

# DRAFT - POLICY IN DEVELOPMENT

## North east London: Sustainability and Transformation Plan

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*Transformation  
underpinned by system  
thinking and local action*



**30 June 2016**

**This draft document has been submitted to NHS England/ NHS Improvement ahead of the review meeting on 14 July 2016. It reflects the high level national requirement. A fuller STP will be developed in the autumn following feedback.**

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### ***Guide to reading this document***

- Acronyms used throughout the document are explained in the appendix, page 43.
- We assign specific symbols to each of our six key priorities, introduced on page 6. Where a section addresses a key priority, the relevant symbol is shown in the top right corner of the page.
- Deliverables are outlined at the end of each chapter or section, where applicable, and detailed deliverables are available in the appendix, pages 41-42.



# 1. Executive Summary

We want people in north east London (NEL) to live happy and healthy lives. To achieve this, we must make changes to how local people live, access care, and how care is delivered. **Over the past six months, 20 organisations across NEL have worked together to develop a sustainability and transformation plan (STP).** This builds on our positive experiences of collaboration in NEL but also protects and promotes autonomy for all of the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. We all recognise that we must work together to address these challenges; this will give us the best opportunity to make our health economy sustainable by 2021 and beyond.

We have adopted a joint vision:

1. To measurably improve health and wellbeing outcomes for the people of NEL and ensure sustainable health and social care services, built around the needs of local people.
2. To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
3. To work in partnership to commission, contract and deliver services efficiently and safely.

**NEL is an area with significant health and wellbeing challenges.** Our population is set to grow by 18% in the next fifteen years, and five out of our eight boroughs are in the lowest quintile for deprivation in the UK. Health inequalities are high, with many residents challenged by poor physical and mental health driven by factors such as smoking and childhood obesity. People frequently move around the patch and are highly dependent on secondary care. This makes our challenges unique and places significant pressure on local services.

**We have developed a NEL level framework that will ensure every patient receives the same level of high quality care.** Our primary ambition is to support local people to manage their own health. On this basis we have built a framework designed to deliver consistent primary care across NEL, promote out-of-hospital services, encourage preventative activities and champion interventions which tackle the wider determinants of health and wellbeing. This framework will be guided by the principle of “system thinking and local action” to enable system-wide change, while allowing for local flexibility.

**We want our hospitals to provide care that is safe, effective and efficient every time.** The majority of our hospitals have underperformed in recent inspections and continue to fail to meet some of the expected standards around waiting times. We want our hospitals to attain a world class reputation for services, and plan to establish this through developing ambulatory care, surgical hubs and streamlined outpatient pathways. This will help us to tackle operational challenges and provide safe and compassionate

secondary care.

**Providers have a unique opportunity to increase their productivity through collaboration.** Cost improvement programmes will no longer be enough to achieve the scale of efficiency required to address our system-wide financial challenge. The STP has given providers the impetus to co-design new opportunities for productivity and service efficiency improvements beyond traditional organisational boundaries. This will give us the strongest opportunity to achieve savings on the scale set out in the Carter Review.

**Our vision for better care and wellbeing will be supported by system reform including the development of new commissioning and provider models.** Across NEL, we have already started to develop innovative commissioning models (for example capitated budgets in WEL) and work is ongoing to explore further opportunities through our devolution pilots (BHR and CH). Our providers are also working differently to ensure their organisational governance and staffing models can support the shift to integrated care and an emphasis on out-of-hospital interventions.

**As part of this transformation, we have identified workforce, technology and infrastructure as key enablers which will require investment and development.** Without this, we will not succeed in implementing better care and wellbeing for people or a sustainable system-wide position. We don't yet have all of the answers about how we can transform our workforce or better use our estates but we are working to identify priorities that we can all sign up to.

**Our total financial challenge in a ‘do nothing’ scenario would be £847m by 2021.** Achieving ambitious ‘business as usual’ cost improvements as we have done in the past would still leave us with a funding gap of £444m by 2021. Through the STP, we have identified a range of opportunities and interventions to help reduce the gap significantly. This will be aided with STF funding, specialised commissioning savings and potential support for excess PFI costs. There is still significant work to do to evaluate the savings opportunities, particularly on specialised commissioning.

**Developing our governance structures will be essential for ensuring the next stages of planning and implementation are effective.** We want a robust governance structure that allows individual organisations to share responsibility while balancing the need for autonomy, accountability and public and patient involvement.

**The NEL transformation journey has already started.** We are committed to meeting all NHS core standards and delivering progress in every workstream. Together we will deliver a sustainable health and wellbeing economy across NEL. **It's a significant challenge, but one we welcome as it provides opportunities to make a real and lasting difference to the lives of local people.**

# 2. NEL Care, Quality and Wellbeing Challenges

There are a number of challenges NEL is facing from a health and wellbeing as well as a care and quality perspective which are summarised below and on page 5. For a summary of the financial challenges see chapter 7.

## Health and wellbeing challenges

### Demographics

- There is significant **deprivation** (five of the eight STP boroughs are in the **worst IMD quintile**). Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is a significant **projected increase in population** of 6.1% in five years and **18% over 15 years**. This population is also highly mobile, with residents who frequently move between boroughs and patches.
- There are significant health inequalities across NEL and within boroughs, in terms of **life expectancy** and **years of life lived with poor health**.

### Wellbeing

- NEL has higher rates of **obesity among children** starting primary school than the averages for England and London. All areas have cited this as a priority requiring system-wide change across the NHS as well as local government.
- **Health inequalities** remain a significant issue in NEL with diabetes, dementia and obesity all disproportionately affecting people in poverty.
- NEL has generally high rates of **physically inactive adults**.



### Long-term conditions

- There is an increased risk of mortality among people with **diabetes** in NEL and an increasing 'at risk' population. The proportion of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is variable. Primary care prescribing costs are high for endocrine conditions (which includes diabetes).
- **Cancer screening uptake** is below the England average and emergency presentation is 5% higher than the national average.

### Mental health

- With a rising older population, continuing work towards early diagnosis of **dementia** and social management will remain a priority. Three of seven CCGs are not hitting the **dementia diagnosis target**. Right Care analysis identified that for NEL, rates of admission for people aged over 65 with dementia are poor.
- Most CCGs, but not all, are meeting **IAPT access targets**.
- Parity of esteem has not yet been achieved across NEL.
- Acute mental health indicators in the Mental Health task force report identify good performance, however **concerns have been identified with levels of new psychosis presentation**. Further work is required to quantify and respond to challenges such as **high first episode psychosis rates**.
- There is a **low employment rate** for those with mental illness.



Care and quality challenges

The care and quality challenges outlined below exist across NEL. They are present in some CCGs, but may not necessarily be in all. We recognise there are some areas of excellent care and quality; nevertheless, the challenge remains substantial. The rest of this document presents several plans and/or solutions that will help reduce and ultimately resolve all of our challenges across NEL.

- Two of three acute trusts failing A&E 4hr target waits.
- Two of three acute trusts failing to return monthly 18 week RTT pathway data.
- Two of three acute trusts (six out of seven hospital sites) in special measures after CQC inspections.
- All seven CCGs failing 75% Category A ambulance response times within eight minutes.
- Variation in emergency bed days and GP referral rates across all seven CCGs.

Core Standards

- Inconsistent consultant assessment for emergency admissions across specialities in NEL providers (standard two).
- Inconsistent consultant ward reviews across specialities in NEL providers (standard eight).
- A need to support patient activation and self-care.

7 Day Services / UEC reforms

- Further work is needed to improve the wider determinants of mental health.
- Inconsistent diagnosis rates of dementia in NEL GPs.
- New access to treatment target for psychosis to be published in April 2016 – no current baseline.
- Perinatal mental health strategy for NEL to be developed to tackle variation in access to services.

Mental Health

- Do not currently meet National Service Model standards for patients with learning disabilities.
- Greater focus required on community and prevention services including dental care, type two diabetes, and breast screening.
- Workforce training required to equip staff with the skills and knowledge to support patients with learning disabilities and autism.
- Need to build capability and capacity within communities to support people with autism and avoid unnecessary hospital admissions.

Learning Disabilities

- CCGs below national average on Patient Survey for success in getting an appointment and ease of getting through on the phone.
- Demand for appointments is rising with GP consultation rates increasing.
- Highly mobile population and high practice list turnover generating further demand.
- Challenge in securing the primary care workforce with example of more than 25% of GPs being beyond retirement age in one borough.

Primary Care

- The increase in births presents a significant challenge to capacity for maternity services.
- There is currently under utilisation of midwifery led care pathways and birth settings.
- There is a lack of continuity of care across the maternity pathway and women's experiences of care are often reported as being poor.
- Variation in benchmarked data of UK perinatal deaths for births across NEL providers.
- Many more women with complex health needs are now becoming pregnant.

Maternity

- Inconsistent patient experience results from Friends and Family Test for A&E, inpatients, maternity and outpatients.
- Inconsistent patient experience results from Friends and Family Test for mental health providers.
- In some areas, only 22-29% of patients are dying in their preferred place of residence.

Patient Experience

- The cancer treatment pathway is very fragmented with many challenges.
- Emergency cancer presentations are 25.5% in NEL (20.6% England average-indicates worse survival rates at one year).
- Lower one year survival rate for all cancers across all seven CCGs compared to all survival rates across England.
- Two of three trusts failing 62 day cancer wait for urgent GP referral.

Cancer

- In cluster comparison of Right Care data, cancer survival is a key area of improvement across NEL.
- Mental health, patient experience, prevention and new models of care are other key opportunity areas for NEL commissioners.
- Potential savings through primary care prescribing:
  - £5-10m in endocrine
  - £3m in respiratory
  - £1-2m in each of CVD, GI and MSK.

Right Care

- Delivery of constitutional standards for RTT, 62 day wait for cancer.
- Resolution of local derogations for certain specialities for example chemotherapy, specialised neurology, NICU.
- Key strategic intervention in NEL is the joint work on neuro-rehabilitation.
- Service reviews for the transfer of cardiac services from UCLH, trauma, and cancer Services.
- NICU capacity.

Specialised Commissioning

- Unable to maintain services; there is a need to recruit and retain to ensure we are able to maintain services in the face of an ageing workforce.
- Over-reliance on agency use.
- A need for the development of new roles/extended scope and skills.
- A need for multidisciplinary teams working to support new care models.

Workforce

- There is a need across NEL to:
- Provide the infrastructure necessary to support new, connected, ways of working.
  - Provide clinicians with a full view of the patient electronic health record in real time that is editable and supports bookings across services.
  - Deliver population health through real time risk stratification scoring.
  - Enable patients to view their own care records and to make bookings in to their primary care providers.

Technology



## Our key priorities

Whilst each of our economies has a different starting point, on the basis of the NEL-wide challenges set out we have identified six key priorities which need to be addressed collectively.

<p><b>How can we ensure that we channel demand with appropriate capacity in NEL?</b></p>  <p>See Better Care (p7)</p>	<p>Our population is projected to grow at the fastest rate in London (18% over 15 years to reach 345,000 additional people) and this is putting pressure on all health and social care services. Adding to this, people in NEL are highly diverse. They also tend to be mobile, moving frequently between boroughs and are more dependent on A&amp;E and acute services. If we do not make changes, we will need to meet this demand through building another hospital. We need to find a way to <b>channel the demand for services</b> through <b>maximising prevention</b>, supporting self-care and innovating in the way we deliver services. <b>It is important to note that even with successful prevention, NEL's high birth rate means that we may need to increase our physical infrastructure.</b></p>
<p><b>How do we transform our delivery models to support self-care, deliver better care close to home and high quality secondary care?</b></p>  <p>See Better Care (p7)</p>	<p>Transforming our delivery models is essential to empowering our residents to manage their own health and wellbeing and tackling the variations in quality, access and outcomes that exist in NEL. There are still <b>pockets of poor primary care quality and delivery</b>. We have a history of innovation with two of the five <b>devolution pilots (see appendix for detailed plans)</b> in London, an Urgent and Emergency Care (UEC) vanguard and a Multispecialty Community Provider (MCP) in development. However, we realise that these separate delivery models in each health economy will not deliver the benefits of transformative change. Crucially, we must <b>establish a system vision</b> that leverages community assets and ensures that residents are <b>proactive</b> in managing their own physical and mental health and receive coordinated, quality care in the right setting.</p>
<p><b>How can we ensure that our health and social care providers remain sustainable?</b></p>  <p>See Better Care (p7)</p>	<p>Many of our health and social care providers face challenging financial circumstances; this is especially true with Barts Health and BHRUT being in special measures. Both are currently being re-inspected to ensure that all necessary recommendations are embedded. Although our hospitals have made significant progress in creating productivity and improvement programmes, we recognise that medium term provider-led cost improvement plans cannot succeed in isolation: our providers need to collaborate on improving the costs of workforce, support services and diagnostics. Our challenge is to create a roadmap for viability that is supported at <b>a whole system level</b> with NEL coordinated support, transparency and accountability.</p>
<p><b>How do we transform specialised services through collaborative working?</b></p>  <p>See Specialised Services (p18)</p>	<p>NEL residents are served by a number of high quality and world class specialist services; many of these are based within NEL, others are across London. We have made progress recently in reconfiguring our local cancer and cardiac provision. However, the quality and sustainability of specialist services varies and we need to ensure that we realise the benefits of the reviews that have been carried out so far. Our local financial gap of £134m and the need for <b>collaboration</b> both present challenges to the transformation of our specialised services. We need to move to a more collaborative working structure in order to ensure high quality, accessible specialist services for our residents, both within and outside our region, and to realise our vision of becoming a truly world class destination for specialist services.</p>
<p><b>How can we create a system-wide decision making model that enables placed-based care and clearly involves key partner agencies?</b></p>  <p>See Governance (p31)</p>	<p>Our plans for proactive, integrated, and coordinated care require changes to the way we work in developing system leadership and transforming commissioning. We have plans to <b>transform commissioning</b> with capitated budgets in WEL, a pooled health and social care budget in BHR and in CH. Across NEL, we recognise that creating accountable care systems with integrated care across sectors will require joining previously separate services and close working between local authorities and other partners; our plans for <b>devolution</b> (see appendix) have made significant progress in meeting the challenge of integration. New models of system leadership and commissioning that are driven by real time data, have the ability to support delivery models that are truly <b>people-centred and sustainable</b> in the long term.</p>
<p><b>How do we maximise the use of our infrastructure so that it supports our vision (and plans owned at a NEL level)?</b></p>  <p>See Infrastructure (p25)</p>	<p>Delivering new models of primary and secondary care at scale will require modern, fit-for-purpose and cost-effective infrastructure. Currently, our workforce model is outdated as are many of our buildings; Whipps Cross, for example, requires £80 million of critical maintenance. This issue is compounded by the fact that some providers face significant financial pressures stemming from around <b>£53m remaining excess PFI cost</b>. Some assets will require significant investment, others will need to be sold. The benefits from sale of resources will be reinvested in the NEL health and social systems. <b>Devolution</b> will be helpful in supporting this vision. <b>Coordinating and owning a plan</b> for infrastructure and estates at a NEL level will be challenging; <b>we need to develop approaches to risk and gain share that support our vision.</b></p>



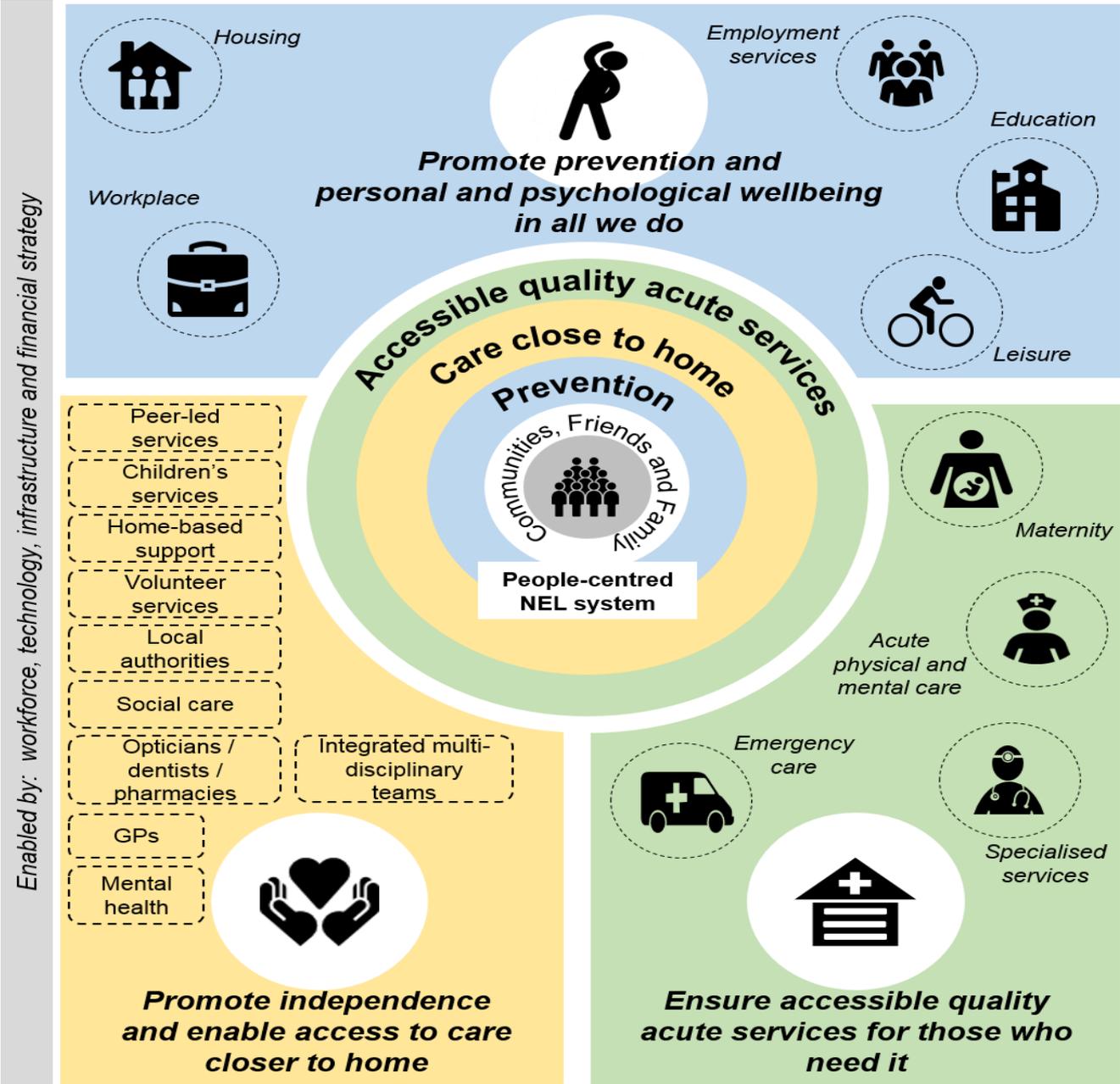
# 3. Better Care and Wellbeing

Through this STP we have developed a single vision for NEL. To implement this vision we have developed a common framework that will be consistently adopted across the system through our new model of care programmes. This framework is built around our commitment to person-centred, place-based care for the population of NEL.

