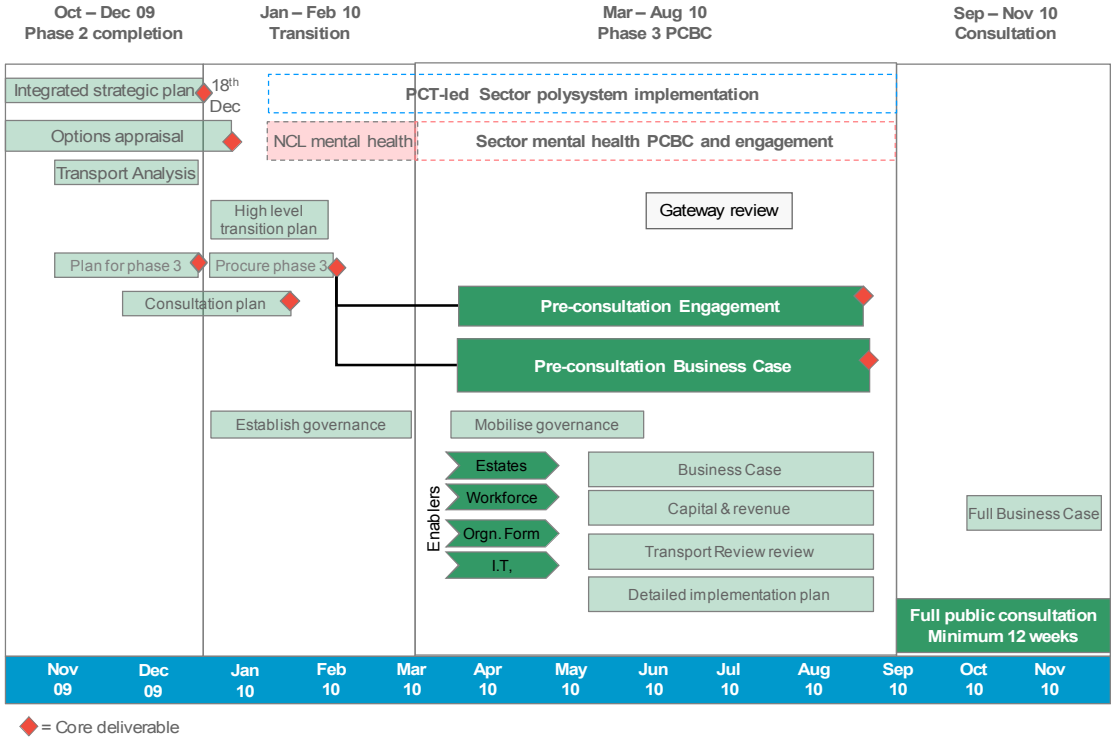
A full time programme team is in place to support the delivery of the BEH Clinical Strategy.

Delivery of HfL acute care settings

Timescales:

The proposed plan for the delivery of the option appraisal and business case can be seen in the figure 31:

Figure 31: Timeline for delivery of HfL acute care settings



Resources:

A full time internal programme team is in place, and will continue to support the review into 2010. It is anticipated that external support will be required on an ongoing basis, to support the development of an outline and full business case and undertake a formal public consultation.

7.3.3 Development of Mental Health care pathways

Overview

Improving inpatient care

Mental health inpatient services are currently delivered from nine different sites across NCL, resulting in inefficient services that could be improved clinically. The Sector mental health working group, made up of clinicians and managers representing commissioners and each of the mental health trusts, has begun to develop an evidence-based clinical model that will improve the management of patients during inpatient admissions and support the shift of care into alternative community settings.

Ongoing and future work includes:

- Modelling and analysis to establish the required bed capacity across NCL. The modelling work will consider the provision of working age adult acute services, rehabilitation services, psychiatric intensive care (PICU) services and acute beds for older people
- Public engagement: initial public engagement will support the development of criteria for the option appraisal. Formal consultation is anticipated to start in September 2010
- An options appraisal process: development of a set of clinically safe and effective options for future configuration; quantification of the impact of each option on capacity and capital investment for each provider; formal option appraisal process by an independent panel using agreed criteria
- Business case development: development of a detailed business case following the identification of a preferred option
- Implementation: following business case development and consultation, implementation of the finalised option will begin in 2011/12

Development of tier three and four CAMHS services

Development of a clinical model for specialist (tier 4) CAMHS provision, coordinating with the pan London work currently being led by Commissioning Support for London.

- Shift of care out of hospitals
- Provision of specialist step-down (tier 3 ½) services in community settings
- Improved resource management across NCL
- Review of tier four provision and sites

Rationale

Improving inpatient care

- Length of stay in NCL is considerably longer than the national average; moving to best practice length of stay will improve patient satisfaction and outcomes, whilst delivering efficiency savings
- The current inpatient stock is fragmented and much is of poor quality. There is a recognised link between the quality of estate and improved outcomes in mental health provision
- Sustainability: the combination of reduced funding in the NHS with the introduction of a tariff system to mental health will require providers to drive significant costs from the system. Consolidation of inpatient sites, with a reduction in overall bed requirements, will provide efficiencies in workforce

Development of tier three and four CAMHS services

Reducing the complexity of both commissioning and provider arrangements of CAMHS services will improve quality and patient outcomes and drive efficiency.

Investment

Improving inpatient care

This initiative will not require any additional monies from commissioners. The shift of patients from inpatient settings will require some funding to be redirected into community mental health provision.

The formal costing of the required investment has not yet been undertaken since, without a preferred option, this would not be accurate. Following the option appraisal, due to take place early in 2010, work on the pre-consultation business case will rapidly commence which will accurately quantify the investment required. This is planned for completion by July 2010. The mental health providers own significant estates; taking a sector-wide approach to assets management could help to free up resources for reinvestment within the health care system.

Development of tier three and four CAMHS services

This initiative will not require any additional monies from commissioners. Efficiency savings may allow the diversion of funding into new service development, for example, adolescent outreach services.

Impact

Improving inpatient care

- Improved quality with increasing specialisation and multi disciplinary teams which only work in a hospital setting
- Better clinical outcomes achieved through the delivery of more effective treatment-focused interventions
- Some shift of activity into community settings and reduced lengths of stay in hospital overall leading to a reduction in bed capacity required for NCL
- Workforce re-modelling to both achieve productivity increases and develop the skills of staff

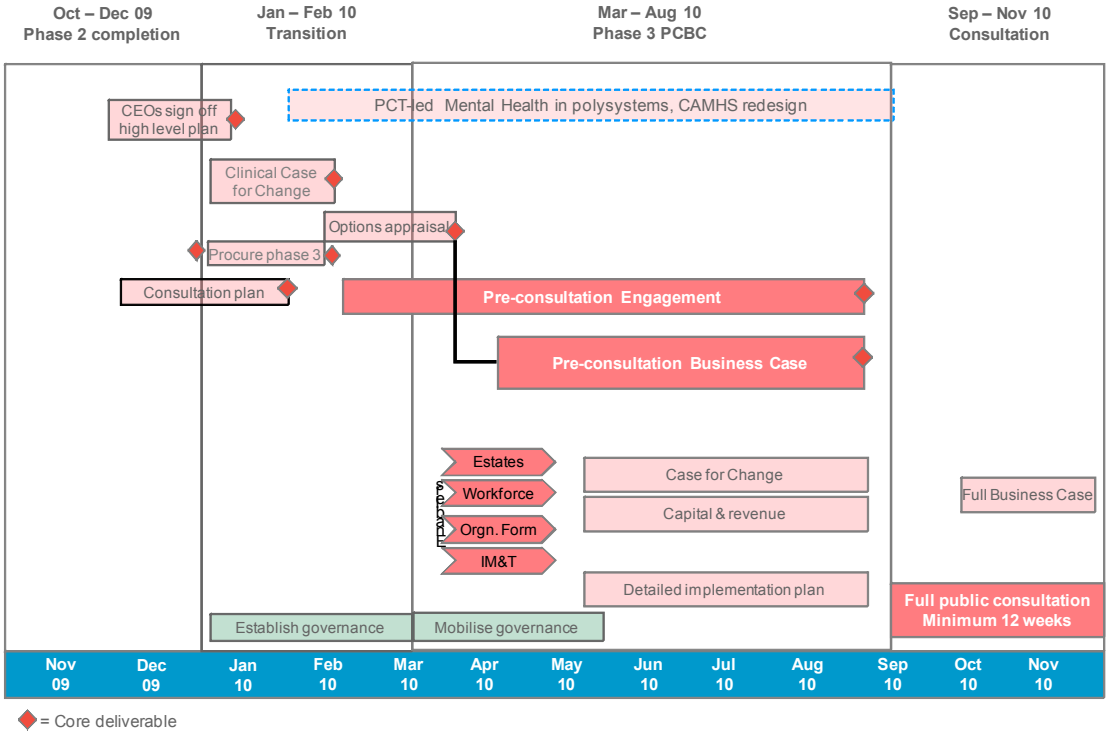
Development of tier three and four CAMHS services

- Development of clearer pathways with improved outcomes for children and young people
- More effective resource utilisation at the high cost end
- Improved transition arrangements as young people move from CAMHS services to adult services

Delivery

Figure 32 gives an overview of the current timescales for conducting the options appraisal and public consultation around mental health inpatient services.

