



**NORTH LONDON PARTNERS**  
in health and care

North Central London's sustainability  
and transformation partnership



# Barnet Health Overview and Scrutiny Committee

STP: Update and implications for Barnet

## Contents of pack

	Section	Slide
1	Purpose of Paper	3
2	Ambitions of the STP	4
3	North London Partners Context	5
4	Structure of the Programme	6
5	Clinical and leadership across North London Partners	7-8
6	System wide working	9
7	Example 1: Health and Care Close to Home	10-11
8	Example 2: Planned Care	12
9	Example 3: Urgent and Emergency Care	13
10	Example 4: Social Care	14
11	Key worker housing	15
12	Next steps	16
13	Continuing to work with you	17

## Purpose of paper

This paper is designed as briefing for the Barnet Health Overview and Scrutiny Committee on the North Central London (NCL) sustainability and transformation plan (STP). It outlines the programme and the ambitions of the plan as well as the clinical leadership from across north central London.

To demonstrate the impacts of the plan for Barnet residents, this presentation outlines four of the largest workstreams as examples. For each, it sets out recent achievements that will impact on local residents and some next steps for each programme of work.

It also outlines the consideration being given to key worker housing within the programme.

If required, a more detailed narrative of each of the plans can be found by [clicking here](#).





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## Ambition of the STP



Ambition for the STP is  
built on existing CCGs  
values and strategy

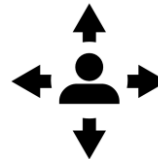
Improve the  
health of the  
local population



Maximise care  
out of hospital



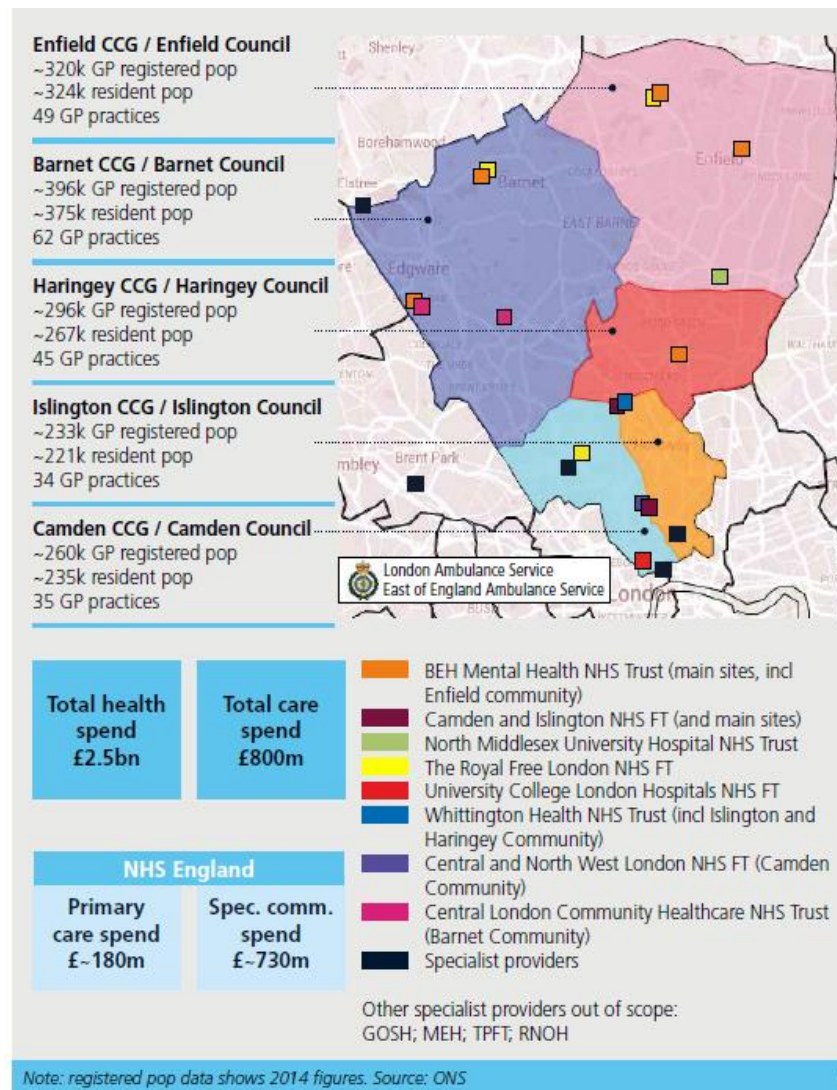
Reduce health  
inequalities



A partnership of the NHS and local authorities, working together with the public and patients where it's the most efficient and effective way to deliver improvements.