Within this framework, our top three priorities for better care and wellbeing are:

1. *Promoting prevention and self-care* – in order to reduce the burden on health care services, we aim to promote self-management and prevention amongst residents in NEL.
2. *Improving primary care* – to meet the rising demand placed on our existing primary care services, we are transforming our primary care around collaboration at scale and the use of multidisciplinary teams (MDTs) comprised of community, social care and healthcare professionals.
3. *Reforming acute services* – our acute care provision does not currently meet the required standards and we will reform acute care through pathway redesign and collaboration at scale.

## Our framework for better care and wellbeing





How we will deliver our system vision

**Promote prevention and personal and psychological wellbeing in all we do**

In the first instance, we aim to prevent illness and promote personal and psychological wellbeing in our population, with a focus on tackling health inequalities. By taking a proactive approach to disease prevention, we are addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We are committed to acting on the London Health Commission’s research on prevention<sup>1</sup>. Through the sharing of information between the different stakeholders, we will ensure that people who are at risk are targeted and appropriate interventions are put in place before escalation.

We will also promote self management by helping people to identify resources available to them that promote personal health and wellbeing. Motivating people to take ownership of their health is crucial to our system vision. Healthy behaviours such as physical activity and leisure will be promoted through mechanisms such as social prescribing to empower people to maintain their health and wellbeing.

As environmental factors are important in influencing people’s health and wellbeing, we will also work with local authorities to promote healthy environments to enhance the quality of life for people in NEL. We have significant health inequalities and deprivation, which presents an additional challenge. By linking in with housing, employment and education, we are better able to address the needs of our population.

**Promote independence and enable access to care close to home**

In our bid to deliver care close to home, we will use a delivery model to wrap support around the individual. This delivery model will integrate primary, community and social care.

1. People will be well-informed regarding the resources and services that are available to them, empowering them to choose the most appropriate pathway for their care, reducing the number of unnecessary admissions and A&E attendances.
2. The foundation of our model is primary care collaboration at scale with hubs, networks and federations treating populations of up to 70,000 people, accessible 8am-8pm, 7 days a week.
3. For people with complex health and social care needs, we will deliver coordinated care to support their health and wellbeing.

**Ensure accessible quality acute services for those who need it**

Whilst we need to ensure that people receive high quality care close to home, it is important that when people fall seriously ill or need emergency care, local hospitals provide strong, safe, high-quality and sustainable services. Given the significant population rise, our challenge is to ensure we reduce any unnecessary admissions and attendances, and have best in class length of stay for both planned and unplanned care.

In accordance with the Briggs report, ‘Getting It Right First Time’, our goal is to identify and administer the correct treatment at the appropriate time to standards. We also want to work towards achievement of the London Quality Standards.

1. We will enhance triage in urgent and emergency care settings so that patients receive the appropriate care at the right time according to the severity of their need. Only patients who require more intensive care are admitted, improving bed capacity.
2. If possible, we will take advantage of appropriate consolidation of planned care services to allow for better outcomes and efficiency. In this way, there will be more effective use of experienced staff and specialised equipment available, enhancing clinical productivity.
3. We want to avoid people spending more time than necessary in hospital. We aim to address this through mechanisms such as early support discharge and greater capability and capacity in the community to help people recover and return home.

<sup>1</sup> The London Health Commission was an independent inquiry established in 2014 by the Mayor of London to examine how London’s health and healthcare could be improved for the benefit of our population. In response to its recommendations and unprecedented engagement with Londoners, all London health and care partners (Londoners 32 CCGs, 33 Local Authorities, NHS England (London) and PHE (London) and the GLA) committed to the overarching goal of making London the healthiest major global city and 10 supporting aspirations as laid out in ‘Better Health for London: Next Steps’. We remain committed to this shared London vision and working with London partners in achieving this goal and aspirations.



**Our system vision is based on the best that each of our health economies has to offer**

This vision takes into account the best elements from local plans and scales them over the whole NEL footprint. We need to share best practices developed in local plans to enable our vision of **place-based accountable care systems** in NEL.

**We have been exploring new service models through devolution pilots and transformative models of care**

Each health economy in NEL has been developing innovative service models. In CH and BHR this has been achieved through two of London’s flagship devolution pilots. In WEL it has taken the form of a large scale transformation programme. What is common to each of the models is that they are people-centred, integrate health and social care, deliver care in the right setting and work towards developing collaborative arrangements between providers.

**BHR – New models of place based care**

- Cluster health and wellbeing services in a locality delivery model. Boroughs are divided into localities which contain a population of approximately 50k – 70k people.
- Use the locality delivery model to ensure care is delivered in the right setting every time. To achieve this, BHR are working to develop primary care collaboration at scale, supported by health and wellbeing hubs with a range of services designed to address the wider determinants of good health.
- Create a new staffing model within localities to deliver health, social care and wellbeing services. This model will extend across traditional organisational boundaries and seek to ensure clinicians and others are able to work in the locality.
- BHR is already piloting a small scale ACO building on its work as Year of Care and PMCF pilots - Health 1000 is a specialist primary care provider led by Consultant bringing together primary care, community health, and social care enabled by a capitated budget. It serves a small population of complex patients with five or more long term conditions who are supported by an integrated team to keep them well and out of hospital.

**We are already implementing new models outlined in the Five Year Forward View including a MCP**

Work is being undertaken to explore the delivery of an ACO alongside BHR’s new service model with the exact organisation form being developed. Tower Hamlets is using its vanguard status and is engaged in developing a MCP to deliver care collaboration at scale at an integrated locality level; this approach will be mirrored in development in the rest of WEL. Similarly, CH providers are considering a range of options to integrate commissioning.

It is only with new models of care and supporting business models that the full range of benefits from a place based service model can be achieved.

**WEL – Transforming Services Together (TST)**

- Care delivered close to home, with accessible GPs working at scale in collaborative provider networks serving at least 10,000 people. This will be combined with integrated health and social care targeted towards at-risk patients in their own homes, helping them stay well and manage their illnesses.
- Hospitals that are strong and sustainable with the development of acute care hubs that allow patients to be seen and treated without being unnecessarily admitted. Hospitals will also work in collaborative networks, with hubs which will all deliver a core set of surgeries. Some hubs will also provide specialised surgical procedures.

**Our service model recognises the common elements of these plans and draws them into a single system for NEL residents**

These models have been developed by each health economy drawing on best practise wherever possible and this acts as a good starting point for future changes. We recognise the need to take the best from existing plans and scale the benefits: this has allowed us to come to a NEL service model founded on place-based, integrated, person-centred care delivered at scale.

**CH – Health and social care integration**

- Fully integrated health and social care teams working with primary care.
- Fully integrated commissioning system moving to capitation.
- A prevention strategy facilitated by devolution status that is directed towards population health priorities.
- A single point of access for crises backed up by rapid access to clinical support.
- One Hackney and City Alliance including: mature GP confederation delivering eight high quality at scale contracts in all practices and out-of-hospital care.
- Proactive risk stratification and targeted actions for patients who are most at risk of admission.

**We are using the STP as a starting point to achieve system-wide change**

This STP provides us with the impetus to harness the best that each area has to offer and move towards a visionary, system-wide transformation plan. This offers us our only opportunity to achieve a sustainable position as a NEL health economy and will enable a healthy population to thrive. Our service vision is supported by a place-based care model and a hospital model.



## Promote prevention and personal and psychological wellbeing in all we do

We recognise that NEL is unique in its diversity and the strength of its communities. Each part of this plan recognises that the citizen and patient are part of a vibrant neighbourhood community. We will build on our existing local health and wellbeing strategies and public health initiatives to ensure services are built around, and support neighbourhoods, so the places where people live enable good health. These places may include home, school, the workplace or community settings.

We are committed to acting on **Healthy London Partnership's** research that suggests we can improve the lives of residents and reduce demand on services through enabling people to change their behaviours. This is especially true with smoking, drinking and physical activity.

To encourage people to help themselves and take control of their lives, we will extend social prescribing as one of the ways to recognise the value of neighbourhoods and build on the social capital that people hold while creating less dependence on services. Staff also need to be supported to be agents of change and 'Make Every Contact Count'. This will include a system-wide focus on smoking cessation.

### Wider determinants of health

Working in partnership with and through local authorities and communities in this way allows us to tackle the wider determinants of health (in line with Marmot principles):

*"The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life .. Including economic policies, development agendas, social norms, social policies and political systems"* - World Health Organization

Health interventions alone cannot deliver the change required to tackle these factors and enable our population to better manage their own health and wellbeing. We will focus our work across the system to deliver this change:

#### 1) Early years, schools and healthy families

Local government is driving the "early help offer" by integrating health visiting, children's centres, nursery education and other services so children are ready to learn. A stronger focus on nutrition and dental health in the early years will enable a reduction in childhood obesity and unnecessary hospital admissions for dental caries.

The Healthy Schools programme is being driven by schools and is making an impact on healthy choices. Schools are a major contributor to the local neighbourhood focussing on prevention including raising awareness of addictions to drugs, alcohol and smoking. Working with CAMHS, schools help to build resilience and mental wellbeing in young children and communities.

As we develop new care models across NEL, we will seek to integrate education services at a neighbourhood level and look at how social prescribing can promote education interventions, as well as aligning the early years offer to those wanting to start families. We aim to widen the roll-out of education interventions to reduce the prevalence of obesity (and Type 2 diabetes) and improve the health and wellbeing of children and young people living in NEL to exceed PSA targets.

#### 2) Environment, leisure and physical activity

Green open spaces and transport systems that promote physical activity and healthy lifestyles can have a major impact on health and wellbeing. We will continue to work together to expand ways to maximise these resources and encourage their use through social prescribing.

Tailored behaviour change support will address Type 2 diabetes and obesity levels through the National Diabetes Prevention Programme. We will also address hypertension through tailored behaviour changes.

#### 3) Housing and planning

We recognise NEL has a lack of affordable housing, and high levels of overcrowding and homelessness, which will be exacerbated as our population grows. This requires us to collaborate to better influence decisions on new building developments, ensuring health impact assessments are conducted. We already utilise the Healthy Urban Development Unit (HUDU) model to help us access Community Infrastructure Levies that guarantee there is funding to build the facilities that ensure our new developments support health and wellbeing.

We will also monitor pilots for private sector licencing schemes to understand the impact on housing quality and feasibility to roll out across NEL.

We will ensure health and housing interventions are better aligned by commissioning joint pathways to ensure that those who need support, such as falls adaptations, are able to receive it in a timely manner.

#### 4) Employment

The link between good mental health and wellbeing in employment is well established. We will learn from pilots (planned or underway) across NEL such as wellbeing hubs, which combine health and employment services in one location. We will extend the scope of these hubs to include housing support to address the shortage of affordable housing for our key workers.

One of the success measures of substance misuse services is employment. This principle will be widened to other services. We will explore options for outcomes based commissioning in this area through the BHR ACO work.

There are also opportunities to better link the recruitment challenges we have in health and care services with employability services in the community. This will provide an opportunity to upskill local people to fill local vacancies.

We will work together to create additional internship and apprenticeship opportunities in the health sector for young people, building on the work already underway at Barts Health. As part of the WEL TST programme, we are specifically exploring new courses to support people into new roles such as physician associates and advanced nurse practitioners.

Multidisciplinary primary care staff will widen access to primary care including an expanded and integrated role for pharmacists and Allied Health Professionals (AHPs).

Through these combined activities, we aim to empower people of NEL, and reduce their dependency on services.



## Promote independence and enable access to care close to home

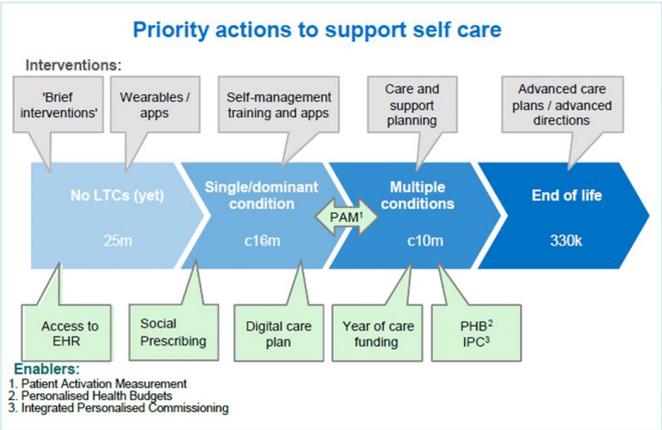
To bring alive the system-wide vision we have for NEL, we have identified a number of service transformation programmes.

### Self-care management and patient activation

Self-care happens when patients are 'activated', and we will promote better self-care, not only by providing better information and resources, and easy access to advice (for example pharmacy) but also through the millions of encounters with health and social services in NEL every year.

A crucial enabler of self-care is IT literacy; residents need to have the skills and the access to technology to identify the right information at the right time and use technology as a route to proactive self-management.

Self-care approaches can be used at all stages of ill-health, with the greatest impact likely to be for those who are living with long-term conditions, frailty or at end of life (see



Self-care has the potential to reduce activity across the pathway and can be applied for a range of conditions: as such the scope of potential impact is broad.

We intend to further develop and scale up our range of self-care schemes, based on local good practice, as well as evidence from the UK and internationally. These focus on:

- Enhancing patient education on how to self-manage.
- Peer support on a one-to-one or group basis (online or in person).
- Providing alternative care or services that facilitate self-care.
- Proactive management and planning for those with complex needs.
- Social change to promote healthy communities.

An example of how we already provide alternative care or services that facilitate self-care is through social prescribing. Through social prescribing, patients are empowered with the confidence to manage their own health so that they visit the GP only when needed. GPs therefore focus on higher risk patients and the demand for high-intensity acute services will be lowered.

Our social prescribing schemes integrate primary and social care, as patients are referred by their GPs to non-medical and community support services to provide psychosocial and practical support. We plan to scale up successful social prescribing schemes across the NEL patch to tackle diseases such as depression. In addition to our evidence based approach, we will also collaborate with the national Social Prescribing Network to guide the scaling-up process.

### Screening and early detection

As part of our goal to achieve a step-change in uptake of screening, we plan to address the inconsistency in quality and levels of screening across the NEL patch and scale up best practices. We plan to implement the NICE referral guidance, the 'faster diagnosis standard' and also increase early diagnostic capacity to reduce the number of patients with emergency cancer presentation, particularly colorectal cancer

We are looking into integrating health screening services within our overall system framework. We would like to build on the bowel screening work in Newham, whereby they have been partnered with a voluntary charity, Community Links. Community Links will call every patient who has not been screened to improve screening rates. We already have local GP endorsement and it has been endorsed by the London Bowel Cancer Screening Hub.

Screening of complex diseases allows early diagnosis and detection, reducing patients with late or emergency presentation. In doing so, we aim to improve outcomes and reduce health inequalities in the long-term; this will support specialist services by reducing complexity of issues downstream.

### Healthy living and smoking cessation programmes

Our prevention programmes targeted at reducing the risk factors for avoidable lifestyle conditions such as diabetes and cancer require coordination between primary and community care providers. We will proactively target at risk patients within the groups and work in a multidisciplinary way to provide support and prevent escalation of need.

Our current smoking cessation programmes have mixed results across the NEL patch. To increase effectiveness of smoking cessation, we will integrate it with mental health programmes to provide a holistic approach of both mental and physical needs. We hope to deliver a 10% decrease in number of smokers.

We wish to widen the implementation of healthy living programmes such as the National Diabetes Prevention Programme to achieve PSA obesity and diabetes targets. However, we have found it difficult to demonstrate its impact. To improve its impact, we will expand our mapping of diabetes prevalence and its risk factors to help identify at-risk patients.



**Enhancing our primary care programme to deliver equality for people in NEL**

In NEL, we have both excellent and poor primary care provision. For example Tower Hamlets and CH have some of the best outcomes nationally under QOF, and we must ensure equality and address the gaps. We will work together to deliver equality for people in NEL drawing on best practice where it is available.

Our enhanced primary care offer will ensure that the GP will focus is on coordinating care for those with complex problems and long term conditions. This will be enabled by other clinicians supporting those with minor illnesses. We will actively consider how the creation of new roles can support this. There will be seamless delegation to the extended primary care team and collaboration with social care, freeing up time for patients and helping to deliver person-centred, planned and preventative care (for example blood pressure management).

Patients will also have greater accessibility to GPs, with practices working together in hubs/networks to offer longer hours (8-8) and appointments for all seven days, aided by e-consultations.

The change required to realise our common vision for primary care across NEL will be owned and driven locally, but aligned to a common set of principles:

- We need to support the stabilisation of practices in the short term to ensure continuity.
- We will develop and implement a common quality improvement approach, supported by performance dashboard and peer review.
- We will develop a Primary Care Quality Improvement Board and utilise PMS reviews to move towards equalisation and delivery of key aspects of Primary Care SCF.
- There are a number of key enablers that we need to address at a NEL level: these include workforce, ICT and estates.
- GP Federations are central to our vision.
- We will work together to share good practice including around primary care technology.
- We will look at options for adopting a common approach to primary care contracting (BHR & WEL).
- We recognise that we need strong, dedicated clinical leadership to support this work and we will work with UCLP to develop this.

A detailed NEL-wide primary care strategy is being developed to underpin this change.

**Primary care collaboration at scale is a crucial feature of our universal framework and will improve patient care experience.**

**Integrated health and social care**

The integration of health and care services to deliver a better, joined up approach is an crucial part of our vision for

person-centred services across NEL. Progress is at different stages but there are detailed borough level delivery plans in place for 2016-17. These have been developed jointly by CCGs and local authorities in order to meet the requirements of the Better Care Fund (BCF).

Each borough has a detailed action plan and stretching target for improving performance against the Delayed Transfers of Care measure, through better patient flow within secondary care and integrated discharge services. BCF plans also describe how seven days services in community and social care services will be implemented to support safe and timely discharge from hospital.

On the next page additional initiatives to integrate health and social care in NEL are described in more detail.

**Integrated urgent and emergency care (UEC)**

The NHS Shared Planning Guidance set out three asks for urgent and emergency care systems by 2021:

1. All patients admitted via the urgent and emergency care pathway have access to acute hospital services that comply with four priority clinical standards on every day of the week.
2. Access to Integrated Urgent Care, to include at a minimum SCR, clinical hub and 'bookability' for GP content; with mental health crisis response in hospital and part of the Ambulance Response Programme.
3. Improved access to primary care in and out of hours.

In NEL we will work together to meet these through the implementation of our common framework for better care and wellbeing, in three different ways:

- At a local level the implementation of our person-centred service models will focus on meeting the eight criteria for Integrated Urgent Care and provide improved access to primary care.
- In BHR the UEC vanguard will provide a an example of rapid movement towards our planned UEC model, with a fast-tracked timeline for meeting the eight criteria for Integrated Urgent Care.
- Across NEL we will work together to implement a 24/7 integrated 111 urgent care service that connects to clinical hubs at all levels, including dental and pharmacy hubs and CAMHS. We will also implement referral pathways between UEC providers.