Figure 32: Timeline for improving mental health inpatient care



Timescales:

The proposed plan for the delivery of the option appraisal and business case can be seen in the following diagram. The timetable for the development of care pathways and optimised bed capacity will be shorter than the timescale associated with estates planning. The CAMHS clinical model will be developed through 2010.

Resources:

The SOR programme team has a mental health lead who will continue to support the project. The mental health working group will continue to provide clinical and managerial leadership.

7.3.4 Implementation of NCL maternity improvement programme

Overview

The maternity commissioners' group has identified five key initiatives to improve quality across NCL, in line with Maternity Matters and has established the NCL Maternity Improvement Programme to deliver these. The five initiatives are:

- Establishment of a sector-wide clinical network to develop clinical pathways, explore cross boundary working and support implementation of the NICE schedules of care
- Ensure as many women as possible have a full health and social needs assessment from a healthcare professional by 12 completed weeks of pregnancy. Data collated by the Maternity Commissioners Group will be used to assess performance against the 12+6 target and analyse potential contributing factors which need to be addressed
- Achievement of 1:1 care in labour across NCL
- Provision of coordinated support for PCTs to deliver the Maternity Matters Choice Guarantees: how to access maternity care, the type of antenatal care, place of birth, and place of postnatal care
- Review of specialist services such as perinatal mental health, in collaboration with the relevant polysystems and mental health initiatives

Rationale

- There is a need to improve quality of services in line with the national standards set out in Maternity Matters
- There is poor performance currently in NCL with only one third of women receiving their first antenatal booking by 12 weeks of pregnancy and only half of those giving birth followed the NICE schedule of visits
- There is a need to deliver the maternity HfL pathway

Investment

PCTs have invested in maternity services through increased HRG4 tariffs.

Healthcare for London has recommended the establishment of maternity networks in each sector with paid clinical sessions from midwifery and obstetrics. The specific budget for the Sector Maternity Improvement Programme is yet to be agreed. The programme will pool resources from across the PCTs.

Achieving one-to-one care in labour will require additional maternity staff, including support workers

Impact

Quality: improvement in quality by increasing the number of women that are seen early in pregnancy thus reducing risk and improving outcome and satisfaction

Key metrics which will be used to assess the impact include:

- Improvement in 12 week + 6 booking figures
- Maternity CQUIN - measurement of 1:1 care in labour with targets set for improvement

Performance metrics will be developed with each acute trust through the contracting review meetings and the maternity network.

Delivery

- The maternity clinical network is currently being established by the commissioners' group
- Achievement of 12+6 and one to one care are being built into the current contract negotiations with providers

7.3.5 Implementation of HfL Stroke strategy for London

Overview

The North Central London Cardiac and Stroke Network is responsible for coordinating the delivery of the new national stroke pathway, with the following key objectives:

- Reducing the number of strokes in London by supporting people to live a healthier lifestyle
- Increasing awareness of stroke and its symptoms
- Delivering world-class stroke care
- Enabling stroke patients to achieve realistic rehabilitative goals and maximise their recovery
- Ensuring carers and families are involved in the development of stroke services and their needs are considered

In NCL, there will be one hyper-acute stroke unit (HASU) at UCLH alongside four new stroke units (SUs), in Barnet, North Middlesex, Royal Free and UCLH where world class rehabilitation services will be delivered. New TIA services will be developed alongside the SUs.

Rationale

Stroke disease is an extremely significant cause of morbidity and mortality across NCL, with 2.9 patients registered per 100 population.

- 20% of patients who suffer a TIA go on to have a full stroke within four weeks; thus the development of an effective TIA pathway will help to reduce the number of strokes
- Less than three quarters of patients from NCL who have a stroke have a cholesterol measurement which is significantly less than the national figure and marginally lower than the London average
- Stroke death rates in people under 75 are higher than both the national and London comparators, despite an overall decline

Investment

London PCTs are investing an additional £23 million per year – of which the NCL contribution is £3.5m - to deliver improved acute stroke care. This additional funding will contribute to the development of the HASU at UCLH, along with the rehabilitation and TIA units. Appropriate staffing, along with appropriate diagnostic facilities, will consume the majority of this additional funding; HASUs will have 24 hour consultant cover and provide instant access to CT scanning facilities. In addition, the rehabilitation units will be better staffed with multidisciplinary teams including a range of therapy staff and specialist rehabilitation doctors. This additional funding will be delivered via a London surcharge to the national tariff.

Impact

Across London it is estimated that 400 lives will be saved by the new acute stroke system and disability will be reduced. Implementing the five recommendations set out in the rehabilitation guidance will mean that stroke survivors will be less dependent, which will result in an increased ability for them to re-engage with the world, both personally and economically.

Although implementing this service will require additional monies initially, the health benefits should start to see a reduction in overall spend on stroke disease and a reduction in stroke morbidity and mortality.

Delivery

- UCLH HASU opening in February 2010
- Contract arrangements, including monitoring and incentives, specifying pathway requirements being developed for 2010/11

7.3.6 Development and implementation of cardiac care pathway

Overview

Since 2003 the North Central London Cardiac and Stroke Network has been working to improve services for cardiac patients across NCL. A pan London review of cardio-vascular services has recently started and the Network will work with HfL and NCL providers and commissioners to implement a new agreed model of care for cardiac surgery, cardiology and vascular services. This is likely to focus on consolidating heart attack centres and co-locating these with vascular services on major acute sites.

Rationale

Cardiovascular disease is an extremely significant cause of morbidity and mortality across NCL; four of our five PCTs have reducing cardiovascular mortality as a prioritised outcome.

- The care received by patients with cardiac problems in London varies depending on where you live. For example, the percentage of patients who receive emergency angioplasty for the treatment of a heart attack within 150 minutes of calling for help ranges from 58% in some parts of London, to 86% in others.
- Centralisation of primary angioplasty for STEMI, treatment for non-STEMI and vascular services will have the benefit of creating high enough volumes to drive improved patient outcomes
- The treatment of acute cardiac patients is highly variable across NCL with high variations in post-admission pharmacological treatments
- Not enough patients are currently receiving electrophysiology (EP) interventions; patients get better outcomes following complex EP procedures when done by an experienced cardiologist in specialist centres

Investment

The investment required to deliver the pan-London strategy is dependent on the outcome of the review. However, given that, unlike with the stroke strategy, the heart attack centres already exist, it is unlikely that significant additional commissioner investment will be required. In addition, since there is likely to be consolidation of two vascular and two heart attack centres to a single location, there may be significant provider-side efficiencies from a reduced number of rotas.

Impact

The changes to the models of care for cardiac surgery and cardiology are expected to have the following impacts:

- Lower waiting times for elective surgery
- Implantation device rates will increase to national targets
- Improved access to heart attack centres for Non ST elevated myocardial infarctions leading to lower morbidity rates

Delivery

Implementation of the HfL review will begin following its publication. It is unlikely that this will be in time to introduce contract arrangements for 2010/12; therefore planning will begin for the 2011/12 contract.