## North London Partners context:

1. Diverse populations with some common and some varied challenges
2. Complex health and social care landscape with overlaps between hospital areas and borough boundaries
3. Providers, commissioners and local authorities all in different financial positions
4. Five NCL CCGs now working under joint arrangements with a single accountable officer and chief finance officer
5. Need to transform, improve and integrate care where this improves health and wellbeing outcomes and sustainability of services
6. Potential to share best practice, innovate and benefit from economies of scale



## Our financial challenge

In our plan in June 2017, we projected that if we do nothing, by 2020/21 the financial deficit in health will rise to £811m plus a funding gap across North London councils on social care and public health of a further £247m(1).

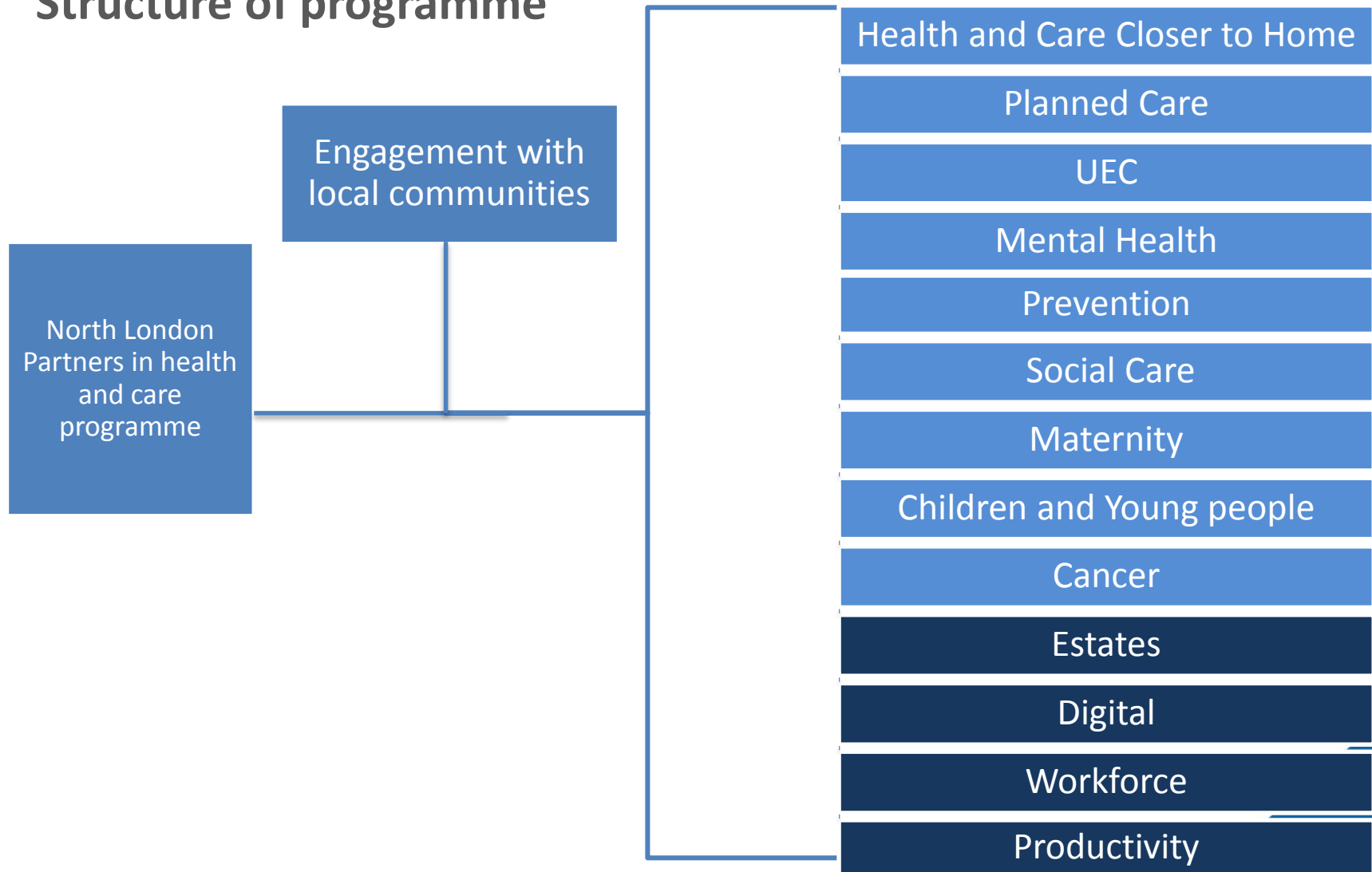
Our plans reduce this financial deficit across the NHS organisations to £75m by 2020/21 but we clearly need to continue to work to identify further opportunities for efficiencies to ensure that we have financially sustainable services. In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London.

Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this We will therefore continue to work to identify additional efficiencies that will help to reduce this residual gap.

(1) <http://www.northlondonpartners.org.uk/downloads/plans/NLPHC-STP-Strategic-Narrative-June-2017.pdf>



## Structure of programme



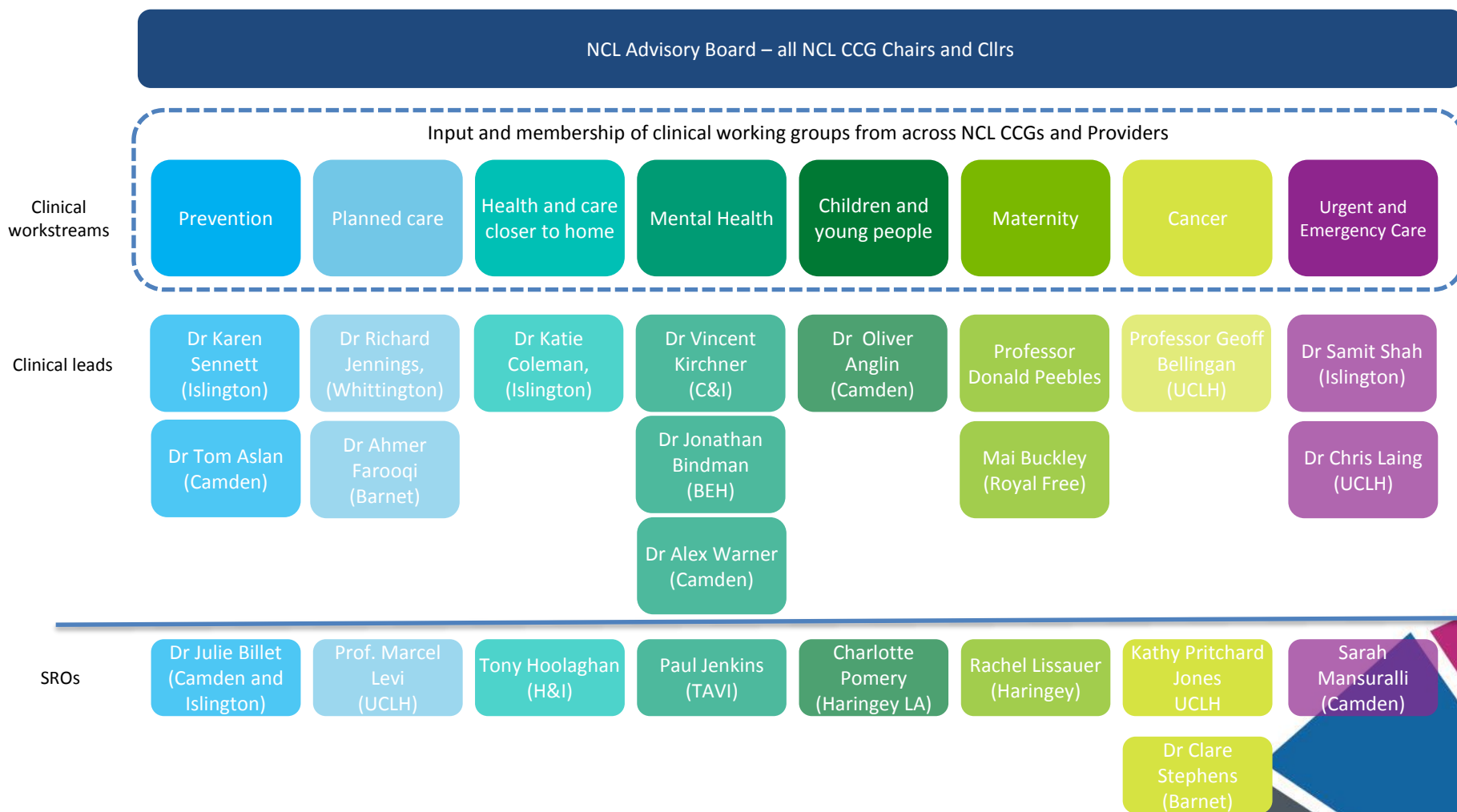


## Clinical and leadership across North London Partners

- Fundamental to development and implementation of every aspect of the STP
- Clinical Input into each workstream essential – with leadership across NCL CCGs (Barnet clinical leads for Planned Care and Cancer)
- Challenge and assurance of STP initiatives via Health and Care Cabinet (NCL CCG chairs and medical directors)
- STP Advisory Board includes Chairs of all CCGs
- Looking at systematic approach to quality improvement across all of the STP, with initial focus on Health and Care closer to Home



# Clinical and leadership across North London Partners





## System wide working

- Changes to focus on the outcome for population and wider system, not on individual organisations/institutions
- Co designing services with patients, providers, clinicians, CCGs and Local Authorities.
- Aim is to speed up local implementation and spread of good practice through 'fastest first principle'
- NHS provider organisations agreeing joint programme of work on productivity, over and above individual organisation savings plans (e.g. patient transport, facilities)
- CCG Commissioner Leads co-ordinating the co-design of services for improved outcomes and system efficiencies (e.g. Barnet CCG leading work on Urology, Stroke, Chronic Kidney Disease)
- As the STP covers the whole of North Central London, lead responsibility for scrutiny of the STP overall sits with the Joint Health Overview and Scrutiny Committee; the Barnet representatives are Cllrs Alison Cornelius and Graham Old.

## Example 1: Health and Care Closer to Home



- Barnet has one network established and another 3 planned (two further go live March 18)
- The clinical focus of the one established is diabetes.
- These will develop to include physical and mental health care delivery as well as aspects of social care and prevention within the community based on a core and locally defined offer.
- Initial approach is linked to particular population segmentation expanding as the models develop.

### Achievements so far:

- **Extended access to GP appointments through hubs** operational since April 2017 across Barnet (8am-8pm)
- Progress in setting up care networks across NCL – focusing on areas from frailty, to mental health ( 1 established I Barnet) – including close links with social care team locally

### Next steps:

- Embedding quality improvement approach across primary care and sharing good practice from across boroughs
- Focus on access to ensure this meets local needs
- Establish remaining 3 integrated care networks in Barnet
- Maximising inputs of elements such as social prescribing