The **NEL UEC** network have been reviewing our current emergency departments to evaluate whether they meet the London Quality Standards and UEC facility specifications. In 2016/17 we will be working to meet the four priority seven day standards for vascular surgery, stroke, major trauma, STEMI heart attack, and children's critical care. We will also establish a work programme and road map to meet these same standards for general admissions to achieve 95% performance by 2020, and meet all three of the asks set out above.



**High quality integrated mental health care and support**

Mental ill-health has a very high prevalence in NEL, with inner east London CCGs in particular reporting the highest levels of new cases of psychosis in England, and very high levels of common mental health problems. Progress has been made to improve the quality of care and treatment across primary and secondary care. The STP represents an opportunity for health and care services across NEL to work together with the voluntary sector and communities to further improve health and life outcomes, and manage the projected increase in demand over the next five years.

We will do this by building community capacity and capability, including self-care and prevention and providing integrated primary and community care as close to home as possible. We will support children with and at risk of mental health problems through our Future in Mind commitments. We plan to improve access to services for children and young people, people with common mental health problems, and people with first episode psychosis, in line with national access standards. We will also improve access to dementia and perinatal mental health services, and services for people when they are in crisis.

Mental health services which **integrate primary, community and social care** support will prevent unnecessary admissions and provide a smooth transition to acute care services if needed.

We know that people with mental health problems experience a range of health inequalities, and that there is significant variation in how they utilise wider health and care support. We will ensure that mental health is at the heart of our delivery model for integrated care to address this and improve the physical health of people with serious mental illness. This will also help us improve the mental health of people who are frail, or who have complex and/or long-term conditions.

To develop the excellent mental health services we want for the future, the infrastructure needs to be right. We will work together as provider and commissioner partners to ensure that improving outcomes for people with mental health problems, and developing high quality productive mental health services, are at the centre of our work on new models of care.

Through the STP process we will further define our vision, priorities, and plans, to develop a five year NEL mental health strategy. Across partners we are committed to the principle of parity of esteem, that there is “No Health without Mental Health” and therefore it will be considered across all we do through the STP to improve quality, experience and value.

**Integrated children’s and young people’s care:**

Children and young people (CYP) are a key area of focus for NEL, given the high proportion of children and young people in NEL and the anticipated growth over the next five years. Across NEL, we aim to place children and young

people at the centre of care and services in health, social care and education. Effective services from early years into adulthood will support this generation, and begin to establish healthy lifestyles and self-care as the norm for future generations.

The TST programme has identified four priorities which we will adopt across NEL to deliver this vision, as outlined below:



Realising the benefits in terms of improved care for children and young people will require collaboration between organisations to deliver the transformation that is needed. In accordance with the 2014 Children and Families Act, commissioners and local authorities in NEL will develop local integrated care plans and identify opportunities for joint commissioning. Furthermore, local models of coordinated care have been developed, whereby multidisciplinary teams of health, social care and educational professionals collaborate to develop structured care plans, with input from parents, carers and patients. Care coordinators will proactively arrange and direct care. We recognise that a child’s chances in life start with the conditions of their birth; we will improve maternity (p16) services to ensure that every child has the very best start.

The high numbers of referrals to general paediatrics and dermatology for conditions that could better managed in primary care such as asthma and eczema, will be addressed through our ‘patient pathway and outpatients’ initiative. We plan to **review referral criteria** and guidelines for these conditions to identify opportunities to provide care in the community. Evidence-based clinical pathways for these conditions will be **co-designed** with children and young people and their families to better support them to manage their own conditions, even through the transition to adulthood.

The need to provide high quality and appropriate urgent care will be addressed through new models of care such as the development of acute care hubs, earlier access to expertise and diagnostics and surgical centres of excellence. This aligns with our goal of ‘ensuring accessible quality acute services to those who need it’ as discussed later.



**Localised programmes for learning disabilities**

Whilst we have relatively low numbers of people with learning disabilities in inpatient facilities, we know that we do not currently meet the National Service Model requirements for patients with learning disabilities.

The Transforming Care Partnerships in NEL are committed to working together to deliver the national service model. In particular, we will improve the resilience of our providers so that they can support people with learning disabilities who are exhibiting challenging behaviour. In doing so, we aim to reduce inpatient admissions. We will also work to increase access to local housing and education to reduce out of area residential provision.

The unnecessary admission of patients with learning disabilities can be reduced if we strengthen local support with input from primary, community and social care.

**Community-based end-of-life care**

We recognise the need for joined up care to ensure a better response from the health and social care systems to sudden, unpredictable or very gradual dying.

Nationally up to 81% of people say they would prefer to die at home. However, locally the majority of patients die in hospital with four of our CCGs having the highest rate in England, 20% above the English average. This indicates that, among other things, we need to get better at having open conversations with families and patients around end-of-life options.

We plan to build stronger partnerships with social and voluntary sectors to increase the provision of community-based, 24/7 access to end-of-life care services. We will improve personalised care planning through better sharing of patients' preferences and care plans with other providers.

**Transforming Sexual Health Services**

NEL experiences high prevalence rates for common STDs relative to England and London, including HIV, with some areas diagnosing HIV later than average. In addition 3 CCGs have above average teenage pregnancy rates and all CCGs have lower-than average prescriptions of long-acting reversible contraceptives (LARC).

We recognise that due to London's array of open access services and NEL's mobile population, a high number of our residents access services in central London. Therefore, we need to work collaboratively at scale to successfully improve access and outcomes. To do this, we are working with the London Sexual Health Transformation Programme (LSHTP), of which NEL is one of six sub-regions.

So far the NEL Sexual Health Transformation Programme (NEL SHTP) has been formed across Newham, Redbridge, Tower Hamlets and Waltham Forest to overcome these challenges by jointly planning and commissioning integrated sexual health services. A number of opportunities have been identified to:

- Improve access to STI diagnostics outside the acute environment (for example self-sampling available online and in primary care).
- Improve access and uptake for long-acting reversible contraceptives (LARC).
- Create appropriate STI treatment opportunities.
- Develop effective partner notification, which is mindful of the LSHTP model and is fit for purpose for NEL.

Through the STP, we will work together across NEL to ensure that we share good practice and adopt a consistent approach to the incorporation of sexual health services into local integrated delivery models.

**Personalisation and Choice**

As part of our commitment to deliver person-centred care we will be working with patients and health professionals to expand our offer of Personal Health Budgets across NEL. Currently, adults and children in receipt of continuing care packages have the right to ask for Personal Health Budgets, which will help them to meet the outcomes agreed between themselves and their health professionals. PHBs operate within all individual boroughs across NEL but the number of children and adults to whom they are available varies. Changing how we commission services to offer more personalised care, whilst not destabilising services for others, is a complex challenge and individual CCGs will be looking to pilot approaches following consultation. Tower Hamlets CCG is one of the Integrated Personal Commissioning (IPC) 'demonstrator' sites, and, further to an NHS England (NHS E) request for Expressions of Interest in becoming an IPC 'early adopter' site. Newham and Waltham Forest CCGs have confirmed their intention to have a conversation with the national team about potentially making a formal application too.

**Integrating beyond health and social care**

We also recognise the potential to maximise the use of resources across public services by exploring opportunities beyond traditional health and social care boundaries. At a London level we have confirmed our interest in formally collaborating with the London Fire Brigade on local 'Fire as a Health Asset' initiatives. This will commence with a pilot programme based on a joint assessment of the Fire and Rescue Service initiatives that are likely to have most local impact.



**Pathway redesign and best-in-class clinical productivity, especially in outpatient care**

As outlined in the 'Getting It Right First Time' Briggs Report, it is important to identify and administer the correct treatment at the appropriate time to a high standard. This will reduce the need for revision surgery and reduce mortality rates. We will also draw on the principles of 'Right Care' to ensure the most appropriate use of secondary care that is high quality and efficient.

One way by which we are approaching clinical productivity is through more efficient delivery of our outpatient care and optimising each clinical pathway. We plan to manage referrals to secondary care in a more effective way and streamline the referral to the treatment process, including diagnostics.

This is a significant clinical productivity area, which will lead to quality and improved use of NHS resources (time and money).

In 2016-17 there will be a particular focus on the following pathways and projects:

- ENT (BHR)
- Ophthalmology (WEL and BHR)
- Orthopaedics (BHR)
- Gastroenterology (BHR)
- Gynaecology (BHR and WEL)
- GP specialist advice service (WEL)
- Renal (NEL)

City & Hackney have put in place consultant advice lines with Homerton Hospital for 40 clinical pathways and now have low rates of outpatient referrals. They have improved long term condition care, with top quintile performance (for example blood pressure control), and now have low rates of admissions for conditions amenable for primary care.

In areas where we are most challenged we also have a 20% reduction target for face-to-face outpatient appointments over the next five years. This will in part be enabled by the use of telehealth and other alternative platforms.

**Improving the treatment of cancer in community and secondary settings**

We recognise that we have much to do to deliver the ambitions outlined in 'Achieving World-class Cancer Outcomes, 2015-2020' written by the National Cancer Taskforce. Aside from reducing incidence through risk factor reduction (addressed earlier in 'Prevention and Proactive care'), we also need to raise our one year survival from c.65% to the national standard of 75% and also integrate 95% of cancer survivors with after care plans.

We will reduce variation in access and quality of service by implementing whole pathway improvements which has already begun under the leadership of the NEL Clinical Senate.

For better post-treatment care, we will accelerate the delivery of the 'recovery' package, including an agreed after-treatment plan. We will also implement stratified follow up pathways to increase the proportion of patients in long term care programmes.

NEL and north central London (NCL) also have the poorest delivery of the cancer waiting time (CWT) standards out of the five London regions. By working with the TCST and the National Cancer Vanguard, we will implement a system-wide programme to deliver sustainable CWTs.

**Reduce unnecessary diagnostics**

National evidence suggests that 25% of pathology testing is unnecessary and recent audit work in CH revealed that 20% of primary care initiated MRI requests could have been avoided.

Over the next five years, we plan to introduce a rolling programme of work focused on standardising the most requested tests across sites. This will reduce unnecessary testing and improve access to testing when it is most needed. We will give GPs the ability to book people in for tests directly without having to see a specialist where testing is appropriate. IT improvements will allow the sharing of test results between GPs and hospitals to reduce duplication.

**Medicines Optimisation**

Leading on from the Five Year Forward Review, the opportunities for medicines optimisation interventions have been established through a number of national documents, including the GP Forward View and the Carter review. In NEL we recognise the potential value of these opportunities in building a sustainable health and social care system. Central to this is the role of pharmacists and their teams (community, prescribing clinical pharmacists and others across the primary and secondary care system) in improving patient care through pathway redesign, promoting patient empowerment and self-care and efficient use of NHS resources through procurement and reducing waste.

Initial discussions have taken place with clinical leaders to agree the re-establishment of a NEL wide Medicines Management Board which will explore nine priority programmes, including:

- Promoting self-care, patient awareness and self-management to reduce unnecessary prescribing of medicines available over the counter.
- Developing consistent pathways and medicines usage across NEL for the management of long term conditions.
- Expanding e-prescribing in secondary care and work with other providers to avoid medicines related delayed discharges.
- Developing a pharmacy workforce strategy, to address gaps in primary and secondary care, and expand the role of prescribing pharmacists.
- Developing a common approach to decommissioning / deprescribing with consistent responses for patients regardless of setting.



### Ensure accessible quality acute services for those who need it

Through encouragement of prevention, self-care and improved care close to home we envision that this will reduce demand. However given the significant population rise, our challenge is to ensure we reduce any unnecessary admissions and attendances, and have best in class length of stay for both planned and unplanned care. The only other alternative would be to increase the total beds across NEL significantly, which would require an additional hospital to be built.

As with the out-of-hospital components of our service vision, transformation is also required in our secondary care service model to improve patient experience. These are focused closely on the features of the hospital model: streamlined outpatient pathways, urgent and emergency care, ambulatory care, coordinated surgery and provider collaboration. Further details are set out below:

#### We will reduce long waiting times and unnecessary hospital admissions by making ambulatory care the default setting

To support our vision of urgent and emergency care being delivered in the right setting, we will develop ambulatory care hubs at each hospital. These hubs bring together clinicians and services that focus on the initial assessment and stabilisation of acutely ill patients.

A greater proportion of patients will be able to gain access to emergency consultant care, so patients with less urgent needs can be treated quickly and sent home. Only patients requiring more than 48 hours of care will be admitted to a specialised ward, thereby significantly improving bed capacity and support the flow of patients, which will help meet A&E targets.

**Acute** care hubs including **ambulatory care** will support our vision in ensuring that patients are seen at the right place in the right time. They will **reduce demand** on our secondary providers by ensuring that people are not admitted to hospital unless it is necessary.

#### Improve the quality of surgery services

We are exploring the creation of surgical centres of excellence at each site. At the moment WEL & Barts Health are more advanced in the stages of planning these changes than BHR and Hackney, but there is a commitment to expanding surgical centres of excellence across NEL<sup>1</sup>.

Through consolidation of planned care across NEL, we can improve length of stay, reduce referral to treatment times (RTT) and improve clinical outcomes for our patients by standardising surgical offerings across sites. We are exploring the ability for each site to have a 'core' surgical offering, combined with a 'core-plus' set of services where safer procedures can be delivered at a higher volume. A 'complex' surgical offering would be consolidated and available in a few sites to make provision safer and more sustainable.

We are planning for patients to be able to access pre-operative appointments and low-risk surgical procedures at their local hospital, while avoiding long delays and cancellations. They will only travel if they need specialised offerings.

These surgical centres of excellence would operate in networks with strengthened cross-site working and inter-hospital transfer, leveraging the use of any free capacity to deliver emergency surgical interventions without delay. This will support the vision of **providers collaborating** to deliver efficient and high quality care and **will reduce our failure to meet quality measures such as transfer delays**.

#### Delivering the Seven Day Standard for Emergency Care

Across the NEL Urgent and Emergency Care (UEC) network we have been reviewing our current emergency departments to evaluate whether they meet the London Quality Standards and UEC facility specifications.

Throughout 2016/17 we will be working to meet the four priority seven day standards (2,5,6, and 8) for vascular surgery, stroke, major trauma, STEMI heart attack, and children's critical care. We will also establish a work programme to meet these same standards for general admissions to achieve 95% performance by 2020.

Health commissioners and providers in NEL remain committed to the safe and timely transition of King George Hospital emergency department from a full admitting Accident and Emergency department to a 24/7 urgent care centre in order to improve the quality and sustainability of acute services. This is in line with the original proposals and public consultation undertaken as part of the Health for Northeast London programme and the changes ultimately agreed by the secretary of state.

Our operational plans for 2016/17 provide the foundation on which providers and commissioners will build towards implementing a full closure by summer 2019 with a potential closure at night before that. In order to achieve this, partners across the system will continue to work together to ensure the agreed enabling actions are executed and that the gateway process provides assurance of the required progress.

Our system plans are already delivering improvements and we have identified the following key conditions for successful implementation:

- The Independent Reconfiguration Panel (IRP) recommendations being met, including sustained performance improvement of the emergency pathway.
- Significant capital investment at both Queen's and Whipps Cross Hospitals to support closure.
- Successful reduction in demand and length of stay at Whipps Cross hospital to create additional bed capacity. Otherwise expansion of the bed base at Whipps Cross will be required.

<sup>1</sup> see: <http://www.transformingservices.org.uk/downloads/Strategy-and-investment-case/TST-Part-3-High-impact-changes.pdf>



- Effective workforce planning and recruitment to ensure that all clinical areas can be staffed safely
- Clear and effective public communication of the plans for partial and full closure, in particular to address the risk that partial closure leads to a bigger shift of activity than currently anticipated
- That the surrounding emergency care system maintains or improves its stability, in particular services at North Middlesex and Princess Alexandra hospitals.

We have system plans in place focused on these areas, and a Chief Executive/Chief Officer led programme in place to lead and oversee progress. By September 2016 we will have confirmed detailed timescales and an agreed system approach to the proposed changes.

**Offer a greater choice of settings for births**

We recognise that the projected increase in births is the most pressing challenge for maternity provision in NEL. To reduce the risk of needing interventions in obstetric-led wards and improve capacity management, we plan to offer expectant mothers a greater choice of delivery settings. There is currently under utilisation of midwifery led care pathways and birth settings.

We plan to increase the uptake of midwifery led births and expand home birthing services, in alignment with the National Maternity Review. Newham, Tower Hamlets and Waltham Forest CCGs are Maternity Choice and Personalisation Pioneers. Through the Neighbourhood Midwives pilot we will offer an expanded range of options to local women.

We are also focusing on models of care that allow continuity of care to be the normal offer for all women. With continuity of care, expectant mothers will experience better, safer care with a lower risk of intervention. To that end, we are establishing midwifery model of care pilots at Barts Health hospitals and at Queen’s hospital.

*This chapter has focused extensively on introducing our system-wide vision, the models of care being developed to bring it alive and the service transformation programmes supporting this change. The remainder of this plan addresses the other critical inputs, including collaborative productivity and enablers, which will need to be simultaneously developed to fully address the NEL wide system challenges.*

2016-17 deliverables	By 2021
<ul style="list-style-type: none"> <li>✓ Continue implementation of TST and finalise ACO business cases in BHR and CH.</li> <li>✓ Develop 24/7 local area clinical hubs, to be available to patients via 111 and to professionals.</li> <li>✓ Primary Care:                             <ul style="list-style-type: none"> <li>✓ Strengthen federations.</li> <li>✓ Develop a Primary Care Quality Improvement Board to provide oversight.</li> <li>✓ Utilise PMS reviews to move towards equalisation and delivery of key aspects of Primary Care SCF.</li> </ul> </li> <li>✓ Extended primary care access model will be established with hubs providing extended access for networks of practices implementing the Primary Care SCF.</li> <li>✓ Ensure community-based 24/7 mental health crisis assessment is available close to home.</li> <li>✓ Active plan in place to reduce the gap between the LD TC service model and local provision.</li> <li>✓ Establish a NEL cancer board to oversee delivery of the cancer elements of the STP.</li> <li>✓ Establish a NEL-wide MH steering group and develop a joint vision and strategy.</li> </ul>	<ul style="list-style-type: none"> <li>✓ New care models operational across NEL.</li> <li>✓ Implementation of SCF standards with 100% coverage in line with London implementation timetable.</li> <li>✓ Reduction acute referrals per 1000 population through improved demand management and primary / community services.</li> <li>✓ Access across routine daytime and extended hours (8am-8pm) appointments within GP practices and other healthcare settings.</li> <li>✓ Alignment with NHS E 2020 goals for LD transforming care.</li> <li>✓ 95% of those referred will have a definitive cancer diagnosis within four weeks or cancer excluded, 50% within two weeks (“find out faster”).</li> <li>✓ Provide the highest quality of mental health care in England by 2020.</li> <li>✓ Deliver on the two new mental health waiting time standards and improve dementia diagnosis rates across NEL.</li> </ul>



# 4. Specialised Services

The provision of specialised services is a key component of the NEL health economy. Patients from across the UK are treated by our providers, and an allocated resource of more than £500m for the NEL population makes up a significant proportion of the income of our five NHS providers.