7.3.7 Improving the delivery of cancer care

Overview

The Board of the North Central London Cancer Network has agreed a set of priorities activities for cancer services in NCL. These are:

- A focus on prevention, early detection and reducing inequalities
- A systematic approach to address the marked variation in clinical practice and outcomes
- An increase in coordination to reduce fragmentation of services thus enhancing patient experience
- An increased focus on survivorship
- Consolidation and centralisation of some services for some tumour sites

The network has tasked the Agency with the production of a cancer commissioning strategy to deliver these priorities by May 2010. In addition, it has been agreed that a provider network will be established, under the leadership of UCL Partners, to drive delivery of the commissioning strategy.

Rationale

Reducing cancer mortality is a priority outcome for three of the PCTs; the network and agency have a role in supporting this through improving detection and prevention.

The Sector is currently not fully compliant with the Improving outcomes Guidance for a number of tumour sites resulting in fragmentation of services and some treatments being delivered from too many sites. Ensuring compliance with the guidance is a priority.

Investment

No additional commissioning investment will be required to deliver these priorities activities; tariff payments will continue as currently planned

Impact

- Improved survival rates through earlier detection, treatment in appropriate locations and with appropriate volumes to ensure improved outcomes
- Improved patient experience through decreased fragmentation and improved pathways

Delivery

The Agency is developing the cancer commissioning strategy; this will be implemented in the 2011/12 contracting round.

7.3.8 Improvement of urgent care through transformation of the London ambulance service

Overview

London Ambulance Service is working with each of the sectors to deliver a responsive and high quality service to the local population.

There is already significant work between the LAS and the Sector to support this, with initiatives already saving a significant number of ambulance hours. Key schemes include:

- Responding more appropriately to alcohol calls at peak times
- Transporting mental health patients to a place of safety in a planned way
- Providing a dual response with the police so patients can be assessed on scene

NCL has initiated a piece of work to address frequent callers, working in conjunction with LAS to give better quality care to patients and to improve ambulance utilisation rates in NCL.

The Sector will need to work closely with the LAS over the next twelve months as the reconfiguration of care settings progresses. This will allow the Sector to:

- Understand current flows to the various locations within NCL and its surrounding areas
- Understand the impact of changing service configurations in line with HfL
- Develop appropriate protocols to ensure patients are directed to the appropriate care setting (major acute, local hospital, polysystem, for example)
- Understand and quantify the need for treat and transfer services between hospital sites with different service configurations
- Develop appropriate signposting of services, including alternatives to A&E

Rationale

Improving ambulance services will support the implementation of emergency pathways, for example, stroke, trauma, emergency services and cardiac. Currently, performance against the CAT A target is 75.3% for London as a whole and 89% for CAT B; an improvement in these numbers will improve outcomes in the pathways outlined.

Investment

PCTs have invested significantly over the past five years in improving ambulance services; no additional growth in investment is anticipated over the period of the plan.

Impact

The commissioning team expects further improvements using the 2010/11 ambulance contract. This will enable them to hold LAS to account for quality and performance as well as providing a financial incentive for PCTs to reduce activity in year, as an element of funding will move from block to variable rate.

Delivery

There is agreement across the London PCTs that NHS Westminster will be the lead commissioner for ambulance services. The ACA will liaise with NHS Westminster to ensure NCL performance is maximised.

7.3.9 Improving quality and productivity across the health system in NCL

Overview

Improving quality and productivity across the health system is a core role of the Sector and, going forwards, will be part of "business as usual" for the acute commissioning agency. There are a number of discrete activities contained within this initiative:

Improving quality:

- Commissioning of screening programmes to improve uptake and consistency
- Implementing hospital standards for end of life care

Improving productivity:

- Decommissioning procedures with limited clinical benefit in line with the NHS London affordability analysis
- Shifting outpatients (adult and paediatrics) to polysystems
- Increasing rates of day case surgery
- Decreasing consultant to consultant referrals
- Introducing a hospice tariff

Rationale

Improving quality:

- Ensuring high quality care is a core part of all recent NHS reform including HfL. Implementing actions that contribute to this should be considered as a given for the Sector

Improving productivity:

- Given the current economic environment and the likely impact on NHS funding, ensuring our services are delivered as productively as possible is essential
- Workforce constraints in certain clinical areas, such as accident and emergency and emergency medicine, mean that we have to utilise our workforce as smartly as possible
- In a number of areas, improving productivity leads to improved quality. For example, a reduction in length of stay reduces the risk of hospital acquired infections

Investment

- This is part of the Agency's work programme, with resources already allocated for delivery
- There may be additional resource required to undertake in-year audit to monitor underperformance against the contract

Impact

Decreasing variation in outpatient referrals, low priority procedures and emergency admission and attendances will save the Sector over £40m per annum.

Figure 33: A&E and outpatient activity across NCL

Activity type	Barnet	Camden	Enfield	Haringey	Islington	Sector total
Accident and emergency	5,280	6,009	8,927	7,303	4,510	32,029
First outpatient appointments	27,017	18,534	21,007	18,490	15,621	100,669
Follow up out patient appointments	52,122	41,509	40,257	33,928	32,608	200,424
Surgical procedures	1,669	1,164	1,373	1,295	1,932	7,443
Total						**340,555**

Figure 34: A&E and outpatient spend across NCL

Activity type	Barnet (£k)	Camden (£k)	Enfield (£k)	Haringey (£k)	Islington (£k)	Sector total (£k)
Accident and emergency	381	453	612	505	321	2,272
First outpatient appointments	3,701	2,444	2,865	2,586	2,160	13,756
Follow up out patient appointments	4,127	3,223	3160	2,825	2,761	16,096
Surgical procedures	2,111	1,295	1,844	1,541	1,310	8,101
Total						**40,225**

Delivery

- Implementation of these activities is part of this year's contracting round
- Protocol for low priority procedures has been developed and awaiting final clinical sign off
- Inclusion of quality and productivity metrics in the contract
- Establishment of clinical quality review meetings to review performance and the reason for variation

8. Delivery

8.1 NCL engagement with patients, public, clinicians and local partners

Engagement with our stakeholders is a fundamental part of our strategy and will be key to its successful delivery. Even at this relatively early stage in the process, NCL has undertaken a range of stakeholder engagement activities in shaping its strategic priorities.

- **Clinical engagement**: clinicians from mental health, primary care (including practice based commissioning), community services and secondary care have been actively engaged in the development of this strategy, including being part of a number of clinical working groups
- **Local authority engagement**: there has been ongoing engagement with the five local authorities to ensure congruence of this strategy with local plans
- **LINks**: the Sector has engaged with the five LINks through regular briefings
- **Patients and public engagement**: consultation with the public has been initiated via a deliberative process involving 80 members of the local population. The first full day event, held in November 2009 with opinion being sought regarding potential models for reconfiguration of acute services. The event involved presentations on the case for change, the emerging clinical model and criteria relating to future option appraisals, and was independently facilitated by an external organisation that specialises in such events. The Chairs of the five LINks organisations were invited to attend this event as observers. Future events with this same panel are planned for the coming months
- **Wider NHS engagement**: as well as clinical engagement, wider contact has been made through regular briefings for provider and commissioner board members and briefings to NHS staff

Further Sector level engagement has been carried out by the Acute Commissioning Agency, which has taken the following actions:

- Established a maternity network which began with a successful stakeholder event attended by clinicians and managers from each of the acute trusts
- Held a stroke rehabilitation event involving stakeholders from all PCTs and Trusts to look at gaps and constraints in the current pathway
- Organised market place days with all acute trusts to talk about the 2010/11 commissioning round and how we can work together

