NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a meeting of the **JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **MONDAY JANUARY 16TH 2012** at 10.00 a.m. in the Committee Room 1, Town Hall, Judd Street, London WC1H 9JE

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Cornelius, Barry Rawlings and Graham Old (L.B Barnet), Peter Brayshaw and John Bryant (Vice-Chair) (L.B Camden), Alev Cazimoglu (L.B Enfield), Gideon Bull (Chair) and Dave Winskill (L.B Haringey), and Martin Klute and Alice Perry (L.B Islington)

OFFICERS
Hannah Hutter and Shama Sutar-Smith (L.B Camden), John Murphy (L.B Barnet), Peter Moore (L.B Islington), Rob Mack (L.B Haringey), Sue Cripps (L.B. Enfield)

ALSO PRESENT
Alison Kemp, Independent Consultant
Lee Bojtor, Barnet, Enfield and Haringey Mental Health Trust
Dr Peter Sudbury Barnet, Enfield and Haringey Mental Health Trust
Claire Wright, NHS North Central London
Martin Machray, NHS North Central London
Elizabeth Stimson, NHS North Central London
Sarah Parker, NHS North Central London - Haringey
Andrew Williams, NHS NCL North Central London- Haringey
Donald Peebles, Lead Obstetrician North Middlesex Hospital
Kathryn Collin, NHS North Central London Maternity Services Commissioner
Debbie Gould, UCH, North Central London Maternity Network Lead Midwives
Jenny Gough, Assistant Director of Public Health, NHS Camden
Terence Joe, NHS North Central London
Sue Dart, NHS North Central London Royal Free Hospital
Pat Gould, Royal College of Midwives
Carol King, Royal College of Midwives

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the Joint Health Overview and Scrutiny Committee.

MINUTES

1. WELCOME AND APOLOGIES

Councillor Gideon Bull (Chair) welcomed all those present to the meeting.

An apology for lateness was received from Cllr Martin Klute (L.B Islington).

2. URGENT BUSINESS

There was none.

3. DECLARATIONS OF INTEREST

Councillor Gideon Bull declared that he was an employee at Moorfields Eye Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Peter Brayshaw declared that he was a Governor at University College London Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alison Cornelius declared that she was a Chaplain's assistant at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

In relation to Item 5, Transforming Community and Adolescent Mental Health Services, Councillor Barry Rawlings declared that he was a part time worker for Community Barnet, but did not consider it to be prejudicial and therefore took part in the consideration of the item.

4. MINUTES

The minutes of the meeting held on 5th December 2011 were agreed, subject to the addition of the word 'provide' in the first sentence on page 7 of the minutes.

It was

RESOLVED –

THAT the minutes of the meeting held on 5th December 2011 be agreed.

TO NOTE: All

Matters arising:

In response to a question regarding the financial arrangements once NHS North Central London had been dissolved, Martin Machray of NHS (NCL) stated that a series of discussions s were taking place between the Strategic Health Authority and NHS NCL which had resulted in some positive results. More information would be known by the end of the following week. In the interim, he had agreed with the Chair that the letter that the last meeting agreed would be sent to the Secretary of State on behalf of the Committee concerning this issue should be delayed. Martin Machray would keep the Committee informed of the progress and noted that the London Borough of Camden were keen to receive clarification on the budget as soon as possible.

ACTION BY: Martin Machray, NHS North Central London

5. IMPLEMENTING TRANSFORMING COMMUNITY AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Alison Kemp, Independent Consultant, NHS North Central London made a presentation to the Committee which gave an update on the business case, actions taken since 5th December 2011 and the key issues.

The Committee raised questions in relation to the engagement of young people in the project, whether the Northgate building would be closing, staff redeployment, the future of the on site school and the education model.

In response to questions Alison Kemp made the following points:-

- There is a young people's project board which has begun to meet on a monthly basis. The young people were seeking to involve their peers in the project, and explore, using social media sites such as Twitter and Facebook. The young people were heavily involved with leading the group areas included, policy, estates and crucially feeding directly into the project working group and implementation plan. Most of the young people involved were current service users;

- Assurance was given to the Committee that there was no intention to close the Northgate building. The services which had been provided at the site had stopped. Staff who had previously been working in those services had been redeployed into the community teams and some into New Beginnings. The new in-patient service would run from the Northgate site. The new model would see a shift in the ways in which staff time and skill was used. , the new service model would focus on therapeutic input, thus, it was not anticipated that the staff bill would increase or be reduced, but clearly natural changes in the staff would occur;

- Barnet, Enfield and Haringey all operated different education models, discussion was taking place with each authority regarding how a education package could be built for each child at the on site school. It

was recognised that this was an area which needed monitoring. Feedback was expected in the near future from colleagues in education regarding the contract negotiations between the providers and commissioners. A position statement could be provided for the next meeting of the Committee.

In response to concerns from the Committee regarding the engagement of young people, it was suggested that Councillors Alison Cornelius and Gideon Bull be invited to attend the young people's project board next meeting as observers. It was agreed this request would be taken back to the young people.

It was requested that a paper outlining an education model, including how it worked with health, and signed off by all three education authorities, be provided to the Committee.

ACTION BY: Alison Kemp, NHS North Central London

RESOLVED –

THAT the report be noted.

TO NOTE: All

6. MATERNITY SERVICES IN LONDON

The Committee gave its consideration to an annual report of the Local Supervising Authority of NHS London on how standards set within the Midwives Rules and Standards (2004) had been met.