We need to transform specialised services so that our residents can come to expect the highest quality when they need complex care, be it at our providers in NEL or at other providers in London. Given the challenges outlined in this document and the needs of our residents, we are focused on making specialised services a core component of our STP. Whilst we have had past successes in reconfiguring our cancer and cardiac provision across north central and east London, there is a need to address the demand, cost and quality of care challenges for all specialised services.

A number of specialised care issues must be addressed in NEL:

- A number of quality issues exist, including the meeting of waiting time targets.
- There is insufficient preventative action and active demand management.
- There is a predicted financial gap of £134m by 2020/21 due to a growing and increasingly ageing population, new technologies and new treatments. (By way of comparison, this is equivalent to 13% of the total budget in the five areas of highest spend combined.)
- On occasion, patients living in NEL have to travel to providers across London or nationally. While this may be reasonable where services are centralised, it is sometimes caused by capacity issues in local services.

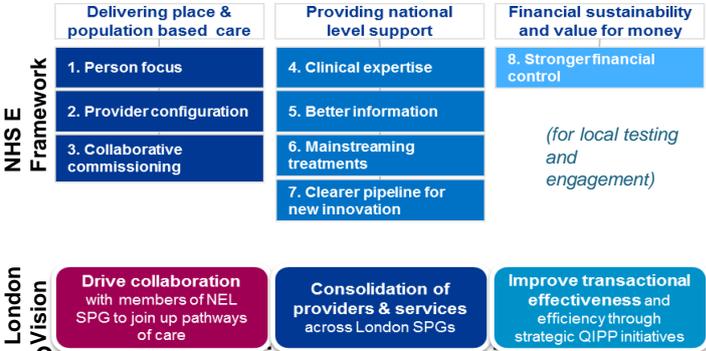
These challenges will require us to work closely with NHS England (NHS E) and other footprints to deliver greater productivity, better services and financial sustainability.

**Our approach**

The STP provides us with an opportunity to assess how our specialised services are delivered and to formulate a vision for how we expect them to look in the future. Through discussion with key stakeholders, we have subscribed to a vision for how specialised services are delivered:

*“Working together to deliver evidence-based, high-quality and affordable specialised services with demand appropriately managed in the community and in secondary care through defined pathways”.*

We will work with NHS E’s strategic framework and the London Specialised Commissioning team’s supporting vision:



One of our key priorities is to work collaboratively with NHS E to develop the best way to commission services in NEL and for NEL residents, including supporting the development of a London wide commissioning structure. This may include developing new contractual arrangements to encourage the management of demand.

As patients in NEL move between other footprints for specialised services, we will need to work closely with other footprints to consider and plan patient flows between them.

We have already had success working with other STPs through the UCL cancer vanguard and the Barts/Royal Free renal collaboration.

We have developed a local delivery governance structure involving specialised commissioners. We will involve CCG and local authority partners in this delivery when considering opportunities to reduce demand for specialised care in the whole-system.

**Prevention, demand management and early intervention**

Specialised services must align with our preventative, person-centred service model. It is vital that we reduce demand for specialised services by empowering our population to self-manage their illnesses and lead healthy lives. When people develop conditions like diabetes, it is crucial that we screen them early and intervene early; this will ultimately lead to better health outcomes and will reduce pressure on specialist services.

**Financial sustainability**

Pathways must be reviewed and reconfigured to repatriate patients (where appropriate), resolve quality concerns, and reduce variation.

As part of our productivity programme, quality and cost improvements need to be achieved so that we can deliver specialised services in a financially sustainable manner.

**Reaching our objective**

To reach our objective of becoming a world-class destination for specialist services with excellent outcomes for residents, we will require a robust set of priorities and close working with our stakeholders.

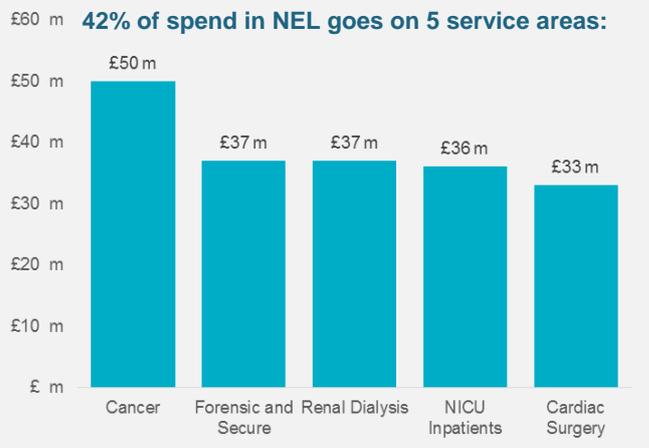


**Approach to identifying priorities for Specialised Services**

Any changes to Specialised Services need to be driven by evidence, targeted according to impact and feasibility, and aligned with the priorities of Transforming Specialised Services in London (TSSL).

We have identified the following NEL priorities based on five key dimensions:

- The views of the five NEL providers and the clinical senate.
- Variation and opportunities highlighted in Right Care, Commissioning for Value and Commissioning for Prevention analyses.
- Areas of high activity, high spend, and high London market share.
- Known quality issues from existing programmes/reviews.
- Feasibility in addressing the challenges within the timeframe.



The graph above illustrates the proportion of spending by service area, and the table below forms our local priorities which we will continue to align with TSSL.

**These priorities will be iterated following further analysis by NHS E, and collaborative clinical planning sessions and involvement of patients to agree on a set of high impact and appropriate initiatives to improve specialised services**

<p><b>Cancer</b> Realising the full benefits of the Cancer Cardiac programme; improving early identification and quicker access to treatments</p>	<ul style="list-style-type: none"> <li>• Reviewing the implementation of the Cancer Cardiac reconfiguration to ensure the full benefits of the change are being realised.</li> <li>• Earlier identification: enhanced diagnosis and better access to services through implementing stratified pathways in outpatient services.</li> <li>• Enhanced access to smoking cessation services to reduce incidence.</li> <li>• Improved pathways for faster identification and access to treatment, for example paediatric oncology (joint with GOSH), haemato-oncology, lung and breast cancers.</li> </ul>
<p><b>Cardiac</b> Integrated pathways, with better prevention, identification, early intervention and access to new treatments</p>	<ul style="list-style-type: none"> <li>• Develop pathways across primary, secondary and tertiary care in order to strengthen prevention, earlier identification and quicker treatment, therefore reducing demand downstream for specialist services. For example, a primary prevention service could reduce the risk of cardiovascular disease through reducing cholesterol levels and smoking.</li> <li>• Improve case-finding, prevention and treatment for atrial fibrillation; this would be in partnership with UCLP and local primary care leaders.</li> <li>• Ensure innovations in treatment can be accessed in the world-class Barts Heart Centre. New techniques in surgery and use of devices are being trialled to ensure better outcomes for patients.</li> </ul>
<p><b>Mental health</b> Closer integration of specialised and secondary care pathways; repatriation and consolidation</p>	<ul style="list-style-type: none"> <li>• Step-down and step-up support for patients in forensic mental health services, and admission avoidance for Tier 4 CAMHS will be integrated through bilateral commissioning arrangements and pathways, ensuring the most appropriate use of resources across the MH pathway.</li> <li>• This will be supported by the applications made by each of our mental health providers to NHS E's New Models of Care process, including considering how to devolve the specialist commissioning responsibility to the local level.</li> <li>• We will also develop an efficient pathway to enable patients with a learning disability in secure mental health settings to be repatriated to NEL and back into the community.</li> </ul>
<p><b>Renal</b> Better community support, and prevention and secondary demand management improving outcomes and reducing demand</p>	<ul style="list-style-type: none"> <li>• Roll out of the community kidney services across NEL to improve identification of those with or at risk of CKD, improve patient information and education, and integrate care. Where this already exists, these services are delivered through electronic advice clinics and surveillance services offered by the QMUL clinical effectiveness team. This has reduced the number of new referrals to services.</li> <li>• Better prevention and secondary demand management through blood pressure control initiatives.</li> <li>• Slow the rise in end-stage renal failure by increasing identification of CKD and AKI.</li> </ul>
<p><b>Neonatal</b> Addressing the capacity gap to repatriate care and reduce use of inpatient facilities</p>	<ul style="list-style-type: none"> <li>• Providers in NEL act as neonatal centres for NEL and South Essex pathways; RLH is the primary neonatal surgical provider. Due to lack of capacity, 30% of neonatal surgical referrals are treated outside the STP footprint.</li> <li>• Admissions of patients are relatively low but there is some potential to reduce admissions through implementing a specialised services review of neonatal hypoglycaemia and jaundice management.</li> </ul>



## 5. Improving Productivity

### Overview

#### **There are significant productivity opportunities across the health and social care landscape in NEL**

The evolution of the health and social care landscape in the next two to five years provides opportunities for all partners to create a more productive system in NEL.

To this end, providers in NEL have begun discussing opportunities for productivity across both clinical and non-clinical areas. This work is very early on in its development but there is appetite for collaborative working and a high level of ambition to capitalise on opportunities in NEL.

In two areas we have started early work to understand the scale of opportunities: providers have articulated CIP targets over and above the 'do minimum.' Alongside this, for some areas of non-clinical work, providers have developed initial hypotheses for the potential size of the collaborative opportunity. More work is needed to develop the scope and depth of these hypotheses.

There is a recognition from providers that to realise the full extent of the benefits of collaboration, there is the need to be a formal collaboration is needed in order to share risk and rewards.

This chapter gives an overview of the collaborative opportunities and detail of the work providers have recently to develop hypotheses.

#### **There are productivity opportunities above the 'do minimum' within provider trusts**

NEL has undergone large changes over the past few years and we have recently seen a consolidation of acute providers:

- Barts Health was formed through the merger of three trusts: Barts and The London, Newham University Hospital and Whipp's Cross University Hospital. It operates over five sites.
- BHRUT is made up of two large acute sites: King George Hospital and Queen's Hospital.

There are, therefore, internal collaborative opportunities for the trusts in NEL due to their scale.

The internal productivity savings above the 'do minimum' from providers totals £64m of which £25m comes from Barts, £25m from BHRUT, £8m from ELFT and £6m from NELFT. The main contributors to this are: implementing Carter recommendations; theatre and LOS productivity; reducing spend on bank and agency staff; skill mix and establishment reviews; and internal clinical programmes.

#### **Provider collaboration can benefit the system across a range of opportunities**

There are both clinical and non clinical opportunities for productivity between providers.

##### **1) Clinical productivity opportunities provide the greatest scope for collaborative gains**

There are great opportunities for clinical services across NEL. We see two main stages to realising these benefits:

- Providers want to move all services in NEL to at least the current median in NEL and best in class if possible. This will be facilitated by having a data driven approach to understand drivers in differences across NEL and

share best practice.

- In the longer term, a NEL wide clinical strategy developed for each service, where we may see services consolidate on fewer more specialised sites.

##### **2) Non-clinical opportunities across the system are also being explored by providers**

Through the STP development, our trusts have come together to assess opportunities for collaboration in non-clinical areas. To date these only consider a few areas of non-clinical spend but early hypotheses suggest that the benefits could total between £21m and £56m in these areas.

Within this set of hypotheses, four collaborative projects in particular have been identified as initial areas for concentration and detailed work. Alongside this, a fifth project will consider potential collaborative forms for all collaborative opportunities. This work will need to align with new models of care and devolution programmes in the long term to ensure there is a consistent approach across NEL.

There is a great opportunity for a more productive use of estates across NEL. The output of this work will be considered alongside the overall NEL estates strategy development to make sure that they align.

#### **There are also opportunities in other parts of the NEL health and care system**

##### **1) Commissioners**

For true collaboration across NEL, we need to ensure that there is equity in commissioning. This involves a system review on how the seven CCGs and their commissioning support can start working collaboratively to purchase care effectively in the best interests for the NEL population. There are efficiencies to be gained through commissioning at a more strategic level. As commissioning evolves, it is expected that the current time intensive system of annual contracts and competitive tendering are likely to lessen; multi-year outcomes based contracts will have a significant impact on commissioners, as they will require different skills and potentially fewer resources.

There are further transactional savings which can be made, such as sharing estates with providers or local authorities. Commissioners will work together to identify collaborative productivity initiatives in the next phase.

##### **2) Primary care**

Primary care in NEL is developing federations to gain productivity and enable the specialisation of staff. To date, the developing of federations in NEL has saved money through the consolidation of back office functions and procurement. There are also schemes planned to reduce variation in referrals and improve prescribing practices across NEL which will enable system-wide savings. Some of the significant opportunities in primary care are explored in the primary care annex.

##### **3) Social care**

Each of our eight local authorities has its own transformation programme. Health and social care integration provides us with great opportunities for collaborative working; we can reduce duplication in health and social care through multidisciplinary teams and joint assessments.



## Collaborative Opportunities

### Providers in NEL have developed hypotheses for collaborative opportunities which could save between £21m and £56m

Over the past few weeks, NEL providers have come together to discuss potential opportunities and options for collaboration. This has considered some non-clinical opportunities with intent to explore other opportunities in the coming months. The result is a series of hypotheses about where collaboration could bring system-wide gain over and above internal CIP plans.

In this early phase, the savings hypotheses have been informed by NEL sector experts as well as by examples of other work across the country. Costs which could be addressed by collaboration in the next five years have been considered.

Detailed work will be done in the next phase to test these hypotheses. Internal CIP plans will be explored further as part of this to ensure that best practice is shared amongst providers. This will help support the internal work being done by the trusts themselves. Investments required for implementation will also be reviewed.

Four key priorities, outlined below, have emerged and will require detailed consideration in the next phase of this work.

#### 1) Collaborative procurement

Our procurement leads have identified a number of areas where there may be collaborative opportunities. Initial high-level analysis suggests that our current spend across these categories is £231m.

Areas highlighted for potential collaboration by providers include:

- Soft facilities management: through consolidation of contracts across providers.
- Consumables: through the rationalisation and standardisation of catalogues, and purchasing across all trusts.
- Patient transport and home deliveries: by procuring transport services as a system, suppliers will be able to optimise their fleet over a continuous geography.

Early work suggests an indicative saving opportunity of £5-14m on this spend, equivalent to 2-5% of total spend. This broadly aligns with work the London Procurement Partnership has done with other London areas to find opportunities between providers. While this figure is lower than some estimates (such as the Carter Review), our varied provider landscape suggests our collective buying power may be less than other footprints. We should be able to realise some opportunities in the next 12-24 months as contracts come up for renewal. In other areas, more planning may be needed (and existing contracts either exited or extended) to realise full system-wide benefits.

#### 2) Common bank and agency approach

At present, NEL spends £196m with agencies. Whilst each organisation has CIP targets aimed at reducing this, there are further opportunities to reduce this amount through a

common approach. In particular, two solutions have emerged:

- Virtual Bank: Clinical staff from our trusts are doing bank and agency shifts at other trusts in NEL. A virtual bank will allow for a more data driven approach to managing bank and agency staff.
- Common approach with agencies: early conversations suggest that many of the trusts in NEL and our neighbours are using the same few suppliers. A common approach across the providers may provide a stronger platform for negotiations with agencies.

Examples in industry suggest that between 13%-25% could be saved through collaboration, demand management and better use of data. In NEL, we think therefore that the collaborative saving could be £4-12m over and above what providers do themselves (2%-7% of spend).

#### 3) Consolidating pathology

NEL currently spends £71m on running pathology services. While some reports, such as Carter's Phase 2 Pathology report, have suggested that 10%-20% of pathology spend could be saved through consolidating services, work has already been begun in this area:

- Barts Health operates a hub and spoke model across its sites, with a major hub at the Royal London.
- BHRUT has consolidated its cold pathology to the Queen's Hospital site.
- Homerton is currently considering options for its pathology service and will make a decision in 2016/17.

Therefore, our early hypothesis for testing is that NEL could save £2-5m (3%-7%) through consolidating services and making better use of automation. Different models need to be explored; there are precedents that NEL can learn from such as South West London Pathology and the Kent Pathology Partnership.

#### 4) Back office functions

NEL providers currently spend £113m on central procurement, finance, HR and IT functions. Business cases and projects that have been developed elsewhere suggest that savings of 12%-25% could be realised by consolidating these functions.

In NEL we have already realised some collaborative savings, with Homerton, Barts Health and ELFT using a shared-service centre for payroll, and Homerton and Barts sharing their financial systems. Trusts also have aggressive internal CIP plans with regards to back office functions. We therefore hypothesise that we could save in the region of £5-16m across NEL through collaborative working (5%-14% of total spend) over and above CIP programmes.

A number of factors mean that much of this saving is likely to be realised in years 4-5 as existing long term contracts and ongoing work on the IT strategy across NEL. There are, however, shorter term actions that can be taken in the next 24 months to help maximise savings across the system. These include standardising processes, sharing best practice between the providers and beginning to evaluate potential future operating model options.



## Collaboration and Timescales

### We are committed to exploring options for formal collaboration between providers

Formal collaboration presents an opportunity to achieve the benefits of collaboration in a way which shares risk (and rewards) amongst participating organisations while potentially reducing transactional costs. In addition to productivity advantages, formal collaboration may support the NEL health and care system to accelerate the realisation of clinical productivity gains and implementation of new system models of care. This work should not compromise either the sovereignty of the current providers or the development of future models of care such as ACOs.

### Over the coming months, we will evaluate a number of options for formal collaboration between NEL providers

The focus of a NEL collaborative partnership will depend on the scale of ambition and partners involved. Practical arrangements should be as clear and simple as possible with the capacity to incorporate a wide range of schemes within a single approach.

At present, a partnership between the five provider trusts in NEL offers the most practical initial scope for the work in order both to realise economies of scale and to maintain a level of simplicity to ensure the ability to achieve gains in the short to medium term. To this end, we intend to develop a Memorandum of Understanding between our five providers to ensure clarity of purpose and senior commitment. In the longer term, other providers such as primary care federations could contribute and share in the benefits.

The initial focus of the collaborative will be on productivity opportunities which offer the greatest potential joint benefit. In the longer term, the scope could develop to include:

- Collaborative productivity (such as procurement and back office functions).
- Infrastructure planning (such as estates and IT).
- Workforce development (such as workforce planning, leadership development and collective training).
- Service planning (such as pathway redesign across NEL).
- Identification of future productivity opportunities and best practice sharing.

We will need to develop an arrangement that is flexible and can develop over time. It is possible that a greater level of collaboration will offer greater benefit in the longer term.

We will need to review various contractual and governance arrangements to make this a reality, which could include a

membership model (see South Yorkshire example) or a joint venture model.