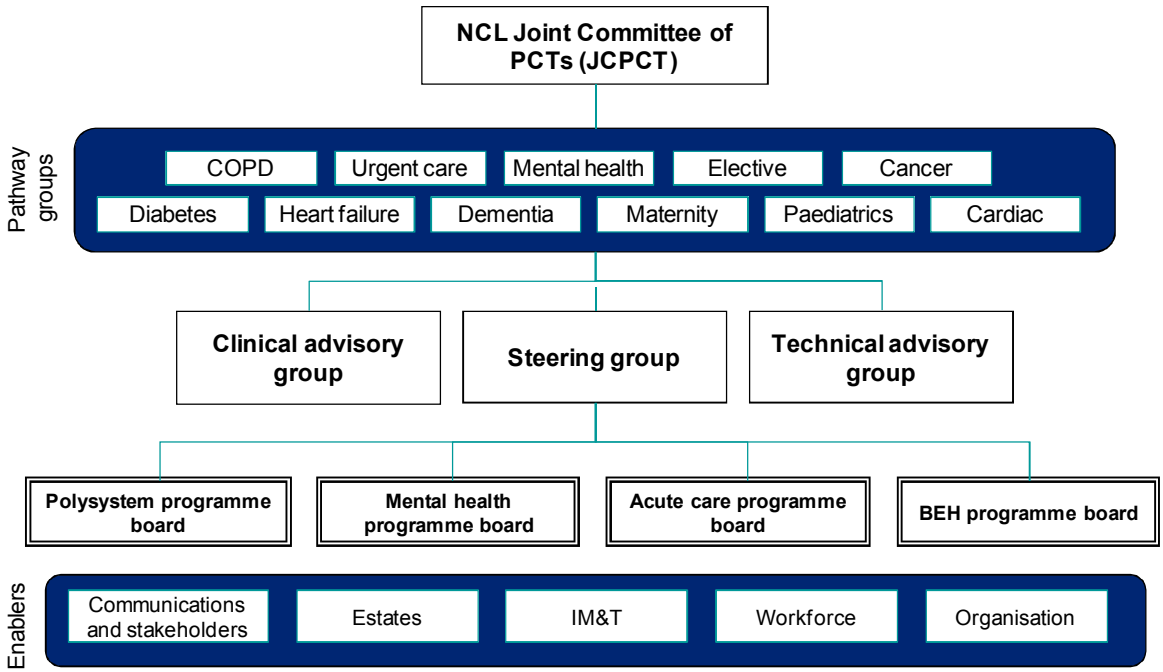
8.2 Sector governance

The overall governance of the Sector is managed through the JCPCT which has overall accountability for delivering the service strategy for NCL. Reporting into the JCPCT are:

- NCL SOR: responsible for developing the Sector approach to HfL care pathways and care settings
- The ACA: responsible for commissioning acute care including performance and financial management
- The BEH programme board: responsible for implementation of the BEH clinical strategy

As the work of the NCL SOR develops, a stronger focus on implementation of pathways and delivery of our initiatives is required. In line with our priority areas of work we will strengthen existing pathways groups or create new ones as required to ensure that we have best practice and consistency across the Sector. Implementation will be driven by our Programme Boards who will be responsible for developing business cases, co-ordinating implementation, monitoring performance and benefits realisation. The NCL SOR will ensure that the enablers as in place to support implementation. The governance of the SOR can be seen in the following diagram.

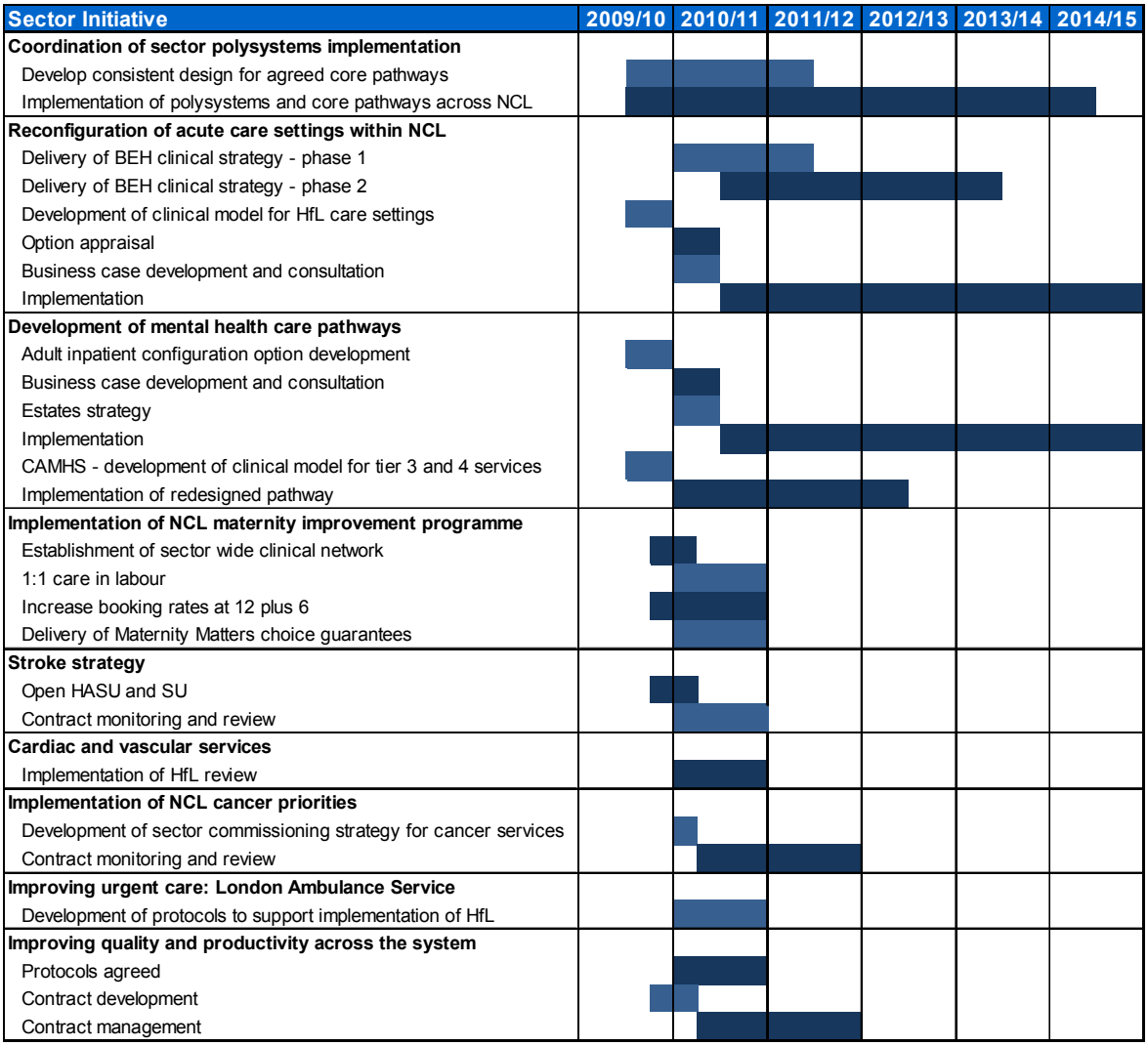
Figure 35: NCL SOR governance



8.3 Initiatives delivery timetable

Delivery and timescales are described in the detail of each initiative, set out in section 7. The following timeline pulls all of the initiatives together and demonstrates the proposed Sector work plan for the duration of this strategy.

Figure 36: Timeline for delivery of Sector initiatives



8.4 Enablers

Delivering the HfL pathways in the appropriate care settings will transform how health services in are delivered. To deliver this level of transformation, there is a need to address key elements of the NHS that shape how care is delivered. NHS London has identified ten enabling strategies and the JCPCT has prioritised four that we believe are critical to delivering to our key initiatives:

1. Estates
2. Workforce
3. IT
4. Communications

In addition, we need to strengthen Sector working to deliver on our initiatives and to work together to achievement financial balance across our organisations. This will require reflection on how we manage and govern ourselves and the Chairs and Chief Executives will address how the Sector develops in 2010 early and put forward proposals in Q1 2010/11.

8.4.1 Estates

Delivering service transformation depends on making the most productive use of the available NHS estate across NCL. We have assumed very limited new capital money will available during the life of this strategy. At the same time, collectively we own a significant number of capital

assets, although the buildings are not necessarily in the right place and many are below standard. Our task is to maximise the use of the estate that we have and to use our assets strategically to deliver our goals.

Currently each Trust is responsible for its own assets and making best use of these. The proceeds from a sale of assets identified as surplus to requirements can be reinvested, subject to business case approval by commissioners and NHS London, in Trust developments. By planning and co-ordinating a sector-wide estates strategy, we have the potential to deliver more strategic benefits. The ability to move capital between organisations would allow the Sector to maximise the use of assets and would benefit the health economy as a whole.

An analysis of the quality of estates based on data collected through the Estates Return Information Collection (ERIC) shows it is possible to compare NCL sites against 3 KPIs:

5. Functional unsuitability
6. Risk adjusted backlog costs
7. Building age profile

The NHS London Estates Review has shown that all sites across NCL have estate issues and identifies Chase Farm Hospital as both scoring relatively low overall and having the most potential to improve and release assets.