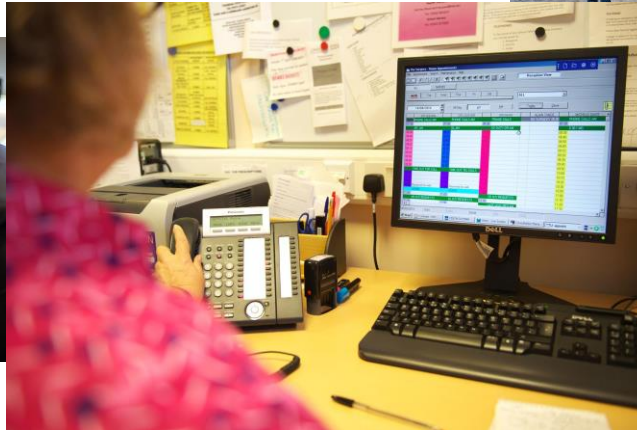
## Example 1: CHINS development status

<b>Burnt Oak CHIN</b>	<b>CHIN 2</b>	<b>CHIN 3</b>	<b>CHIN 4</b>
<b>Clinical lead:</b> Dr Aash Bansal <b>Focus:</b> Diabetes <b>Population:</b> 40,000 <b>Involving:</b> 5 practices <b>Operational since:</b> Jan 18 <b>Road map:</b> All system partners involved by April 2019 <b>Contract with:</b> Federation <b>Contract:</b> Heads of Terms	<b>Clinical lead:</b> Dr Anita Patel <b>Focus:</b> Long Term Conditions <b>Population:</b> TBC <b>Involving:</b> 7 practices <b>Go live:</b> Mar 18 <b>Road map:</b> All system partners by April 19 <b>Contract with:</b> TBC <b>Contract:</b> TBC	<b>Clinical lead:</b> Dr Alexis Ingram <b>Focus:</b> Long Term Conditions <b>Population:</b> TBC <b>Involving:</b> 5 practices <b>Go live:</b> Mar 18 <b>Road map:</b> All system partners by Apr 19 <b>Contract with:</b> TBC <b>Contract:</b> TBC	Final CHIN, which would complete full borough coverage is to be defined
<i>Established</i>	<i>To be established in 2018</i>	<i>To be established in 2018</i>	<i>To be established in 2018</i>

<b>Barnet QIST</b>
<b>Clinical lead:</b> Dr Anuj Patel <b>Focus:</b> Diabetes <b>Operational since:</b> Feb 2018 <b>Contract with:</b> Federation <b>Contract:</b> Heads of Terms
<i>Established</i>



## Example 2: Planned Care



### Achievements so far:

- Barnet approach to improving how GPs order tests (and reduce waste) implemented across borough and now being extended to NCL
- Tele-Dermatology – new technology for examining skin complaints piloted at Royal Free to be rolled out across NCL
- Urology pathways across NCL being redesigned with specialists from Royal Free Hospital and implemented from Jan 2018
- New model of GPs being able to access specialist advice implemented at XXXX in Jan, other hospitals to go live through 2018

### Next steps:

- Clinical redesign of the following pathways to focus on preventative, proactive care:
  - Chronic Kidney Disease
  - Musculoskeletal Disease
  - Urology
  - Cardiology
- Further work to minimise unnecessary testing and trips to hospital through better use of technology



## Example 3: Urgent and Emergency Care

1: Integrated urgent care	2: Admission avoidance	3: Simplified Discharge	4: Last Phase of Life
To bring together and enhance current urgent care services which are outside of hospital, in order to create a single, unified urgent care service for NCL citizens	To develop same day emergency care services in both acute and community settings to enable rapid assessment, diagnosis and treatment – and avoid the need for overnight stays in hospital	To develop improved discharge processes to reduce delays in patients leaving hospital when they are medically stable	To bring specialist advice to staff who are looking after patients in the last year of their lives, in order to ensure best possible care and support to patients and reduce inequalities of care provision

### Achievements so far:

- NCL is one of the first areas nationally to launch the new integrated urgent care model (this includes warm transfers for mental health and “star divert numbers” for clinical professionals)
- Piloting new improved discharge processes to prevent delays at all NHS trusts in NCL (discharge to assess pathway)
- A single NCL-wide referral form for rehabilitation services after hospital stays – reducing delays across boroughs
- Patients phoning NHS 111 out of hours can be booked directly into a GP appointment if necessary in Barnet

### Next steps:

- Patients phoning NHS 111 will be able to be booked directly into a GP appointment if necessary in hours (across NCL)
- Continued implementation of pathways that mean patients do not have to wait to be assessed before leaving hospital
- New Ambulatory Care models will mean people can receive emergency treatments without being admitted to a hospital bed overnight
- Redesign of community service to prevent admissions to hospital
- Implementation of nursing support to care homes and Single Point of Access for specialist palliative care advice

## Example 4: Social care

The five local authorities in North London face a financial pressure of £110m in adult social care by 2021/21.