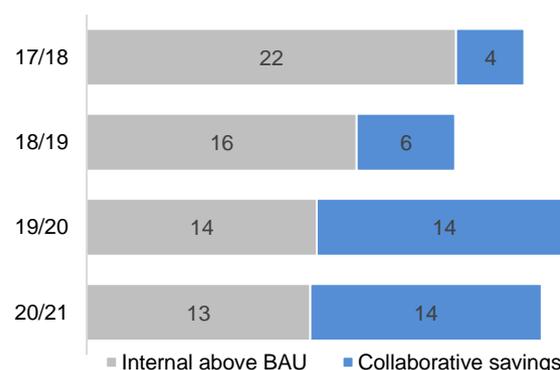
The options outlined would represent a radical shift in our thinking and approach; they are changes that have not been attempted in London yet and therefore we need to proceed sensitively. Through this STP we have the opportunity to develop our shared thinking around collaborative arrangements, and drive forward conversations that will enable the kind of transformative changes that will enable our system to be sustainable.

South Yorkshire may provide a useful guide to achieving the benefits of collaboration, bringing together seven acute providers with a collective turnover of around £3bn. This collaboration has a number of features:

- Driven by strong chief executive-level leadership enshrined in a Memorandum of Understanding.
- Collectively funded with a total cost of around £700k per annum.
- Covers clinical and financial improvement, best practice sharing and informatics.
- Has delivered early benefits on shared procurement and shared patient records.

### Phasing for realising collaborative savings

Our current hypothesis is that from 2017/18 we can realise non-structural collaborative benefits through benchmarking, sharing best practice and aligning ways of working to ease later implementation. The majority of collaborative savings, however, will be realised in 2019/20 and 2020/21 as some will require structural change and capital investment.



The more complex productivity savings, such as better use of estates and service transformation, are also likely to come in the later years of the STP delivery.

2016-17 deliverables	By 2021
<ul style="list-style-type: none"> <li>✓ MoU between providers underpinned by principles of collaboration.</li> <li>✓ Clear timescales for consolidating non-pay contracts.</li> <li>✓ Joint approach for agencies in place with key suppliers.</li> <li>✓ Options analysis of collaborative opportunities with pathology across NEL with agreement on a preferred option.</li> <li>✓ Options analysis for consolidating back office functions completed with a preferred option across the system.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Proactive approach to finding areas for collaborative working in NEL.</li> <li>✓ Vision for shared back office approach and functions realised</li> <li>✓ Joint infrastructure and workforce planning across NEL's organisations. This may be done only to inform rather than replace organisation plans.</li> <li>✓ All trusts in NEL have implemented the findings of Carter and achieved agreed efficiency savings contributing to their financial sustainability.</li> </ul>



# 6. Enablers for Change

## 1. Workforce

Our workforce transformation needs to be based on the specifications of the new service models and through working closely with professional bodies and staff. As the development of these models will take time, we have focused our efforts in year one on establishing the infrastructure required to realise this change and will subsequently develop our approach in response to any changes in the models.

Developing the existing workforce is critical for the scale, pace and sustainability of the required transformation. We envision our 'workforce of the future' will have the capability to fully support the new service models. For example, the workforce should be able to work across integrated health and social care systems.

Our NEL workforce strategy recognises the local initiatives across our footprint, and seeks to agree the overarching priorities we will work on collectively. Moving forward, we will be coming together through a Local Workforce Action Board (LWAB) to deliver our vision.

**Our current workforce is not sufficient to meet the challenges of growth in demand and system transformation.**

- Given the anticipated growth in our local population, we will have varying gaps between supply and demand of professional groups, with a 30% shortfall in nursing and a surge of ST3-8 doctors completing their training. The cost of meeting demand in primary care is unaffordable and we need to rethink how we work to maximise resources.
- Vacancy rates and turnover rates across secondary care are too high, leading to a strong reliance on temporary staff against a required reduction in agency spend.
- About 17.5% of registered roles in social care lie vacant, illustrating the difficulty of recruiting the right staff. We need to make NEL a better and more affordable place for NHS staff to live in.

Our five key priorities to transform the workforce are outlined below.

<p><b>1) Retention of existing staff</b> <i>It is more cost-effective to retain existing staff.</i></p> <ul style="list-style-type: none"> <li>• We will analyse key reasons for people staying versus leaving the workforce through exit data and interviews with long-serving staff.</li> <li>• We will create an action plan to maximise retention of people who plan to leave in the future and set our five year goals through our LWAB and map any savings.</li> </ul>	<p><b>3) Workforce integration to support new models of care</b></p> <ul style="list-style-type: none"> <li>• Our Year One focus will be to standardise and promote new 'integrated' roles such as care navigators.</li> <li>• We will work with local authorities and schools.</li> <li>• We will transform the workforce using education initiatives to enable staff to work across all settings. As new service models develop, we will be in a position to train and deploy the required workforce.</li> </ul>
<p><b>2) Promoting NEL as a place to live and work</b> <i>To recruit more staff, we need to make employment within NEL more attractive.</i></p> <ul style="list-style-type: none"> <li>• Jointly market the benefits of living in NEL with social care to attract more health and social care workers.</li> <li>• Create career opportunities via central recruitment of apprenticeships and engaging with local business partners to develop shared opportunities. Our Community Education Provider Networks (CEPN) can support this engagement with local communities.</li> <li>• Keeping the NEL health and care workforce healthy.</li> <li>• Address the lack of affordable housing for our social care workforce with the Mayor of London office.</li> </ul>	<p><b>4) Whole systems organisation development</b> <i>There are operational and financial benefits of working together.</i></p> <ul style="list-style-type: none"> <li>• We plan to streamline our HR functions to offer faster mobility of staff across a greater footprint, through integrated HR policies and services (for example 'central recruitment to support general practice').</li> <li>• In Year One, we will mobilise our LWAB to steer local transformation programmes. We will also break down the education and training barriers for social and health care. We will build on this work to establish clear HR and OD operational models to be deployed.</li> </ul>
<p><b>5) Primary care transformation</b> <i>To support the shift of patients from hospitals, we need our primary care workforce to have the right skills.</i></p> <ul style="list-style-type: none"> <li>• Our primary care practitioners will need to act as a single point of care coordination to support the new models of care. Furthermore, we will need to provide a shared resource bank to support and build up GP federations.</li> <li>• In year one, we will build on our existing workforce modelling work to assess new roles (for example care navigators and physician associates) and ways of working to implement over the remaining five year-period. We cannot rely solely on creating new roles but need to also consider retraining our existing workforce to work across multidisciplinary teams. To that end, we will work with local education providers to ensure there is appropriate training available.</li> <li>• We will also develop our CEPNs using the model in place in CH where the CEPN has taken the lead for workforce development planning and implementation. This will ensure they can support us in implementing the new roles and delivery of workforce development initiatives in years two to five.</li> </ul>	

2016-17 deliverables	By 2021
<ul style="list-style-type: none"> <li>✓ Local Workforce Action Board.</li> <li>✓ Development of retention and joint attraction strategies to promote health and social care jobs in NEL.</li> <li>✓ Standardisation, testing and promotion of new/alternative roles.</li> <li>✓ Preparation to maximise the benefits of the Apprenticeships Levy as a sector.</li> <li>✓ Enhanced workforce sustainability models for our Community Education Provider Networks</li> <li>✓ Preparation for the removal of bursaries through strategic engagement with HEIs.</li> <li>✓ Developing the education infrastructure to realise changes with our education providers.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Retention improvement targets set in Year One and bank/agency reductions, delivered.</li> <li>✓ Full implementation of the right roles in the right settings.</li> <li>✓ Integration of roles at the interface of health/social care.</li> <li>✓ All staff to have structured career pathways.</li> <li>✓ Aligned/converged HR processes.</li> </ul>



## 2. Technology

As our system moves to new service and delivery models, it is essential that our technology enables these changes to occur. In doing so we will also meet the aim laid out in the Five Year Forward View of “fully interoperable electronic health records so that patients’ records are paperless”.

### Our current technology landscape and its direction

NEL Informatics have defined a series of key themes for the delivery of this vision. This is articulated slightly differently in each of the local strategies but delivers on three key themes of shared care records, advanced informatics, and patient access. These themes are supported by the delivery of fit for purpose infrastructure.

**NEL is signed up to the Healthy London Partnership’s aims of access for clinicians and patients.** We are fully engaging in the HLP digital programme which is connecting up all health and care systems across London and all of our approaches, although different, are supportive of this London-wide transformation programme.

Whilst each health economy has its own delivery plan the end result will need to align to our system vision:

#### 1) Shared care records enhancing collaboration

Providers will collaborate with health, social and community care. Systems will therefore need to be interoperable to allow for providers from primary, community, social and secondary care to work together. At present, fully interoperable systems across providers remains a crucial objective and we have already made some good progress towards interoperable systems through the Health Information Exchange (HIE) programme. In CH and WEL, this has already started to share the health records between GPs and providers. In BHR, interoperability has also made progress and the area is aiming towards a shared care record across sectors.

HIE links between Barts, ELFT, GP practices and the Homerton allow doctors in hospitals to view ten pages of GP held patient records and GPs to access discharge summaries, future appointments and test results for radiology and pathology. This is already used more than 5000 times a week by clinicians across the system and this usage continues to rise. The integration of other care providers is planned with social care integration starting with Newham council in 2016 and then expanding to other councils in subsequent years. Further care settings are also

planned with urgent care and GP out of hours systems to be integrated in 2016.

As further organisational systems are joined, the richness of patient information available to all will increase.

#### 2) Patients’ access to their own information

Patients require the ability to view their own health records and book appointments with their GP. This functionality is already available to most GP practices across NEL but it is not widely enabled or well communicated. At present, our GPs offer very few appointments online for fear of reducing access to patients without access to technology. Currently all of the NEL CCGs are planning to enhance the availability of current technologies for patient access and booking. Bids for money from the Estates and Technology Transformation Fund are being made to employ extra resources to make a significant effort to increase the use in each CCG. We are also piloting the use of alternative online channels for patients’ appointments including the use of Skype for patient consultations. It is crucial that we share best practice and that this functionality is integrated into the rest of NEL.

#### 3) Our health system will need to be proactive at preventing patients from escalating ill health and our interventions will need to be evidence-based

At present, each CCG has separate BI tools. In the future we will need advanced system-wide analytics to provide insight, prompt early interventions to enable informatics driven health management programmes.

There has been some progress on this in WEL where the Discovery Project will be used to enable real time reporting on programmes by providers and commissioners, supporting outcomes-based mechanisms and to use predictive analytics to anticipate individual patient health needs. Detailed work is now beginning which will see data feeds established and the system itself created in its initial form during the remainder of 2016/17. A Community of Interest company is being created that will hold the application and the data from all sources. This system will need to be delivered on an NEL level by 2021.

#### Looking forward

Our technology roadmap will need to progress according to the key aims of interoperability, patient access and unified analytics. We have three local digital roadmaps (LDR) at the moment and it is crucial that we align these so that our system vision is supported to deliver outcomes across NEL.

A high level NEL view, which aggregates the three LDRs into one, can be seen in the appendix.

2016-17 deliverables	By 2021
<ul style="list-style-type: none"> <li>✓ Gap analysis of whether we have sufficient capacity to deliver on the transformation objectives set out in the other workstreams.</li> <li>✓ Investigate whether we can create a unified LDR for NEL.</li> <li>✓ Further refinement of a common technology vision and strategy for NEL.</li> <li>✓ Establish detailed implementation plan for 2016/17 and beyond.</li> <li>✓ Start to deliver against targets in online utilisation, shared care records, and eDischarges.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Full interoperability by 2020 and paper-free at the point of use</li> <li>✓ Every patient has access to digital health records that they can share with their families, carers and clinical teams</li> <li>✓ Offering all GP patients e-consultations and other digital services</li> <li>✓ Utilizing advanced/preventive analytics towards achieving population health and wellbeing</li> </ul>



### 3. Infrastructure

Estates are a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit-for-purpose buildings and to meet the capacity challenges produced by a growing population.

Due to rapid population growth, we may need to increase our infrastructure to handle the sheer number of births in NEL. In WEL alone, it is estimated that in the 'do nothing' scenario, we will require an additional 1.1 million primary care appointments, and 550 beds by 2025. We are likely to see similar demand in CH and BHR.

Some of our estates are faltering under the pressure of population growth, Care Quality Commission (CQC) requirements and performance targets. For example, the current Whipps Cross Hospital facilities and estates infrastructure do not support the provision of high-quality modern health care services. Barts health and partner organisations are now reviewing the configuration of clinical services on the site.

In NEL we have a significant opportunity to make a major **contribution to life sciences by transferring exciting discoveries from academic research into ground-breaking NHS clinical practice** that improves patient care. This can happen not only through developing new drugs or new medical technologies, but also increasingly through the application of large-scale data analytics to health care. A crucial element of this approach is our work at Royal London.

**Our estates strategy is based on the following principles:**

- We are currently estimating 111,178m<sup>2</sup> of unutilised space spread across acute and community care estates. We will make effective use of 'void' space.
- Our approach to estates needs to build on existing plans to support delivery at scale.
- We will only undertake new builds where **opportunities to rationalise and maximise utilisation of the existing estate have been realised** or where such developments deliver a whole life cost-saving versus continuing use of the current estates.
- The **development of the NEL estates strategy will be led by the new system vision**, enabling more effective delivery of care at scale.

**Summary of indicative investment and savings opportunities**  
 Estimated net capital investment: £500-600m  
 Annual net savings: £10-20m

**We have agreed to a number of priorities for our estates roadmap**

This covers both clinical and administrative estates, both of which will need to be rationalised. Clinical capacity needs to be used for clinical space as much as possible:

- 1. Clinical estates priorities**
  - Implementing any **changes from new models of care** including surgical centres of excellence and delivered care at scale.
  - Improving estates to deliver quality care. Bringing Whipps Cross to a level where it is fit to deliver quality services, at an estimated cost of £450m.
  - Seven acute hospital sites with reorganised focus.
  - Reducing the amount of **unoccupied land** in NEL.
  - Focusing on utilisation, **reducing non-patient occupied areas** as is currently being explored in Barts and BHRUT.
- 2. Administrative and academic estates priorities**
  - Building a Life Sciences campus as part of the development of land in the Whitechapel area adjacent to the Royal London Hospital.
  - **Consolidation of administrative functions**, to deliver greater productivity across providers and reduced use of leased space.
  - Co-location of **administrative functions on fewer sites**.

**Our asks and priorities for estates:**

- We request flexibility and support in exploring options for reducing the cost of the PFI.
- We ask to **recycle the proceeds of sale** including NHS Property Service buildings.
- We need to establish appropriate system leadership to ensure that people think about estates at an NEL level whilst building on local priorities.

2016-17 deliverables	By 2021
<ul style="list-style-type: none"> <li>✓ Agree common estates strategy and governance and operating model.</li> <li>✓ Establish detailed implementation plan for 2016/17 and beyond, which reflects opportunities for savings and investments as well as demand and supply implications resulting from other workstreams and demographic factors.</li> <li>✓ Achieve a consolidated view for utilisation and productivity, PFI opportunities, disposals, and new capacity opportunities and requirements across the patch.</li> <li>✓ Explore sources of capital, working with NHS and Local Authorities for example One Public Estate.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Realise opportunities to co-locate healthcare services with other public sector bodies and services.</li> <li>✓ Dispose of inefficient or functionally unsuitable buildings in conjunction with estates rationalisation.</li> <li>✓ More effective use of 'void' space and more efficient use of buildings through improved space utilisation.</li> <li>✓ Investment in capital development works to support strategy delivery.</li> </ul>



# 7. Five Year Affordability Challenge

## Introduction to NEL finance and activity modelling

While substantial progress has been made on the financial and activity modelling for the NEL STP, the finance and activity plan for the June 30<sup>th</sup> submission should not be regarded as the final position. Further detailed worked-up analysis will follow over the coming months. We recognise that it is important to maintain this momentum and so this analysis will be conducted by the recently established finance working groups and will be supported by appropriate resources.

The basis for the financial modelling has been the five year Operating Plans prepared by individual NEL commissioners and providers, all of whom followed an agreed set of key assumptions on inflation, growth and efficiencies. The individual plans have then been fed into an integrated health economy model in order to identify potential inconsistencies and to triangulate individual plans with each other.

### The NEL NHS FY21 affordability challenge is £847m in the 'do nothing' scenario

A number of different scenarios, based on different levels of CIP and QIPP delivery have been developed for NEL to identify the potential five year NHS affordability challenge. The forecasted NEL FY20/21 'do nothing' affordability

challenge is £847m. This assumes growth and inflation in line with organisations' plans but that no CIP or QIPP would be delivered in any year.

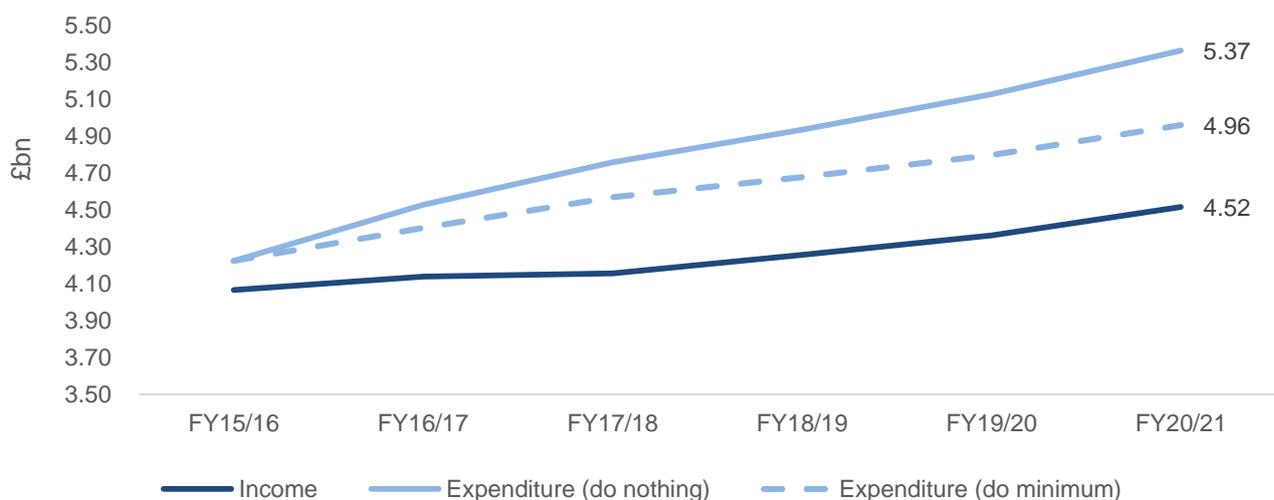
In the 'do minimum' scenario<sup>1</sup>, in which 'business as usual' efficiencies of 2% across all years have been included, the affordability challenge would be £444m by FY20/21.

Specialised commissioning<sup>2</sup> and differences in contract assumptions<sup>3</sup> are included in these projections. The local authority position is modelled separately and a summary is available in this chapter.

A number of factors are driving our rising expenditure. One significant factor is our growing and ageing population in line with GLA projections. We also face a non-demographic demand growth which are due to factors such as new technology and increases in disease prevalence; we have assumed that this growth is 1% per year although it may be refined later to account for local circumstances. Pay and price inflation have been assumed in line with NHS I guidance. This results in a steady increase in expenditure over the planning period.