Our modelling shows that we will have an excess of beds by 2016 and we need to work closely with Trusts to ensure our estate is fully utilised. Any surplus estate could be used to fund capital developments in line with our plans.

With regard to mental health estates, there are sites that are relatively under-utilised and others that mostly comprise of very old stock. Our aim is to re-provide services, where possible, in updated facilities. On several sites, mental health services and acute services are co-located and as we implement our plans this may create opportunities for acute and mental health providers.

All the PCTs are conducting a review of their estates at present; as a Sector, we will bring these together to ensure benefits across NCL.

Capital requirements

Once the Sector review is completed with clear options for service improvement, we will develop the pre-consultation business care which will identify capital requirements. At present there are two areas when capital investment is already prioritised by the Sector:

- Investments in polysystem hubs
- The BEH Clinical Strategy

There are a number of sources for capital that can be used:

- Trust borrowing
- PFI
- LIFT
- Joint Ventures
- Third Party Capital
- GPs
- Land sales
- Public Dividend Capital

Each of these sources will be considered on a case by case basis as we produce our business case. It has been proposed that land sales on the Chase Farm site should be a contributory source of funding for the North Middlesex development, although this is yet to be agreed.

PCT plans reflect the expectation that they will manage the implementation of polysystems within the resources available to each PCT.

Actions

8. PCTs to complete estate review and identify sites and funding sources for polysystem development
9. Sector to identify potential capital developments with acute and mental health trusts
10. Sector to work with CSL to shift estate strategy development functions to the Sector

8.4.2 Workforce

'Workforce for London – A Strategic Framework' outlined the workforce changes required across London to deliver the HfL vision. The Sector will develop a local workforce strategy and implementation plan to support the delivery of the Sector Plan.

The Workforce Strategy will reflect:

- The Sector initiatives for delivery of its vision and goals
- The need for a flexible workforce reflecting the competencies required to work across pathways and in different care settings
- The need to ensure productivity improvement to ensure that the workforce planned will be affordable
- The workforce implications of the changing provider landscape
- The impact on training and education of the Sector strategy

The implementation plan will detail how the Sector will address:

- The interventions required at a London, Sector and local employer level to ensure that the workforce supply meets the future needs of NCL at an affordable cost
- Workforce planning to inform education and training commissioning for NCL and to ensure future workforce supply
- The design and development of new roles and ways of working to build a polysystem workforce
- Working collaboratively with stakeholders and in partnership across NCL to ensure the effective management of workforce changes as a result of service re-configuration and commissioning decisions. The implementation plan will reflect and learn from the work already underway in NCL associated with the Barnet, Enfield and Haringey clinical strategy
- Fostering and developing leadership across NCL to ensure delivery of the Strategy Plan

Workforce Gap Analysis

NHS London commissioned a workforce gap analysis to assist sectors to understand the future shape and scale of the workforce, and to identify the major workforce changes required.

Across London an oversupply of staff is expected during the life of the Sector Plan. However, the picture varies according to staff group. In some staff groups there will be in oversupply, while there are predicted shortages in other groups.

Staff groups likely to require an increase in staff compared to the 2008/09 position include:

- GP and GP trainees
- Advanced practitioners (across both acute and community settings)
- Assistant Practitioners
- Registered midwives

Actions

11. The Sector has established a senior post for Workforce Transformation. This post will work closely with NCL stakeholders, NHSL and CSL in developing the Sector workforce strategy and implementation plan to 2015. The first phase of this work will be completed by April 2010

12. NCL will work closely with the NHS London Workforce Intelligence Unit to support the development of the workforce planning system in London to ensure informed education commissioning and workforce supply
13. NCL is actively supporting the Sector Healthcare Education and Innovation Cluster (HIEC) and will work with both UCLH and partners and the NCL HEIC to deliver a workforce which fully supports the strategy

Organisational Development

Over time it is expected that sectors will be strengthen by combining the skill and resources of their constituent PCTs and this will lead to improved commission against the World Class Commissioning assessment criteria. In 2010/11, NCL JCPCT has identified the need to conduct a skills audit, consider how it will approach financial balance across NCL and reflect on the governance and accountability arrangements that might be required to underpin this.

Our first priority is to strengthen our financial management to ensure the future development of healthcare in North Central London. The five PCTs are committed to sector-wide working and there are already several examples of this:

- Establishing a contingency fund to manage acute sector commissioning risk
- Creating a wider pool of non recurrent funding to support transitional change with clear rules on incentives and penalties around accessing the fund
- Implementing a core programme of common demand management and decommissioning areas for all PCTs. In addition, all PCTs will work to a common set of contractual levers through the Acute Agency
- Identification of priority programmes for sector-wide working

The Acute Commissioning Agency is developing an Organisational Development Plan to ensure the development of acute hospital service commissioning in North Central London. This will completed during the first quarter of 2010/11.

The Sector will consider the implications of delivery of the Sector plan ensuring that we maintain the strong clinical leadership required to transform health care. We will reflect on the governance arrangements in place and strengthen as required to ensure delivery. We will stimulate work across NCL to build an integrated approach to organisational development with a focus on leadership and talent management to enable the implementation of new pathways of care in polysystems.

8.4.3 Information Technology

As more health care in provided either at home or closer to home along agreed pathways of care, it will be essential to ensure that all the health professionals involved have access to an up to date patient record. At present there is a London wide Connecting for Health Programme with three work streams - acute, primary care and mental health – that links to 18 local health communities. A series of workshops have been provided to discuss the IT implications for polysystems, organisational merger, mental health and integration to emphasise the dependency of change delivery on robust IT systems. The outputs of these workshops and a number of London pilots schemes will be incorporated into future strategy work.

NHS London has scoped an enabling strategy for IT which will support integrated care across London. The main actions that will facilitate polysystem development are:

- London-wide rollout of the Summary Care Record; this ie being piloted and is due to complet by March 2011
- The roll out of image exchange systems, such as PACS, between hospitals and potentially polysystems. This will enable consistent patient care, for example between hyper acute stroke units and their networks. This will be implemented in 2010
- Pilot polysystem appointment systems

At a Sector level, there is an opportunity now to begin to integrate the development of IT with our pathways and care settings so that implementation is fully co-ordinated. This will require dedicated resource at the Sector level and clarity of roles and functions between national, London, sector and organisational level and a clear programme of delivery via the BT contract.

Actions

14. NCL will explore the need for a senior post to co-ordinate the Sector IM&T Strategy and the interface with the connecting for health London programme
15. Work with London Connecting for Health to align our CSP with a Sector IM&T Strategy
16. Each workstream will identify IT dependencies required to implement the initiatives in this Plan.

8.4.4 Communications

The Sector recognises the fundamental importance that effective communication will have in the achievement of its sector-wide vision. The main focus of the North Central London Communications Strategy is to support the successful reconfiguration of services within the Sector by ensuring stakeholders are as engaged and supportive as possible.

Objectives of NCL communications and engagement

- To ensure that the views of stakeholders properly inform and shape the work of the Sector
- To ensure stakeholders have sufficient information about Sector activities to meet their needs
- To deliver a broad range of communications and engagement activity, using a wide range of tools and techniques, that will serve to engage fully and appropriately with as wide an audience as possible
- To work in a co-ordinated way with PCTs and providers so that there is a consistency of messages, communications and engagement activity across NCL
- To support the undertaking of formal public consultations, when necessary to support Sector initiatives (e.g. SOR).

In the short term, the aim is to inform stakeholders of the NCL case for change and emerging plans for reconfiguration to ensure that accurate messages are in the public domain. We need to build effective structures to enable this. Over the longer term the NCL Communications team aims to build up relationships and develop effective stakeholder involvement that will shape local services.

The NCL Communications team has identified a range of comprehensive stakeholder engagement channels, events and opportunities ensuring particular focus on hard to reach groups and work with wider stakeholder groups including local and campaign groups. Robust stakeholder engagement structures will be established so that deliberations and recommendations of the SOR Steering Group and individual work streams are informed by relevant stakeholder views.