During 2017 we have been working together to identify our shared challenges across five boroughs and where a shared response would deliver greatest benefit to local people. We have agreed 4-5 key areas for further work in 2018, working alongside NHS and wider partners as part of the STP. N.B. This work would have equal benefit in Barnet as the other five boroughs.



DASS  
Workshop (21  
May '17)



DASS  
Workshop (21  
July '17)



Project team  
starts (1 Aug '17)



DASS  
Workshop (6  
Oct '17)



DASS  
Workshop (10  
Nov '17)



DASS  
Workshop (15  
Dec '17)



DASS  
Workshop (19  
Jan '18)

### Social care analysis report recommendations (Apr '17)

1. Streamline health and social care processes around the hospital

2. Develop a sustainable social care market

3. Develop a sustainable social care workforce

4. Look at specific support to people with learning disabilities

### Shortlist of specific actions (Oct '17)

1. Increase direct payment take up
2. Align reablement processes
3. Provide intensive care home support
4. Streamline hospital discharge processes

1. Share pricing strategy for purchasing care
2. Align/share brokerage activity
3. Develop more O65 nursing home capacity

1. Focus on nursing recruitment and retention
2. Focus on independent sector workforce recruitment and retention
3. Develop shared practitioner training and development across health and social care
4. Focus on occupational therapist recruitment and retention

1. Establish NCL-wide operational forum for case management
2. Ensure annual health checks are taken up across GP practices
3. Establish LD provider forum jointly with CCGs
4. Review complex needs provision, focusing on young people transitions and/or working age adult complex needs
5. Develop LD/autism/challenging behaviour accommodation/support capacity

### Areas for further exploration (Nov '17 onwards)

1. Improve consistency in the social care element of the hospital discharge process

2. Build more capacity in the nursing home sector looking at options for joint-capital investment to build more homes;  
3. Joint brokerage of health and social care packages of care, looking at options to combine the existing operations run by Councils and CCGs; and

4. Develop a joint approach to recruitment and retention of staff in health and social care, focusing on nursing and the independent sector;

5. Develop a stronger provider market to support people with LD and challenging behaviour, focusing on prevention of needs escalating into the 'transforming care' cohort and those transitioning from children to adulthood.



## Key worker housing:

- There are no current specific health projects being led by the estates workstream of the STP on this.
- However, work is currently underway to understand key drivers for attracting and retaining staff in North Central London – which will include lifestyle factors such as housing amongst other issues.
- Therefore, it is being actively considered as part of both the estates workstream and the workforce workstream as elements of future planning.
- As part of this, the STP estates workstream and workforce are taking part in some national policy development work around key worker housing to understand how we can work effectively in this area. This will help inform our strategy on this.
- With regards to ongoing local developments, Barnet, Enfield and Haringey Mental Health NHS Trust is anticipating some on-site affordable housing being made available to staff through the redevelopment of the St Ann's site.



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## Next steps for the Programme in 2018/19



Work with all our  
partners and public to  
design plans



Ensure plans are  
clinically led and  
evidence based



Communicate with our  
stakeholders and  
communities about the  
changes ahead



Align our plans and  
ensure these  
contribute to financial  
sustainability



Continuing to explore  
scope for NCL working  
and greater impact





## Continuing to work with you

- We want to work more closely with you to refine and enhance our collective ambition and models of care across the workstreams, to ensuring we are providing the best possible outcomes for the residents of Barnet.
- Are there particular aspects of the programme that can be recommended to the JOSC for future meetings?