We see significant increases in CCG allocations throughout the planning period. However, STF and some other non-recurrent provider income (such as asset sales) primarily affect the initial years and have little impact from FY18 onwards. This leads to an initially slower growth in the income position for the whole health economy.

**Total system-wide income and expenditure for 'do nothing' and 'do minimum' scenarios**



<sup>1</sup> 'Do minimum' scenario includes: FY17 full QIPP as per CCG plans, no QIPP delivery for FY18 onwards and 2% CIP delivery in FY17 and beyond

<sup>2</sup> Specialised commissioning is estimated to be an additional £134m pressure for NEL.

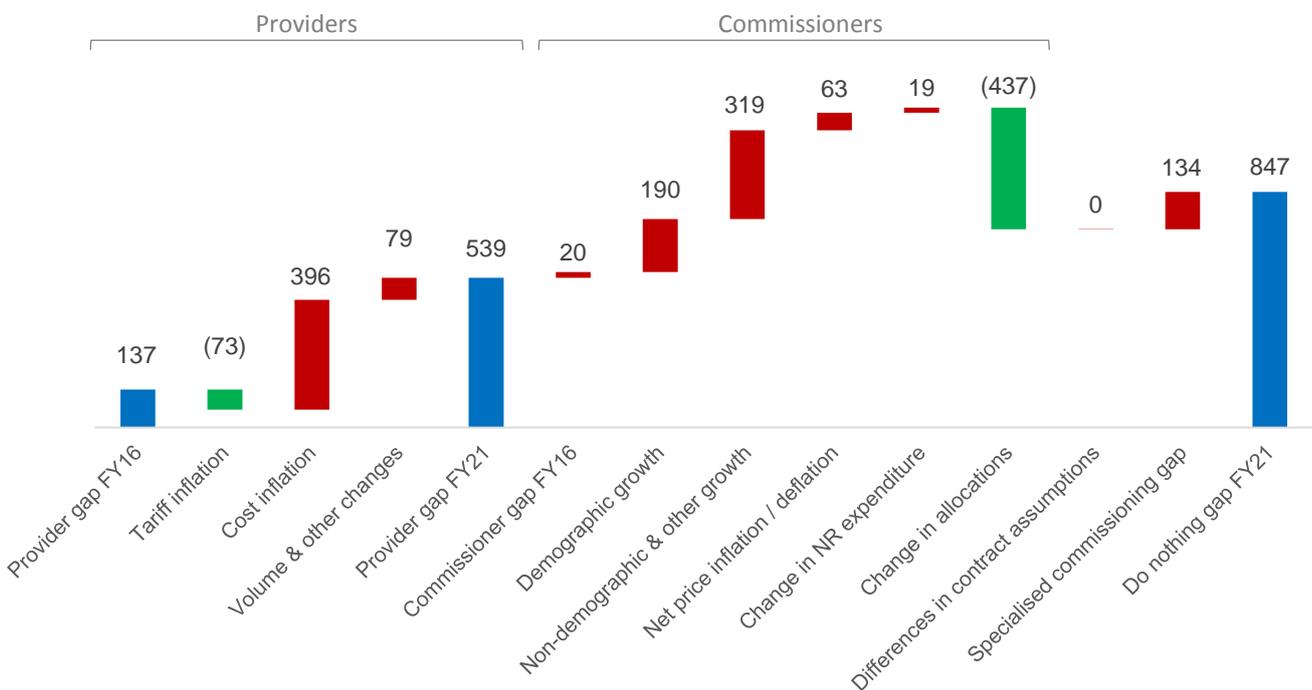
<sup>3</sup> Contract assumption differences between CCG expenditure and provider income are modelled as an additional affordability pressure to the system.



**FY20/21 bridge in 'do nothing' scenario**

The opening NEL provider deficit in FY16 was £137m which will rise by £402m to £539m in FY21. In FY16, NEL CCGs had a planned £20m draw down from prior year surpluses and CCG allocations uplifts of £437m are not sufficient to offset cost pressures over the planning period. Differences in contract assumptions net out to zero overall but specialised commissioning represent a £134m pressure, resulting in a total financial challenge of £847m in the 'do nothing' scenario.

NEL commissioner and provider financial bridge from FY16 to FY21 in £m



Detailed bridges for each organisation which provide further transparency about the assumptions underpinning this scenario and the challenge faced by each individual organisation are found in the finance appendix.

**NEL local authority challenge**

All NEL local authorities and the Corporation of London have provided financial data for the STP modelling, although further work is required to confirm some additional assumptions that have been made.

For the 'do nothing' scenario, the combined FY17 local authority challenge is estimated as £86m reaching £230m by FY21. A 'do minimum' scenario, where 'business as usual' savings are assumed, will need to be completed as soon as possible.

Further work is also planned to investigate with local authorities how financial challenges and proposed service changes will impact on health services.



### Closing the gap – workstream view

Starting from the ‘do nothing’ gap of £847m, ‘business as usual’ efficiencies would reduce the affordability gap to £444m. Within the ‘business as usual’ efficiencies, it has been assumed that CCGs deliver their FY17 QIPP targets and that providers deliver 2% CIPs in each year from FY17 to FY21. The latter assumption is aligned with the implied efficiency requirement in the tariff guidance issued by NHS I and with the average assumptions made by the other London STPs. Furthermore, reported average CIP achievement over the last three years has been above 2% for NEL providers<sup>1</sup>.

Should NEL providers deliver their CIP targets for FY17 in full in line with operating plans, the ‘do minimum’ gap would reduce further to £350m. A number of providers have put forward savings plans slightly higher than 2%; these are valued at £64m and will be realised after FY17 and would bring the gap down to £292m. Delivery risks around these targets are being assessed and closely monitored so that a realistic risk rating can be included in our final submission over the next months. The FY21 position shown in the closing the gap charts below is the recurrent position. For Barts Health, there are pressures evident in achieving the FY17 control total on an outturn basis, however as the Trust intends to hit the control total on a run-rate basis, this will not change the FY21 position.

The bridge below includes transformational savings from the Hackney devolution pilot, the WEL TST programme, the BHR ACO programme and the Healthier London Partnership (see Better Care Section, Page 7). Some of the targeted savings of these programmes can only be delivered in close collaboration with Local Authorities and have to be considered in this context.

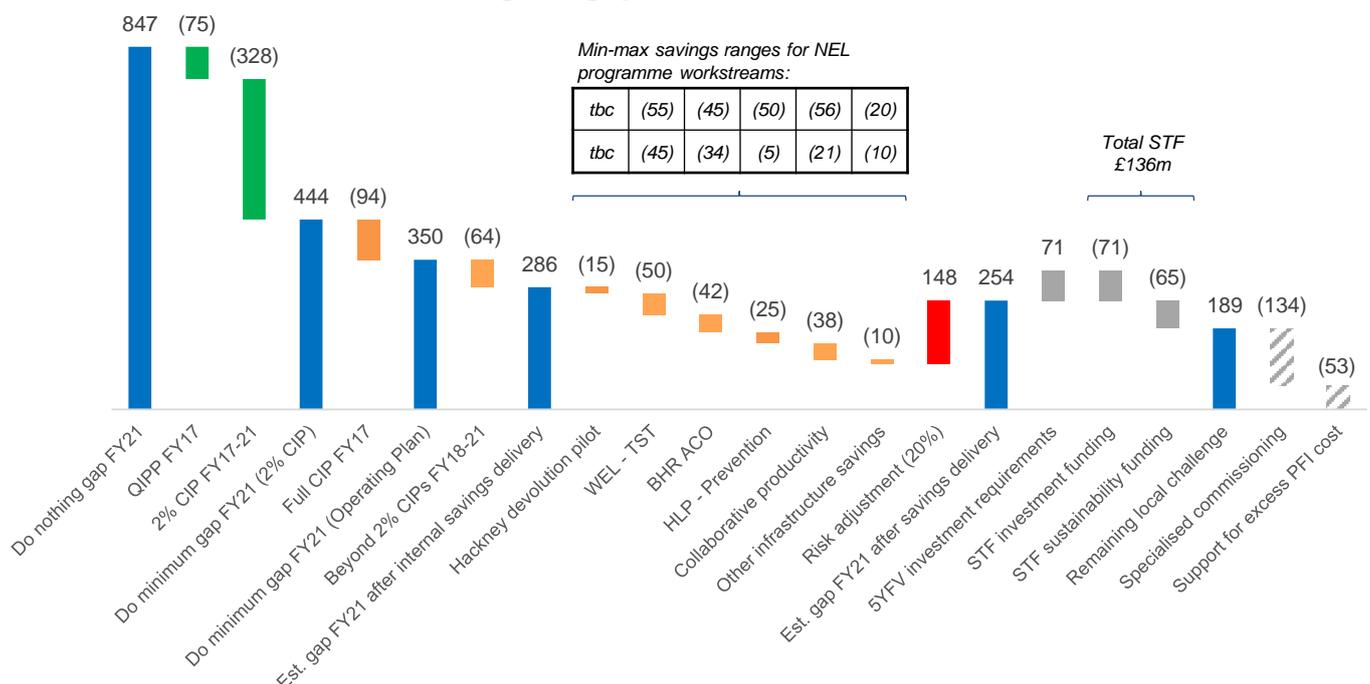
The QIPP (£75m) and CIP (£328m + £94m) values are built into the 2016/17 Operating Plans. Beyond this, a further £244m in total of savings opportunities have been identified through the productivity, transformation and infrastructure workstreams. Many of these are at an early stage of development. A risk adjustment of 20% has then been applied on the entirety of the savings values, not directly assigned to specific items at this stage but providing an overall risk buffer.

The ‘beyond 2% CIPs’ in FY17-21 amount to £64m. A further contribution of £38m to closing the gap is expected from collaborative productivity opportunities (see chapter 5). Key areas across all categories of provider productivity include bank & agency spend, back office, procurement, theatre productivity, diagnostics, length of stay and pharmacy (see Productivity, p21). Due to the consolidated provider landscape in NEL, some efficiencies that would be considered ‘collaborative’ elsewhere can be captured by provider internal initiatives in NEL.

Infrastructure opportunities are reliant on major capital investments of £500-600m (£800m costs offset by c.£250m receipts). These investment costs relate predominantly to the Whipps Cross site, and while a range of different options are being explored, a solution will have to be found in any scenario (see chapter six).

By FY21 the notified indicative STF is expected to be £136m. Of this, the sum of £65m currently provide in FY17 for organisational support is expected still to be required, with the balance of £71m therefore available for new system investments to deliver the NHS Five Year Forward View priorities. As a result, NEL will be able to further develop the plan to close the gap excluding specialised commissioning if additional funding for excess PFI cost (estimated at £53m) can be made available.

### Closing the gap in £m - workstream view



<sup>1</sup> Historic CIP delivery for NELFT to be confirmed

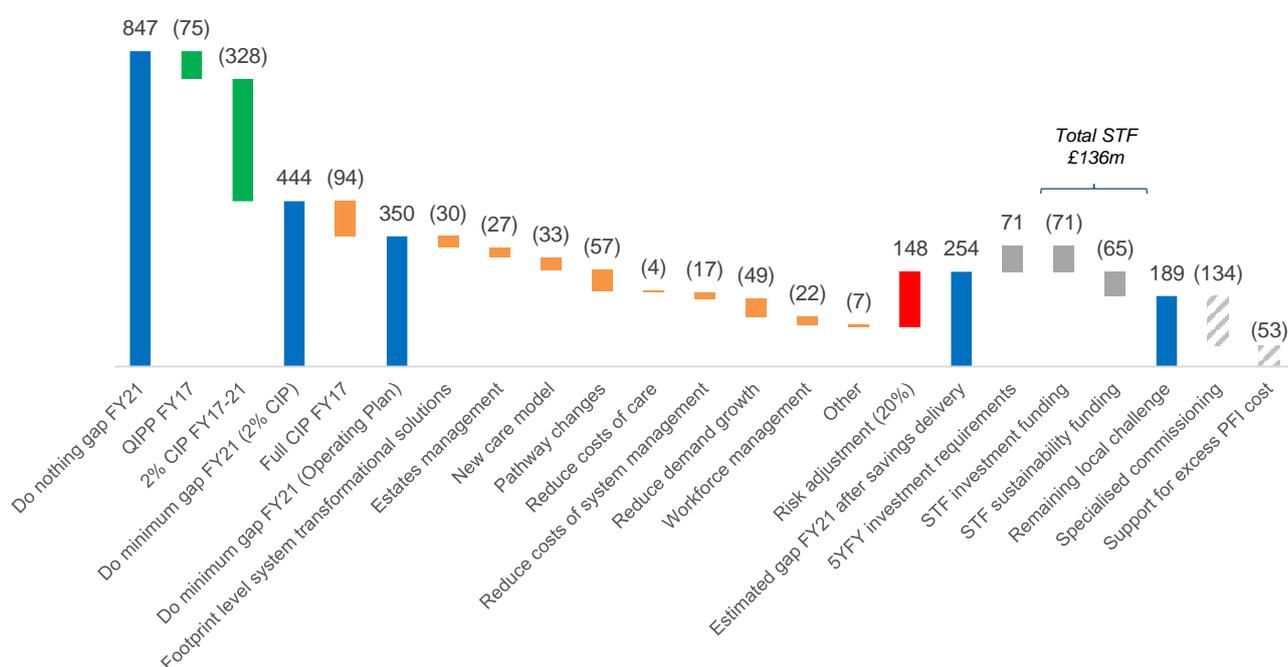


## Closing the gap – functional view

An alternative analysis of how NEL aims to close the gap can be provided by describing and classifying the efficiencies along functional levers that align with the NHS Five Year Forward View.

Please note that some of the mapping from workstream to functional categories still need to be confirmed by the workstream leads and is subject to change.

### Closing the gap - functional lever view - in £m



Additional detail of the preliminary mapping is provided in the table below for reference.

NEL workstreams in columns, functional levers in rows Values are in £m	QIPP FY17	2% CIP FY17-21	Full CIP FY17	Hackney devolution pilot	WEL - TST	BHR ACO	HLP - Prevention	Beyond 2% CIPs					Collaborative productivity	Infrastructure	Specialised comm.	Total
								BHR	HUH	ELFT	BH	NELFT				
BAU efficiencies – commissioner	(75.2)															(75)
BAU efficiencies – provider		(328.1)	(94.1)													(422)
Footprint system transformation										(10.1)	(1.9)	(18.4)				(30)
Estates management					1.3	(15.2)								(10.0)		(27)
New care model				(5.0)	(18.9)	(8.8)										(33)
Pathway changes				(5.0)	(20.5)	(8.8)		(14.5)			(7.3)		(0.9)			(57)
Reduce costs of care					(2.9)								(0.9)			(4)
Reduce costs of system mgmt								(6.8)		(0.6)		(1.8)	(7.6)			(17)
Reduce demand growth				(5.0)	(8.8)	(8.8)	(25.0)						(0.9)			(49)
Workforce management								(3.9)		(6.6)		(2.4)	(8.6)			(22)
Other										(1.0)	(4.7)		(1.0)		(134.3)	(141)
<b>Total</b>	<b>(75)</b>	<b>(328)</b>	<b>(94)</b>	<b>(15)</b>	<b>(50)</b>	<b>(42)</b>	<b>(25)</b>	<b>(25)</b>	<b>(8)</b>	<b>(25)</b>	<b>(6)</b>	<b>(38)</b>	<b>(10)</b>	<b>(134)</b>		



**More detailed breakdown of provider productivity opportunities**

Given the importance of provider productivity, the table below provides another alternative breakdown of all CIPs for FY17 (in total £159m), beyond 2% CIPs for FY18-21 (£64m) and collaborative productivity (£38m) by savings lever.

Category	£m
Workforce (bank, agency, substantive)	69
Procurement	33
Run-rate reductions	30
Unidentified	23
Back office	18
Theatre productivity	16
Other	13
Infrastructure - estates & IT	12
Diagnostics	12
LoS efficiency	10
Clinical service redesign	10
Pharmacy & drugs	5
Income related	4
Clinical strategy	3
CSS	2
Outpatients	1
<b>Total</b>	<b>261</b>

**Finance outlook**

It is recognised that a number of key questions will still need to be answered before final NEL plans can be submitted over the next months:

- Specialised commissioning gap: specialised commissioning is important for all of our providers. To date, the specialised commissioning gap is not yet fully broken down to CCG-level and the opportunity analysis is in very early stages. NEL recognises the importance of specialised commissioning for its providers. We welcome and will fully participate in the announced specialised commissioning programme initiated by Simon Weldon
- Organisation level financial balance: the bridges in the finance appendix indicate the magnitude of the financial challenge for each organisation. We appreciate that the impact of BAU and transformation efficiencies on each organisation and their ability to achieve financial balance needs to be worked up in more detail. In parallel, system-wide risk sharing agreements could be explored
- Monitoring of delivery: operating plans are based on delivery of substantial savings in this financial year. We recognise the associated risks and the necessity to monitor delivery carefully to ensure plans are based on realistic assumptions and are updated without delay once the level of achievement versus operating plans becomes clearer.
- Firming up savings estimates and delivery plans: for several of the NEL workstreams, savings estimates and delivery plans will be worked up in greater detail over the next months.



# 8. Governance and System Leadership

We have made rapid progress in the development of governance arrangements for the delivery of local programmes including the commitment to a memorandum of understanding in BHR, long-established governance guiding TST and an integrated care programme board in CH. In order to successfully deliver place-based systems of care, we need a robust governance structure that will allow individual organisations to have a shared responsibility while balancing the need for autonomy and accountability.

As leaders of the NEL health system, we will continue to have honest and open discussions about what is right for our population, and through this, we will jointly shape the governance arrangements required to achieve our ambitions. We are committed to establishing robust leadership arrangements based on agreed principles, that provide real clarity and direction, and can drive through the plans outlined in this STP. Through the detailed planning phase we will define the most appropriate delivery levels for each of the initiatives outlined in this plan (i.e. at a NEL STP level or a local programme level).

The STP will act as an ‘umbrella’ plan, weaving together the local area plans to ensure:

- Best practice and learning is shared across the local programmes.
- Progress is consistently tracked both at a NEL and local level.
- Issues are addressed and unblocked to enable delivery of system benefits.
- Local engagement is maintained to ensure continued traction.

The NEL health system has a diverse stakeholder landscape. Focused and tailored stakeholder engagement is critical to ensuring the support required from across the system to deliver these plans. In particular, we are committed to serving our patients and local residents and believe that their voices are vital to the shaping and delivery of these plans.

**Creating shared accountability and responsibility for delivery**

In April 2016 we outlined the governance and leadership arrangements that we had put in place for the high level planning phase of our STP. As we move into the detailed planning and implementation phases we will update our governance arrangements so that they remain appropriate, based on the following agreed principles:

- All areas of the NEL health and care system will be represented in the governance process.
- The governance will be collaborative and streamlined to ensure timely decision making.
- Patients and local communities will be represented to ensure they have active input into any changes.
- There will be strong clinical leadership and involvement to ensure proposals have a robust clinical rationale.