Actions

17. To develop a stakeholder map and related database to support communications and engagement activity with each identified stakeholder or group of stakeholders who may influence or have an opinion on the development of the SOR. This will be closely aligned with the Acute Commissioning Agency
18. To support the development of a stakeholder map and related database for each of the NCL workstreams
19. To deliver a broad range of communications and engagement activity (from early engagement, through pre-consultation and any formal public consultation processes), using a localised ‘North Central London’ branding and a wide range of tools and techniques. This activity will serve to engage with the widest possible audiences in the development of NCL plans. A range of approaches will be used including deliberative events, face to face interviews, focus groups, letters, briefing sessions and website construction. We will aim to use a wide range of feedback channels

20. To establish the level of resource that is available within PCTs to support both pre-consultation engagement and the future delivery of formal statutory public consultation; coordination of this resource
21. Develop the first draft of the full and summary public consultation documents for any full public statutory consultation, which will present to the public the agreed Cases for Change for clinical services and suggested reconfiguration, and any recommendations developed through the pre-consultation engagement work
22. To develop a wide acceptance across all stakeholders of the need for a whole-system transformation of the NHS in North Central London, in line with the NCL CSP
23. To ensure a consistency of messages and of communications and engagement activity across NCL, including alignment with the work of the ACA, the BEH strategy and other sector-wide initiatives

Feedback gathered from communications channels prior and during any consultation will be reported in a timely efficient manner and shared with necessary decision makers. The communications and engagement strategy sets out clearly the roles, functions and skills required for effectively informing, engaging and involving stakeholders.

The NCL team aim to build up positive relationships with media by providing pro-active press releases and re-acting in a positive manner to press inquires.

8.5 Risk Management

Figure 37 identifies delivery risks against each of our key initiatives alongside mitigating actions.

Figure 37: Risk matrix for NCL with associated mitigating actions

#	Risk	Impact	Likelihood	Mitigating actions
	General : Affordability			
1	The sector funding gap identified is incorrect due to inaccuracy of the financial modelling assumptions used	High	Low	Ongoing review of emerging demand and funding information and refresh of modelling as appropriate
2	Staff capacity and capability required to deliver the strategy is not in place	High	Medium	Develop existing staff skills within sector and PCT teams Commissioning of external support as appropriate
	Initiative: Coordination of sector polysystem implementation			
3	Plans and timescales for implementing individual polysystem hubs do not align with the timescales for transfer of work from acute settings	Medium	Low	Timeline for completion of pathways is 2010/11. Individual PCTs involved in pathway work
4	Lack of clarity on organisational form and governance of polysystems delays implementation	Medium	Medium	Established working group to examine possibility of vertical integration Continued liaison with CSL
	Initiative: Reconfiguration of acute care settings within NCL			
5	Local and national politics inhibit progress and influence final outcomes	High	High	Communications and engagement plan implemented and refreshed quarterly. Pre-consultation business case to identify benefits of reconfiguration
6	Stakeholders are not engaged adequately throughout the process and core stakeholder buy-in is not maintained	High	Medium	Communications plan in place. Existing governance structure of the review programme to continue to ensure adequate engagement with key stakeholders.
7	Lack of clinical consensus and leadership result in options that are not sufficiently ambitious	High	Medium	Continued clinical engagement via the CAG and medical directors Widen clinical engagement during the option appraisal and business development phase
	Initiative: Development of mental health care pathways			
8	Links with the development of polysystem pathways are not maintained and speed of development is not consistent	Medium	Medium	Mental health representative on the polysystem working group
9	Local and national politics inhibit progress and influence final outcomes of site rationalisation work	High	High	Communications and engagement plan implemented and refreshed quarterly. Ensure appropriate level of engagement with local authority partners Pre-consultation business case to identify benefits of reconfiguration
	Initiative: Implementation of NCL maternity improvement programme			
10	Increased resources required to commission maternity services appropriately due to changes in HRG4	High	High	Close coordination with ACA around maternity commissioning to iron out HRG 4 impact Integrated commissioning of primary and secondary care services to negate potential funding decrease
11	Additional requirement for maternity funding at risk due to financial constraints	High	High	Close coordination with ACA around maternity commissioning to iron out HRG 4 impact Redesign of primary and secondary care services to negate potential funding decrease
	Initiative: Stroke			
12	Slippage in implementation of the HSAU	Medium	Medium	Close coordination with ACA and UCLH
	Initiative: Cardiac			
13	NCL porviders not compliant with the new London review of co-dependancies	Medium	High	Review of services with Cardiac Network and agree plan with ACA to ensure quality and move to compliance as required
	Initiative: Cancer			
14	Failure to meet IOG and performance standards	Medium	Medium	Cancer network and commissioning board agree paln. ACA monitor develivery

9. Declaration of board approval

NCL SOR has engaged extensively with clinicians, NHS staff and health partners and has begun engagement with patient and the public to inform development of the Sector commissioning strategy plan. Our CAG has met on a monthly basis since July 2008 and more often as required. Their work has generated a clinical model based on implementing the HfL care pathways that is shaping our options for future delivery. This work has been reported to the JCPCT.

The Technical Advisory Group has overseen the development of a detailed finance and activity model by external consultants, ensuring that the assumptions and the outputs are reasonable and make sense to local organisations. The outputs have been reported to the JCPCT and underpin our affordability analysis.

We commissioned an independent organisation to facilitate a deliberative event with members of the public who reflected the make up our population to gain insight into their views on the case for change and we plan to run a series of similar event through the life of the programme.

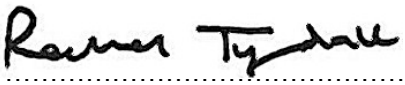
The JCPCT approved the case for change and has discussed a draft CSP in its December and January Boards. The JCPCT has provided challenge and leadership to this process, and there is clear evidence that the Plan has changed and developed following JCPCT discussion. The JCPCT is fully committed to the priorities it contains and to developing and monitoring plans to transform health care in NCL. The strategy has been reviewed by NCL's constituent PCTs.

At its January meeting, the JCPCT empowered the Sector Chair and Chief Executive Officer to submit the documents and sign the declaration on their behalf.

25th January 2010

Paul Kahn — Date

Chair of North Central London Joint Committee of Primary Care Trusts



25th January 2010

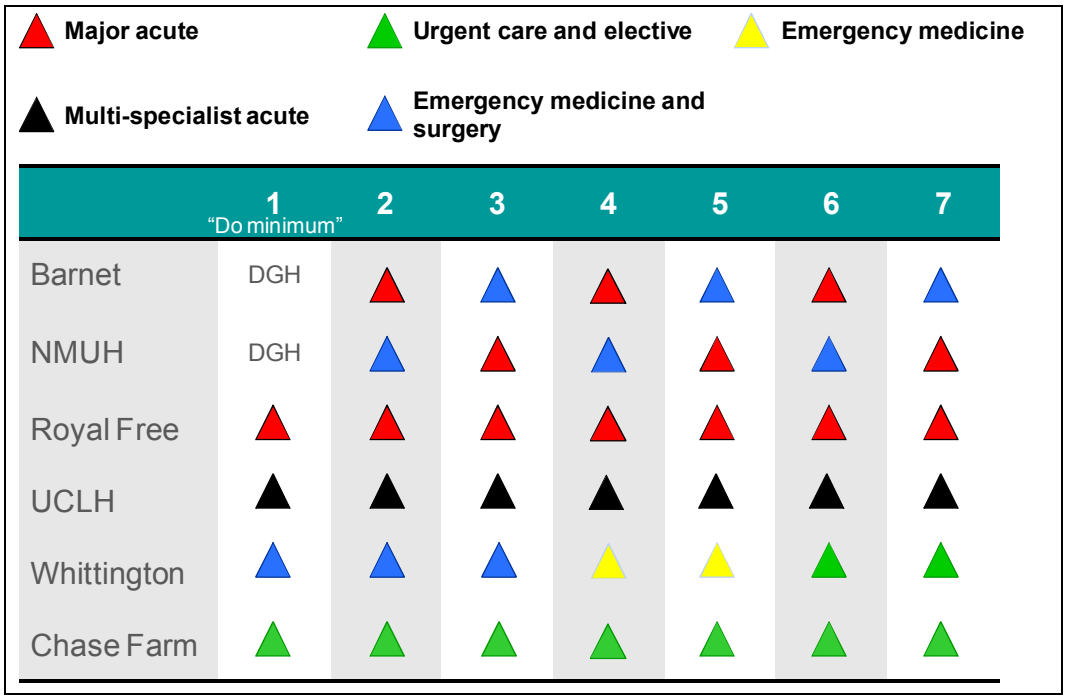
Rachel Tyndall — Date

Chief Executive Officer for North Central London Sector

Appendix A: Acute reconfiguration scenarios

The following tables outline the seven potential reconfiguration scenarios being reviewed by the JCPCT. Figure 38 summarises all seven options; the following figures outline the details of each individual option. The term DGH (district general hospital) refers to a current configuration of services as opposed to an HfL configuration.

Figure 38: The seven reconfiguration scenarios

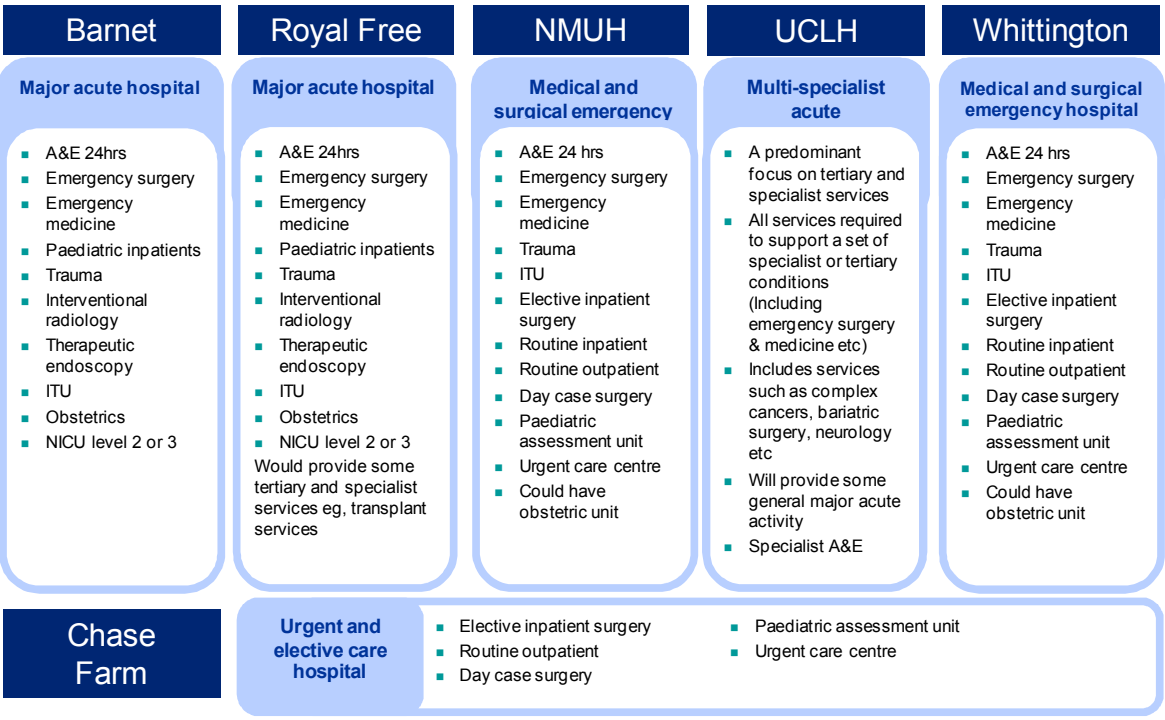


Scenario 1 is the "do minimum" option, where the BEH clinical strategy is implemented, and the Whittington moves to the HfL local hospital model

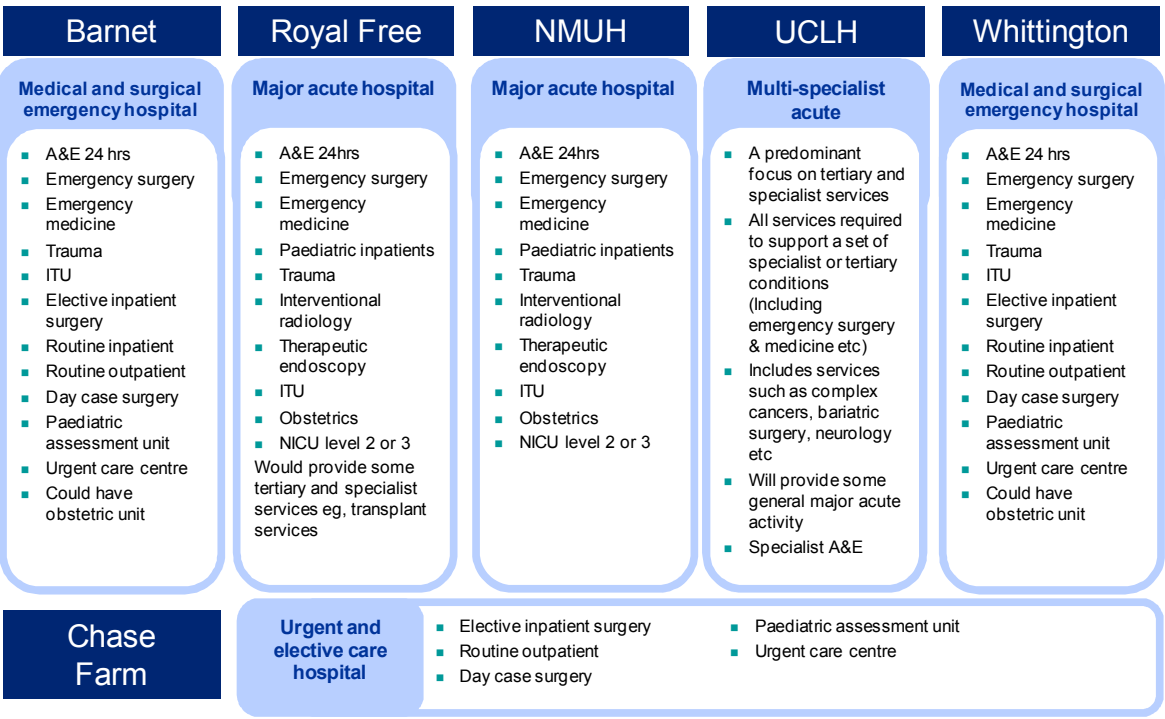
Barnet	Royal Free	North Midds	UCLH	Whittington
As per BEH strategy	Major acute hospital	As per BEH strategy	Multi-specialist acute	Medical and surgical emergency hospital
DGH	▪ A&E 24hrs ▪ Emergency surgery ▪ Emergency medicine ▪ Paediatric inpatients ▪ Trauma ▪ Interventional radiology ▪ Therapeutic endoscopy ▪ ITU ▪ Obstetrics ▪ NICU level 2 or 3 Would provide some tertiary and specialist services eg, transplant services	DGH	▪ A predominant focus on tertiary and specialist services ▪ All services required to support a set of specialist or tertiary conditions (Including emergency surgery & medicine etc) ▪ Includes services such as complex cancers, bariatric surgery, neurology etc ▪ Will provide some general major acute activity ▪ Specialist A&E	▪ A&E 24 hrs ▪ Emergency surgery ▪ Emergency medicine ▪ Trauma ▪ ITU ▪ Elective inpatient surgery ▪ Routine inpatient ▪ Routine outpatient ▪ Day case surgery ▪ Paediatric assessment unit ▪ Urgent care centre ▪ Could have obstetric unit

Chase Farm	Urgent and elective care hospital		
	▪ Elective inpatient surgery ▪ Routine outpatient ▪ Day case surgery	▪ Paediatric assessment unit ▪ Urgent care centre	