- Decisions will be taken at the most appropriate level.
- Any decision that has a material impact on patient services will be approved by the statutory organisations legally responsible for those services.
- The system level governance will be aligned with local delivery plans and governance arrangements, to enable decisions to be made at the most appropriate level.

The NEL Sustainability and Transformation Board (STB) will continue to act as a central voice, representing the whole system. The board will be widely represented across the system, with representatives from all CCGs, providers, local authority STP leads, HEE, NHS E, NHS I, patients and lay members. The STB will draw on the expertise of the STP Executive, a smaller group of senior leaders who will work through content and provide recommendations to aid the decision-making process.

The finer details of future governance arrangements are currently being developed with the system leadership team.

**Working together to address the difficult issues**

We have a history of working together collaboratively and are committed to building on this through further system level organisation development. We have agreed a set of core principles that will guide our leadership behaviours:

- We will work collaboratively in the best interests of the NEL health economy and put patients and local communities at the heart of our decision making.
- Where appropriate sector-led decisions must take priority over local decisions.
- We will ensure that benefits are delivered at pace with clear accountability; having governance arrangements, delegation procedures and explicit leadership to facilitate continuous progress and timely decision making.
- Each organisation will act in a supportive manner exhibiting strong, strategic leadership underpinned by shared values which should permeate from the top down to the front line.
- We will recognise the sovereignty of organisations, but work within this to deliver system level benefits.
- All organisations will commit appropriate resource and funding to system level change.
- We will openly share information to support the development of robust system-wide plans.
- We will support each other to solve our collective and local issues.
- We will tackle the really difficult decisions that will arise during the planning and implementation of the five year plan.



**Ongoing dialogue with stakeholders**

Continuous and meaningful communications and engagement is central to achieving our vision to transform local health and care services and ultimately delivering the vision set out in the Five Year Forward View.

Our communications objectives are:

- To inform and involve local communities in the development of the STP and our emerging vision for health and care in NEL.
- To involve local people in the creation of plans and services.
- To reassure people that this is a piece of work which will make a positive impact on their lives and the quality of care they receive.
- To clarify and reassure how the STP will interface with other plans that are currently in development or delivery.

For all audiences, communications and engagement will be planned, clear and informative so that stakeholders are reassured and their needs are managed.

We have been working with stakeholders, including Healthwatch and patient engagement representatives to look at how to best ensure patients, staff and the public are involved as we continue to develop the STP and these discussions are ongoing. We have held system leadership events with local authority chief executives and provider and CCG representatives and held workshops with partners across the system to develop our plan, and more are planned. We are currently planning how to engage more formally with board and partners in July and beyond.

We recognise that involvement of the local authorities is central to the success of our ambitious plans to develop truly person-centred and integrated health and social care services. We have committed dedicated resources to engagement with local authorities and health and wellbeing boards. Regular updates are provided via our local authority engagement lead.

Listening to feedback from local authorities, Healthwatch and patient representatives, we are looking into how we can involve local people in the formal governance structures within the STP. We envisage this involving a lay member representative on the board, on each steering group and using virtual groups to review communications materials. We will use a range of approaches to engage with the population, including digital and social media alongside the more traditional approaches of focus groups, meetings and forums. We are also looking at using co-design to develop services, so change is truly user-led.

We are committed to National Voices' six principles for engaging people and communities that set the basis for good, person-centred, community-focused health and care and will embed these across our work. We also believe that staff have a crucial role to play in the success of the STP. We want them to contribute to its development, to understand and support its aims, and feel part of it, and be motivated by it.

We recognise that any changes proposed in the STP may require public consultation, and are committed to the government's principles for consultation (2016). We will look at how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

**Meeting our equalities duties**

We are committed to ensuring that everyone has equal access to high-quality services and care, regardless of gender, race, disability, age, sexual orientation, religion or belief. We will work closely with patients, staff, partners and voluntary organisations to help reduce inequalities and eliminate any discrimination within NHS services and working environments. As part of the development of the final STP we will carry out engagement with people who have protected characteristics as set out in the Equality Act 2010. We will conduct equality impact assessment screenings to identify where work needs to take place and where resources need to be targeted to ensure all groups gain maximum benefit from any changes proposed as part of the STP.

**Modifying system incentives to favour collaborative working**

We acknowledge the need to gradually move from incentives that reward activity to systems that drive population health and share risk. Although the transition towards outcome-based incentives and capitation will be complex and will require changes to policy and commissioning, this change is integral to transforming our system of care.

**Aligning transformation funding to the objectives of the STP**

We are committed to putting in place processes that will ensure that the allocation of financial resources are aligned to the strategic objectives of the STP.



# 9. System Reform

## Building on our progress to achieve our system vision

Our approach to system reform will build on the progress we have made to date to deliver our ambitious vision for accountable care systems NEL-wide. Place-based care requires providers, local authorities and CCGs to work together to focus on outcomes. At present, providers across sectors are not incentivised to work together to deliver integrated care or rewarded on outcomes.

Our response has been to develop innovative models of commissioning, contracting and moving to **place-based accountable care systems**. NEL has planned two of the five devolution pilots in London and implemented a range of other innovative system configurations.

### Hackney's Devolution pilot

CH's aim is to develop a fully integrated commissioning function with governance across the CCG and the two LAs. Through this, they will commission for outcomes and encourage provider collaboration in order to deliver integrated, person-centred care.

So far, CH has developed a range of integrated service models and commissioning arrangements with the help of the Better Care Fund. This includes an integrated care model underpinned by an alliance contract, a health and social care independence team that focuses on intermediate care and reablement, and a fully integrated mental health service.

In addition, CH is exploring ways to improve the quality and coordination of out of hospital services through the "One Hackney" provider network, which uses an alliance contract to support the collective delivery of metrics and outcomes.

Through the devolution pilot (see appendix) Hackney will take the opportunity to develop their ideas around systems and access in order to develop the correct organisational forms.

### BHR's Devolution Pilot

BHR are using the opportunity of devolution to bring health and wellbeing services together as an ACO. Their devolution business case (see appendix) outlines a plan to achieve fully integrated health, social and other LA services, which places people at the centre and achieves care at scale.

Such changes are only possible with wide-scale system reform, and therefore the plan is underpinned by the pooling of health and social care budgets, commissioning by outcomes, and an ACO business model to enable aligned incentives and collaborative working. New models of contracting will be crucial as BHR moves away from commissioning on a tariff based or block contracting approach, and towards commissioning for outcomes.

In this model, there will be a single leadership team accountable for both the development of the ACO and BAU activities. An ACO model represents an opportunity to address BHR's current system challenges. This will ultimately work towards the creation of a person-orientated, sustainable service model that will radically improve the lives of local people and build strong resilient communities across BHR.

### Waltham Forest, Tower Hamlets & Newham

Over the past two years, the Transforming Services Together programme has developed the vision around accountable care systems for each borough. Tower Hamlets has developed an Integrated Provider Partnership (THIPP) with Barts Health, East London NHS Foundation Trust, the London Borough of Tower Hamlets and Tower Hamlets GP Care Group, for which Community Health Services is planned to start in October. The lead provider in this model is Tower Hamlets GP Care Group, which subcontracts to the other providers; crucially payment is based on outcomes rather than activity and partners are expected to provide a range of services within the organisation. Newham and Waltham Forest are planning a similar model.

WEL is taking a phased approach to capitated budgets to ensure payment is outcomes based. In development since 2015, WEL is currently using a shadow capitated budget that will be fully integrated by 2016/17.

Through commissioning by outcomes and multidisciplinary working WEL are aiming to achieve the vision of person-centred, affordable care. This will require significant reform of existing structures including the way that GPs and other providers work together.

### In all of these cases, providers will need to reform in order to meet new contracts and commissioning models.

Our providers already have significant plans for improving their clinical and collaborative productivity. Reforming incentives will require changes to the way they design, measure and deliver services. Providers will need to:

- Develop new models for joined up working (and appropriate governance). As providers will have increased accountability they will need to develop inter-organisational forums and processes for decision making and holding each other to account.
- Reform focus towards outcomes: Capitated budgets will require significant provider reform as they reorient their systems towards achieving outcomes rather than activity.
- Collaborate to deliver integrated care: Integrated care will need to depart from traditional, competitive and siloed behaviours by focusing on the way patients flow through the system.
- Provider productivity: New contracts will require providers to collaborate more effectively and to deliver services at greater scale; to facilitate this they will need to explore productivity arrangements such as sharing back office functions.

### Looking Forward

The challenge now is to leverage these innovations and collaborate with local, national and regional partners to achieve our system vision of integrated and joined-up-care, where local authorities and NHS providers intentions are aligned.



### Taking System Reform Forward

Our pilots for system reform all share a common purpose: to integrate care around people and to make the system accountable as a whole for the health outcomes of local people.

Taken together they are the foundation of achieving our system vision, and as such, they are aligned with a common set of 'asks' for the STP as a whole.

#### A common set of features underline our devolution pilots

Each of the pilots share a number of features in common and these features support our system vision:

- **Patient centred:** Each devolution pilot encourages providers to plan and deliver the service together and as payment will be outcomes based rather than activity based, services will be more fully centred on the needs of people.
- **Integrated:** All of the commissioning and delivery models above combine primary, social, community and acute care into a accountable care systems, which enhances integrated care, improving patient experience and reducing duplication.
- **Provider collaboration:** This system offers a range of productivity gains for the whole system. For example, our whole-system need to reduce unnecessary testing is more achievable as the incentives of various providers are aligned and patient pathways can be more effectively designed.
- **Whole system productivity:** When working as a single contracted organisation, synergies can be achieved in sharing of staff and reduced duplication of activities.

#### Our system reform 'asks' for the STP

Our localities have formed a number of 'asks' that will enable their local plans, which support the system vision. These 'asks' include:

- **Regulation:** Accountable Care Organisations and integrated care require whole system collaboration and a shared commitment to patient outcomes. As such, they need consistent regulatory responses that treat the underlying partners in care as a single system. We request that where plans exist for accountable systems, the system be regulated as a whole, despite the fact that there are distinct underlying organisations.
- **Governance:** We welcome the freedoms of devolution pilots and are looking to achieve similar standards across NEL. We request flexibility on health and social care funding arrangements and freedom to break from existing regulation to deliver system-wide objectives.
- **Accountability:** We request specific governance arrangements that are agreed with the centre between NEL and our accountable care systems. We request that these arrangements cover safety, quality, finance and health and wellbeing standards and outcomes.

- **Commissioning:** We request the ability to develop and account for single system-wide budgets for all health, wellbeing, and social care services.
- **Contracting:** We request that there is flexibility around tariffs and payment mechanisms.

#### Innovation is critical to support reform agenda

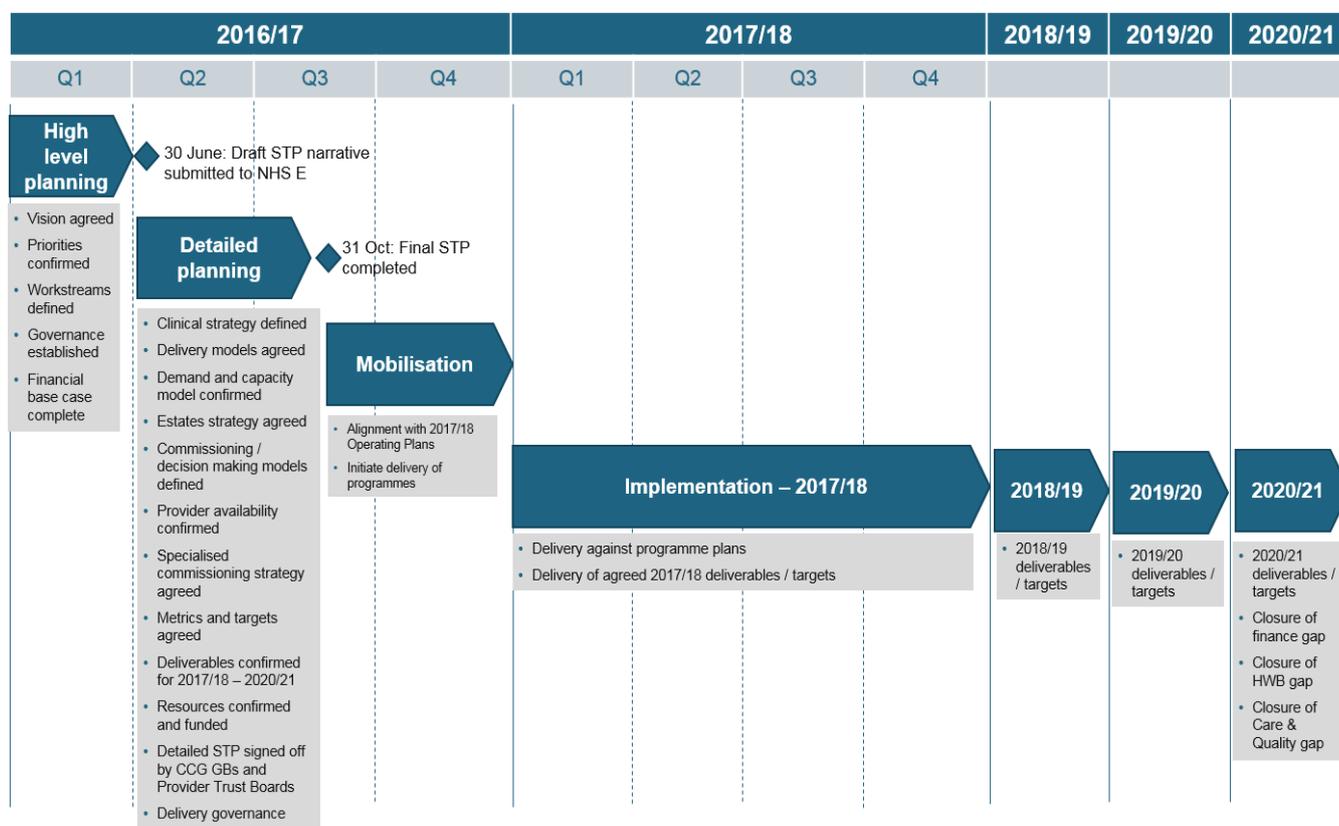
NEL has made progress in collaborating with academic institutions to deliver innovative care for our residents. These are aligned to our priorities for transforming care and present the opportunity to deliver better care:

- UCL Partners, our academic health science network, hosts the National Innovation Accelerator which brings screened, high value innovations and support for implementation.
- Currently, work is underway within the Clinical Research Network to enable access to clinical trials. This will help us to deliver on our world class ambition by enabling early access to therapies for the people of NEL.
- NEL hosts the only innovation test bed in London at Care City (jointly set up by NELFT and LBBDD) which is focused on helping patients to manage their own health conditions and to remain as independent as possible.
- Digital Health London which aims to identify high impact innovations to support systems to address. We need to capitalise on the recent Innovation Tariff's announced to enable digital innovations.
- NELFT Memory Services are award-winning services with ratings of double excellent (Royal College of Psychiatrist accreditation).
- Workforce reform for example a rotational nurse programme which aims to train nurses so that they are competent in both physical and mental health – this holistic approach has already seen benefits in relation to patient care and efficiency in treatment pathways.

Each local plan for system reform is aligned to the overall vision of creating accountable care systems that are person-centred. This can only be achieved through providers collaborating with a focus on patient outcomes and affordable high quality services. Old ways of working, in which providers are incentivised to compete for activity will no longer support this vision. We will need to enhance our collaboration with each other and with our national stakeholders to create a system of incentives that encourages providers to work towards our vision of person-centred care.



# 10. Making Progress



Through our STP development process we have developed an initial delivery structure comprised of four portfolios (transformation, productivity, infrastructure, specialised commissioning) and four supporting enablers (workforce, technology, finance, communications and engagement). Senior responsible owners, delivery leads and programme managers have been aligned to each area. We will continue to review this delivery structure as we move into the detailed planning and implementation phases, and modify as required.

We recognise that the further development and delivery of the plans in the NEL STP will involve significant financial modelling, project management and design resources. It is crucial that we secure these resources in order to ensure an appropriate level of grip and the realisation of benefits. Therefore we have agreed that all partners will contribute resources and have devised a set of core principles that will define the appropriate level of investment from each organisation.

We have conducted an initial resourcing workshop for partner organisations to agree the principles of the resourcing of the next phase of the programme. Also, we have organised a planning workshop involving senior leaders from Local Authorities, CCGs, providers as well as lay representatives to develop the governance arrangements for the next phase of the NEL STP programme.

We will implement a robust benefits management process as part of our delivery plan to ensure that all benefits are clearly articulated, quantified, tracked and realised.

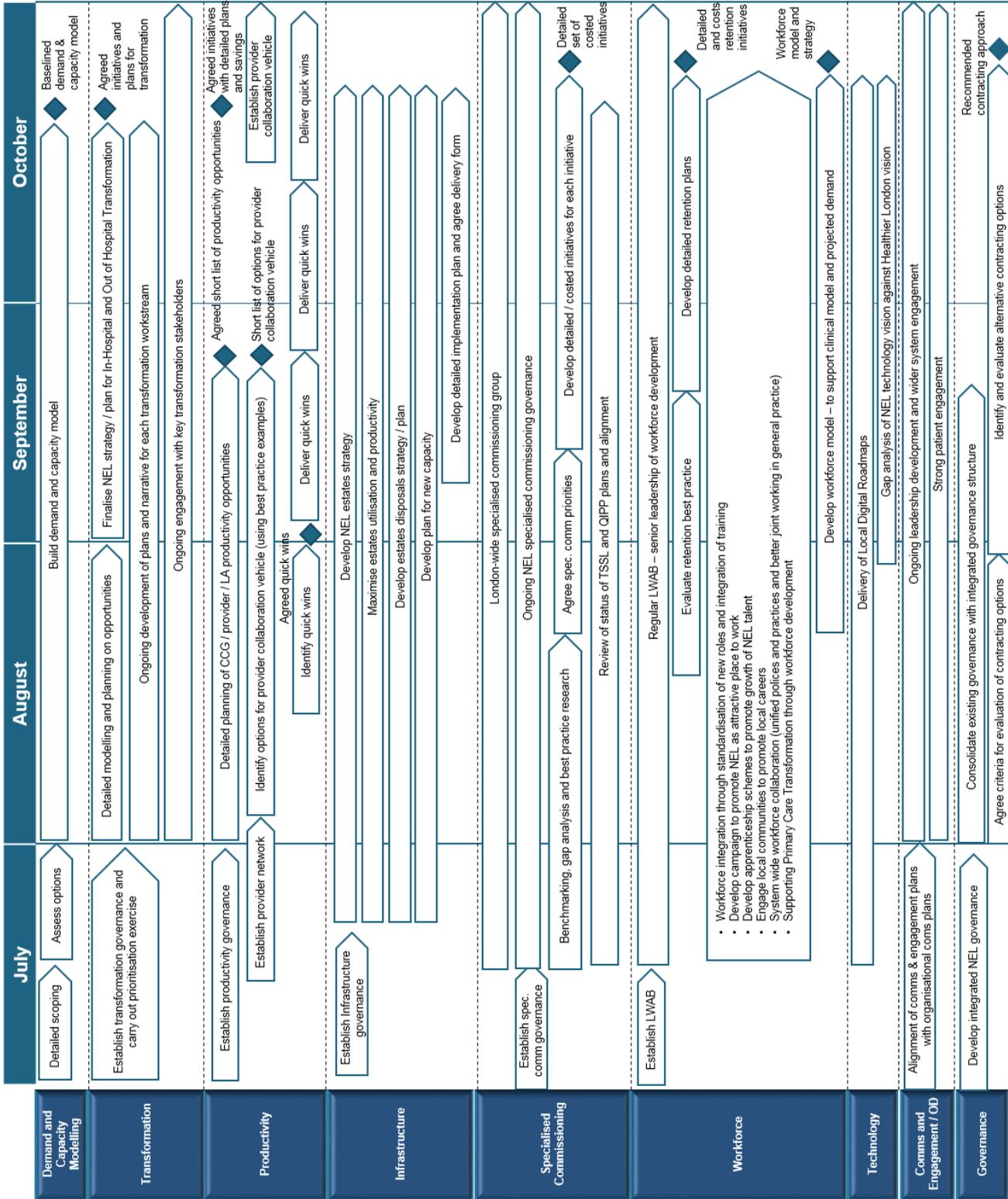
Throughout this process we will continue to ensure that there is total alignment between the five year plans outlined in the STP and the one year operational plans that our CCGs develop each year.