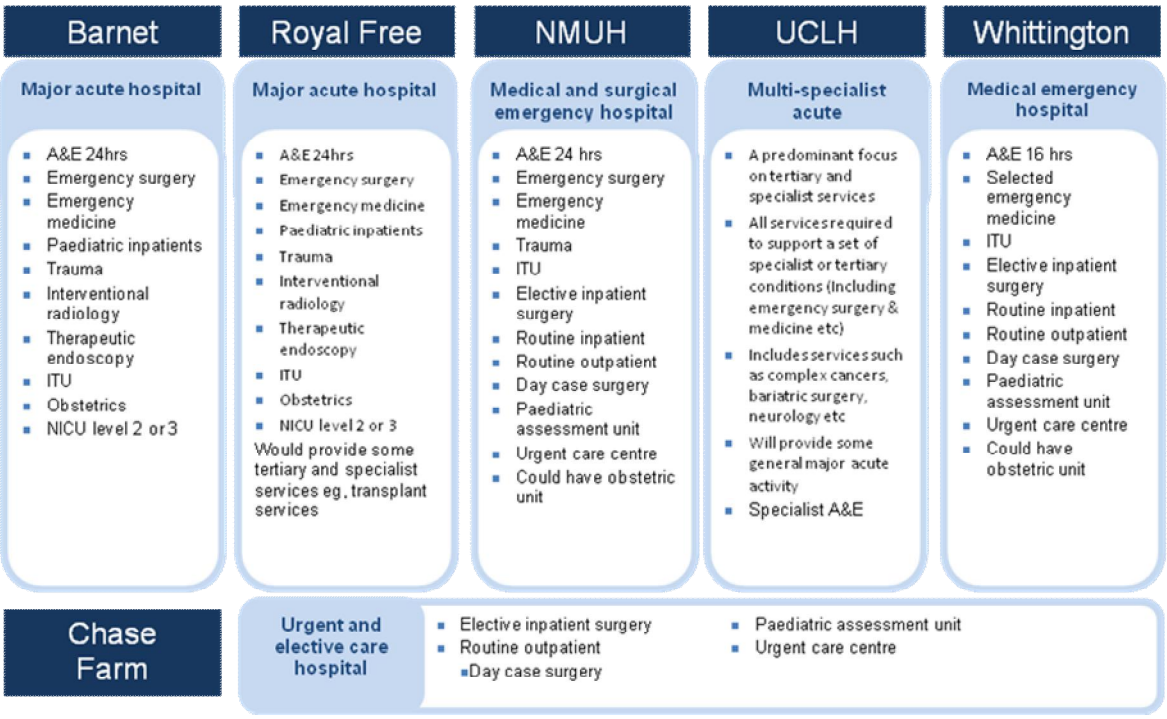
Scenario 2 builds on the BEH strategy; Barnet is a major acute and NMUH and the Whittington become medical and surgical emergency hospitals



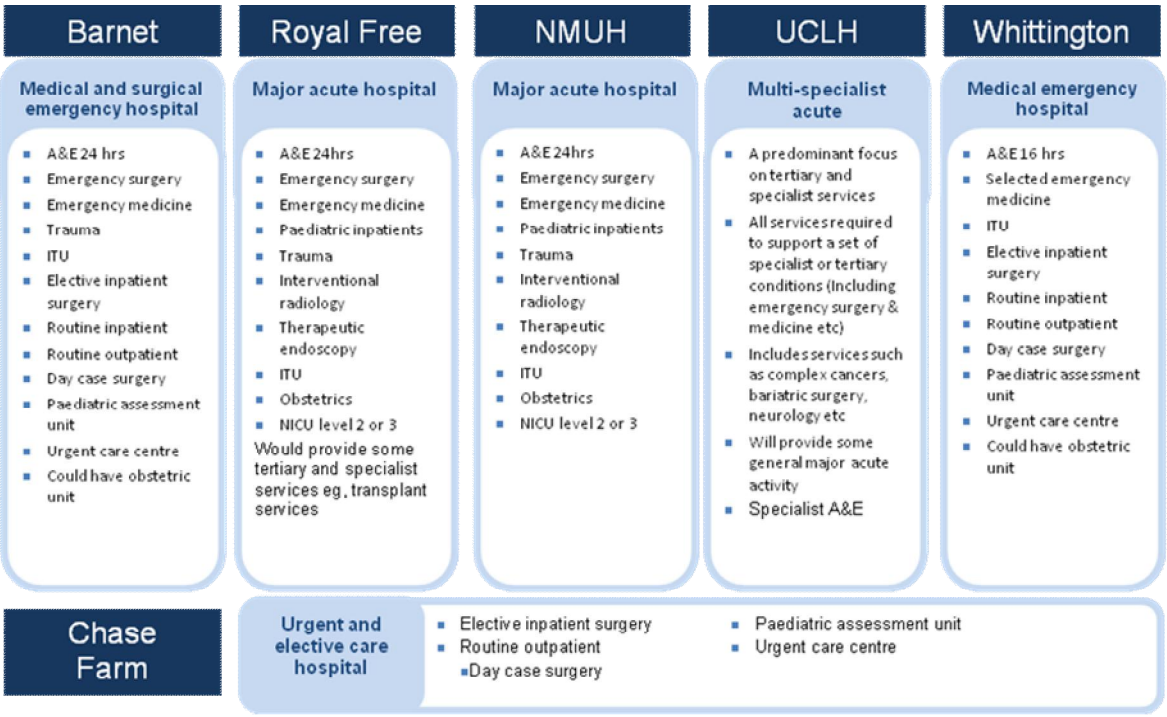
Scenario 3 builds on the BEH strategy; NMUH is a major acute and Barnet and the Whittington become medical and surgical emergency hospitals



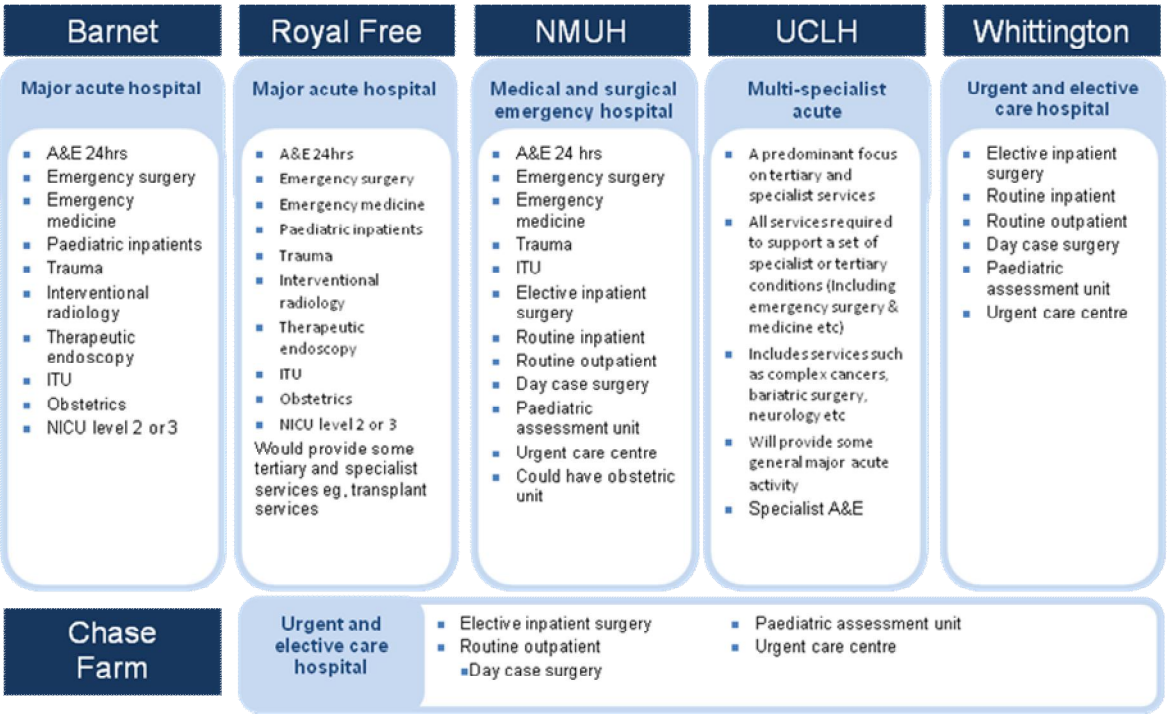
Scenario 4 builds on the BEH strategy; Barnet is a major acute, NMUH a medical and surgical emergency hospital, and the Whittington a medical emergency hospital



Scenario 5 builds on the BEH strategy; NMUH is a major acute, Barnet a medical and surgical emergency hospital, and the Whittington a medical emergency hospital



Scenario 6 builds on the BEH strategy; Barnet is a major acute, NMUH a medical and surgical emergency hospital, and the Whittington an urgent and elective care hospital



Scenario 7 builds on the BEH strategy; NMUH is a major acute, Barnet a medical and surgical emergency hospital, and the Whittington an urgent and elective care hospital