### Managing risks to the delivery of our plans

We have established a robust proactive risk management process. The key risks to the delivery of our STP that we are currently managing are:

- The plans defined in the NEL STP may not be sufficient to address the full scale of the financial gap.
- The system partners may not be able to work together collaboratively to deliver the cross-system plans to close the health and wellbeing, care and quality and financial gaps.
- Due to the size of NEL and the range of stakeholders in this area, it may not be possible to secure the required level of stakeholder buy-in for the STP.
- There may be a legal challenge to the plans outlined in the STP.
- There may be adverse media coverage of the NEL STP, leading to public suspicion of the plans.

## Key activities and indicative timelines to finalise the NEL STP





# 11. Our ‘Asks’

We will work together to achieve our system vision, but this will require significant collaboration with the centre and a reform of the way our system relates to national and regional bodies. These ‘asks’ are NEL wide and are reflective of the individual asks that support our devolution pilots.

<p><b>Governance and accountability</b></p>	<ol style="list-style-type: none"> <li>1. In order to achieve our long term aims we need consistent accountability and governance over the next five years. We request clear and specific governance arrangements are developed and agreed between NEL and our accountable care systems, and regulators. We request that these arrangements cover safety, quality, finance and health and wellbeing standards and outcomes.</li> <li>2. We welcome the freedoms of devolution pilots and are looking to achieve similar standards across NEL. We request flexibility on health and social care joint funding &amp; commissioning arrangements (see note below) and freedom to break with existing regulation to deliver system-wide objectives.</li> </ol>
<p><b>Estates</b></p>	<ol style="list-style-type: none"> <li>3. This sector has a number of PFI funded arrangements including the UK’s largest hospital development. To succeed, we need to have central support to cover PFI costs above normal levels.</li> <li>4. We request that we are allowed to retain control of capital receipts and use them for reinvestment, including NHS Property Services, to support the STP vision.</li> <li>5. We request that there is a support for a consistent NEL approach to estates management across providers/agencies, including NHS Property Services and CHP for all relevant assets.</li> </ol>
<p><b>Commissioning and contracting</b></p>	<ol style="list-style-type: none"> <li>6. We request that the role of central commissioning arrangements is explored especially in areas of devolution. We want to develop and account for a single system-wide budget for all health, wellbeing, and social care services.</li> <li>7. We request specific financial risk regulations are modified to reflect the consequences of holding health economy wide budgets and provisions are made for the first two years while transitional arrangements are executed (which may include double running).</li> </ol>
<p><b>Specialised Commissioning</b></p>	<ol style="list-style-type: none"> <li>8. We welcome the opportunity for collaboration with NHS E as the main commissioner of specialised services. We request the ability to review and vary clinical specifications/standards and contract for outcomes, in collaboration with NHS E, to improve value for our population.</li> </ol>
<p><b>Regulation</b></p>	<ol style="list-style-type: none"> <li>9. For system-wide leadership to work, we need regulators to support system accountability. We request a consistency of response across regulators so that all organisations are able to respond in a way that maximises system gain. For example when dealing with an ACO, we request the system be regulated as a whole, rather than applying a regime to the underlying organisational units.</li> <li>10. We also request that all regulators and other external bodies work with us to agree the assurance criteria, accountability structures and provision relating to risk mitigation new care models.</li> </ol>
<p><b>Investment</b></p>	<ol style="list-style-type: none"> <li>11. To achieve transformation we will need funding, either through STF funding or through other means. We request that we have access to CCG surpluses and the 1% top slice in order to reinvest in achieving our system vision.</li> <li>12. We request support to devolve some central PHE budgets to strengthen public health and specialised service transformation in NEL.</li> </ol>
<p><b>Primary Care</b></p>	<ol style="list-style-type: none"> <li>13. We request that the resources identified in the GP Five Year Forward View to support the management of Workload and Care Redesign are delegated to the STP to manage. We will establish a new governance arrangement that will involve our GP federations, RCGP, LMC and UCLP to oversee the programme to deliver the support and improvements we need at pace.</li> </ol>

*Note: This is linked with devolution asks regarding amendments to existing statutory provisions, including section 14Z3 of the NHS Act 2006 (as amended by the Devolution Act 2016) to ensure that London CCGs and London local authorities can commission jointly, including via the establishment of a joint committee*



# 12. Conclusion

We have set out a bold plan for how we intend to work together as one system to deliver outstanding health and wellbeing services for all local people. We began by recognising the six key priorities that we needed to answer as a system. A summary of the actions we are going to take in response to each question is set out below:

<p>How can we ensure that we channel demand with appropriate capacity in NEL?</p> 	<p>To meet the fundamental challenge of our rapidly growing, changing and diverse population we are committed to:</p> <ul style="list-style-type: none"> <li>• Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care.</li> <li>• Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary care at its heart.</li> <li>• Establishing effective ambulatory care on each hospital site, to ensure our beds are only for those who really need admission, so we don't need to build another hospital.</li> <li>• Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care.</li> <li>• Ensuring our estates and workforce are aligned to support our population from cradle to grave.</li> </ul>
<p>How do we transform our delivery models to support self-care, deliver better care close to home and high quality secondary care?</p> 	<p>We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy; this will build on our two devolution pilots in BHR and CH, and the TST programme (which is being implemented already in WEL). At its core we are committed to:</p> <ul style="list-style-type: none"> <li>• Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges.</li> <li>• Addressing hospital services: streamlining outpatient pathways, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice and encouraging provider collaboration. This will allow us to meet all of our core standards including those relating to RTT and A&amp;E, and enable the planned ED closure of King George Hospital.</li> </ul>
<p>How can we ensure that our health and social care providers remain sustainable?</p> 	<p>Our health and social care providers are committed to working together to achieve sustainability. Changes to our NEL service model will help to ensure fewer people either attend or are admitted to hospitals unnecessarily (and that those admitted can be treated and discharged more efficiently):</p> <ul style="list-style-type: none"> <li>• We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (for example procurement, clinical services, back office and bank/agency staff).</li> <li>• The providers are now evaluating options for formal collaboration to help support their shared ambitions.</li> <li>• Devolution pilots in BHR and CH are actively exploring opportunities with local authorities, which will be set out in their forthcoming business cases.</li> </ul>
<p>How do we transform specialised services through collaborative working?</p> 	<p>We will continue to deliver and commission world class specialist services. Our fundamental challenge is demand and associated costs are growing beyond proposed funding allocations. We recognise that this must be addressed by:</p> <ul style="list-style-type: none"> <li>• Working collaboratively with NHS E and other STP footprints, as patients regularly move outside of NEL for specialised services.</li> <li>• Working across the whole patient pathway for our priority areas from prevention, diagnosis, treatment and follow up care – aiming to improve outcomes whilst delivering improved value for money.</li> </ul>
<p>How can we create a system-wide decision making model that enables placed based care and clearly involves key partner agencies?</p> 	<p>We are committed to establishing robust leadership arrangements, based on agreed principles, that provide clarity and direction to the NEL health and wellbeing system, and can drive through our plans. For us, involving local authority leaders is the only way to create a system which responds to our population's health and wellbeing needs. Building on our history of collaboration, we have agreed a set of principles which our leaders will be accountable for, including a commitment to making NEL-wide decisions as opposed to local decisions whenever appropriate. This will help us to deliver the scale of change required at pace to deliver place-based care for our population.</p>
<p>How do we maximise the use of our infrastructure so that it supports our vision (and plans owned at a NEL level)?</p> 	<p>Infrastructure is a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single NEL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.</p>

# Appendix

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Note that further appendices are available in a separate document.



# ‘Ten Big Questions’ outlined by NHS E

## Our approach to the ‘Ten Big Questions’ outlined by NHS E

As a whole, our STP meets the ten questions outlined by NHS E in the guidance. This is done in various sections. A tick below indicates that the section covers the relevant question.

	1. Better Care	2. Specialised Services	3. Productivity	4. Enablers	5. Finance	6. Governance
How are you going to prevent ill health and moderate demand for healthcare?	✔	✔				
How are you engaging patients, communities and NHS staff?	✔			✔		✔
How will you support, invest in and improve general practice?	✔			✔		
How will you implement new care models that address local challenges?	✔	✔		✔		✔
How will you achieve and maintain performance against core standards	✔	✔		✔		✔
How will you achieve our 2020 ambitions on key clinical priorities?	✔	✔	✔	✔	✔	✔
How will you improve quality and safety?	✔	✔	✔	✔	✔	✔
How will you deploy technology to accelerate change?	✔			✔		
How will you develop the workforce you need to deliver?	✔		✔	✔		
How will you achieve and maintain financial balance?					✔	

Financial balance runs throughout our plans. It is tackled in-depth in the finance section.

# Key Deliverables

	2016-17	By 2021
<b>Better Care and Wellbeing</b>	<ul style="list-style-type: none"> <li>✓ Continue implementation of TST and finalise ACO business cases in BHR and CH.</li> <li>✓ Develop 24/7 local area clinical hubs, to be available to patients via 111 and to professionals.</li> <li>✓ Primary Care:                             <ul style="list-style-type: none"> <li>✓ Strengthen federations.</li> <li>✓ Develop a Primary Care Quality Improvement Board to provide oversight.</li> <li>✓ Utilise PMS reviews to move towards equalisation and delivery of key aspects of Primary Care SCF.</li> </ul> </li> <li>✓ Extended primary care access model will be established with hubs providing extended access for networks of practices implementing the Primary Care SCF.</li> <li>✓ Ensure community-based 24/7 mental health crisis assessment is available close to home.</li> <li>✓ Active plan in place to reduce the gap between the LD TC service model and local provision.</li> <li>✓ Establish a NEL cancer board to oversee delivery of the cancer elements of the STP.</li> <li>✓ Establish a NEL-wide MH steering group and develop a joint vision and strategy.</li> </ul>	<ul style="list-style-type: none"> <li>✓ New care models operational across NEL.</li> <li>✓ Implementation of SCF standards with 100% coverage in line with London implementation timetable.</li> <li>✓ Reduction acute referrals per 1000 population through improved demand management and primary / community services.</li> <li>✓ Access across routine daytime and extended hours (8-8) appointments within GP practices and other healthcare settings.</li> <li>✓ Alignment with NHS E 2020 goals for LD transforming care.</li> <li>✓ 95% of those referred will have a definitive cancer diagnosis within four weeks or cancer excluded, 50% within two weeks (“find out faster”).</li> <li>✓ Provide the highest quality of mental health care in England by 2020.</li> <li>✓ Deliver on the two new mental health waiting time standards and improve dementia diagnosis rates across NEL.</li> </ul>
<b>Transforming Hospital Services</b>	<ul style="list-style-type: none"> <li>✓ Establish joint vision for surgical hub model across NEL.</li> <li>✓ Establish midwifery model of care pilots at Barts Health and Queen’s Hospital (community hubs are already in place at Homerton).</li> <li>✓ Midwifery services will be reorganised to ensure that women can be offered continuity of care and improved choice for each part of the maternity pathway.</li> <li>✓ Increase numbers of women giving birth at home and in midwifery-led birth centres – with new midwifery-led unit opening at RLH.</li> <li>✓ Develop a clear roadmap for the safe transfer of our existing patients from KGH and ensure that care outside of the hospital will be resilient to support this transition.</li> <li>✓ Begin implementing full ambulatory care model on all Barts Health sites.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Implemented phase 2 and 3 7DS standards.</li> <li>✓ Establish surgical hubs at each hospital site that work together in a network.</li> <li>✓ Midwifery services will be reorganised to ensure that women can be offered continuity of care for each part of the maternity pathway.</li> <li>✓ Community care hubs will be established with full IT integration to allow seamless communication across the maternity pathway.</li> <li>✓ Safely transition patients from King George Hospital’s emergency department, with closure in 2019/20.</li> </ul>
<b>Productivity</b>	<ul style="list-style-type: none"> <li>✓ MoU between providers underpinned by principles of collaboration.</li> <li>✓ Clear timescales for consolidating non-pay contracts.</li> <li>✓ Joint approach for agencies in place with key suppliers.</li> <li>✓ Options analysis of collaborative opportunities with pathology across NEL with agreement on a preferred option.</li> <li>✓ Options analysis for consolidating back office functions completed with a preferred option across the system.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Proactive approach to finding areas for collaborative working in NEL.</li> <li>✓ Vision for shared back office approach and functions realised</li> <li>✓ Joint infrastructure and workforce planning across NEL’s organisations. This may be done only to inform rather than replace organisation plans.</li> <li>✓ All trusts in NEL have implemented the findings of Carter and achieved agreed efficiency savings contributing to their financial sustainability.</li> </ul>



	2016-17	By 2021
<b>Specialised Commissioning</b>	<ul style="list-style-type: none"> <li>✓ Agreed service priorities governance structure for the programme.</li> <li>✓ Understand of the gap and size of the opportunities.</li> <li>✓ Agreement as to level of commissioning for each service (national, London, local).</li> <li>✓ Governance structure for managing any new commissioning arrangements in place.</li> <li>✓ Plans in place for redesigning pathways and services by 2020/21.</li> </ul>	
<b>Workforce</b>	<ul style="list-style-type: none"> <li>✓ Local Workforce Action Board.</li> <li>✓ Development of retention strategies</li> <li>✓ Standardisation, testing and promotion of new/alternative roles.</li> <li>✓ Enhanced workforce modelling based on new service models.</li> <li>✓ Joint attraction strategies to promote health and social care jobs in NEL.</li> <li>✓ Preparation to maximise the benefits of the apprenticeships levy as a sector.</li> <li>✓ Sustainability models for our Community Education Provider Networks.</li> <li>✓ Preparation for the removal of bursaries through strategic engagement with HEIs.</li> <li>✓ Developing the education infrastructure to realise changes with our education providers.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Retention improvement targets set in Year One# and bank/agency reductions, delivered.</li> <li>✓ Full implementation of the right roles in the right settings.</li> <li>✓ Integration of roles at the interface of health/social care.</li> <li>✓ All staff to have structured career pathways.</li> <li>✓ Aligned/converged HR processes.</li> </ul>
<b>Infrastructure</b>	<ul style="list-style-type: none"> <li>✓ Agree common estates strategy and governance and operating model.</li> <li>✓ Establish detailed implementation plan for 2016/17 and beyond, which reflects opportunities for savings and investments as well as demand and supply implications resulting from other workstreams and demographic factors.</li> <li>✓ Achieve a consolidated view for utilisation and productivity, PFI opportunities, disposals, and new capacity opportunities and requirements across the patch.</li> <li>✓ Explore sources of capital, working with NHS and Local Authorities for example One Public Estate.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Realise opportunities to co-locate healthcare services with other public sector bodies and services.</li> <li>✓ Dispose of inefficient or functionally unsuitable buildings in conjunction with estates rationalisation.</li> <li>✓ More effective use of 'void' space and more efficient use of buildings through improved space utilisation.</li> <li>✓ Investment in capital development works to support of strategy delivery.</li> </ul>
<b>Technology</b>	<ul style="list-style-type: none"> <li>✓ Create a common technology vision and strategy for NEL .</li> <li>✓ Establish detailed implementation plan for 2016/17.</li> <li>✓ Start to deliver against targets in online utilisation, shared care records, and eDischarges.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Full interoperability by 2020 and paper-free at the point of use.</li> <li>✓ Every patient has access to digital health records that they can share with their families, carers and clinical teams.</li> <li>✓ Offering all GP patients e-consultations and other digital services.</li> <li>✓ Utilizing advanced/preventive analytics towards achieving population health and wellbeing.</li> </ul>

## List of Acronyms

Acronym	Name
ACO	Accountable Care Organization
AKI	Acute Kidney Injury
Barts	Barts Health NHS Trust
BAU	Business As Usual
BCF	Better Care Fund
BHR	Barking, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
BI	Business Intelligence
CAMHS	Child and Adolescent Mental Health Services
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CEPN	Community Education Provider Network
CHP	Community Health Partnerships
CH	City and Hackney
CIPs	Cost Improvement Programmes
CKD	Chronic Kidney Disease
CQC	Care Quality Commission
CYP	Children and Young People
DS	Dental Services
ELFT	East London Foundation Trust
GLA	Greater London Authority
GOSH	Great Ormond Street Hospital
HEE	Health Education England
HEI	Healthcare Environment Inspectorate
HLP	Healthy London Partnership
HUDU	Healthy Urban Development Unit
HWBB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies

Acronym	Name
IMD	Index of Multiple Deprivation
IT	Information Technology
LA	Local Authority
LoS	Length of Stay
LWAB	Local Workforce Action Board
LMC	Local Medical Councils
MCP	Multispecialty Community Provider
MDTs	Multidisciplinary Teams
NEL	North east London
NELFT	NEL Foundation Trust
NICE	National Institute of Clinical Excellence
PFI	Private Finance Initiative
PHE	Public Health England
PMS	Primary Medical Services
PSA	Prostate Specific Antigen
QIPP	Quality, Innovation, Productivity and Prevention Programme
QMU	Queen Mary University
QOF	Quality of Outcomes Framework
RCGP	Royal College of General Practitioners
SCF	Strategic Commissioning Framework
STB	Sustainability and Transformation Board
STD	Sexually Transmitted Diseases
STEMI	Segment Elevation Myocardial Infarction
STF	Sustainability and Transformation Fund
TCST	Transforming Cancer Services Together
THIPP	Tower Hamlets Integrated Provider Partnership
TSSL	Transforming Specialised Services in London
TST	Transforming Services Together (working across Newham, Tower Hamlets and Waltham Forest)
UCLP	UCL Partners
UEC	Urgent and Emergency Care
WEL	Tower Hamlets, Newham and Waltham Forest Clinical Commissioning Groups