Kathryn Collin, North Central London, Senior Maternity Manager, Professor Donald Peebles, Lead Obstetrician North Middlesex Hospital and Debbie Gould, UCH, North Central London Maternity Network Lead Midwives gave a presentation to the Committee which informed the Committee of the work of the North Central London Maternity and Newborn Network.

Kathryn Collin described the network structure and the partnership between the commissioners and providers. It was stated that there was commitment to the Network from all five of the authorities which make up the North Central London Cluster. The Network was chaired and led by senior clinicians, who had been in discussions with NHS London sharing the good practice demonstrated by the Network.

Donald Peebles addressed the Committee and spoke about the requirement to have senior experience on the labour ward. All units in the Cluster were now achieving the minimum of 60 hours of consultant presence. He also informed the Committee of how the caesarean section rate had steadily been increasing. He stated that the Network promoted normal births and that a daily review of caesarean sections had

been introduced. However, this contradicted the newly updated NICE guidance which recommended that women without medical indications should be offered a caesarean on request following advice and support on a normal birth. He wished to make it clear that sector policy was not to offer routine Caesareans apart from in exceptional cases.

Debbie Gould spoke about the models of care group and how the reporting figures of midwife to birth ratio were calculated. It was noted that the ratios could not easily be compared as there was no standardisation of how the figures were collected.

Further discussion took place regarding the future challenges and issues surrounding maternity services. The following points were noted:-

- UCLH had introduced care rounds which ensured that midwives could collect real time feedback on the service. The feedback was entered on a daily basis and it was highlighted that the compliments outweighed the negatives. If there was a complaint it would be dealt with immediately and on an individual basis.

- The quality of relationships between the midwife and patient was measured using a net promoters score used by private marketing companies. All women would be asked two questions at the end of their post natal care.

- The cluster was delivering above the 90% national care standards. Only 4% of women, when in labour, were left in the delivery room without a midwife/medical professional when they did not want to be.

- It had been identified that more work needed to be carried out on improving early access to maternity services. The national target for seeing women by the 12th week of pregnancy was 90% the cluster were currently achieving 75%. There were many factors which contributed to not achieving 90%, which included the cultural differences in the population, which impacted upon the amount of women who still did not present to their GP until after week 12. Examples given were the North Middlesex hospital (NMUH) had particular population challenges as 30% of women who booked late were not in the country during the first 12 weeks of pregnancy, and in the Whittington some orthodox Jewish women did not wish to use maternity services.

- Work was being undertaken to reach and educate different parts of the community, such as working with pound shops to provide information when customers were buying pregnancy tests, working with religious leaders, children centres and community centres.

- An action plan had been implemented to carry out work around maternal deaths. It was highlighted that the reporting on maternal deaths were misleading as not all maternal deaths were related directly to pregnancy. It was felt that there needed to be differentiation between those figures.

- If a trust was operating from a single site and the service had to be suspended, it would be recorded as a serious untoward incident (SUI). However, if a trust was operating units on multiple sites and only one site had to be closed, it would not be recorded as a SUI. This meant that a closure of one of the two sites that were part of Barnet and Chase Farm hospitals would not be recorded as long as the other site remained open, even though women in labour might be transported between sites. The Committee were of the view that this might disguise issues at particular sites and that the suspension of a service should be recorded for each hospital unit that was closed rather than merely for each trust.

- There was a set list of classifications for a serious incident on a maternity ward. One example would be if there was not enough staff to operate the service safely, then the service would close which would be classed as serious. A serious incident didn't mean that something serious had to happen before the service would be suspended;

- The shortage of midwives, across the cluster and London was concerning. Retirement eligibility was amongst existing midwives with 18% of midwives eligible for retirement now, and a further 11% will become eligible for retirement by 2017. It was questioned whether midwives were counted as key workers as in the report, housing costs were cited as a barrier to recruitment. A letter should be raised through the LSN to NHS London citing concerns about the retention policy.

- There were additional complexities of providing midwifery services in London including complex populations, high birth rates and busy units.

- Supervisors of midwives played a key role in improving professional practice, and often supervisors were called back to the front line in busy units. Protection of the role was varied, and was best where there was good leadership in the unit, and the role was clearly defined. The Committee welcomed the work undertaken by the Network and requested that the midwife to birth ratio figures for the cluster be circulated to the Committee, and that further details of the number of closures of the maternity unit at Chase Farm and Barnet be provided.

  ACTION BY: Kathryn Collin, North Central London, Senior Maternity Manager

  RESOLVED –

  THAT the report be noted.

TO NOTE: All

7. NHS NORTH CENTRAL LONDON TRANSITION UPDATE REPORT

Consideration was given to a report of NHS North Central London updating the Committee on the progress of the Transition Programme, which would see the transition to the new structure, replacing the roles and responsibilities of PCTs within the cluster.
Martin Machray, NHS North Central London, summarised the main points of the report and stated that the Health and Wellbeing Boards would be key in helping the transition take place.

During discussion members expressed their interest in retaining the Joint Committee after the North Central London Cluster disbanded. Further discussion took place regarding the support services for the Clinical Commissioning Groups (CCG). Four CCG's were going for partial budget delegation, and Camden was going for full delegation of the relevant parts of the PCT budget. It was noted that a commissioning support organisation prospectus had been published. The organisation would be hosted by the NHS Commissioning Board until 2016 when it was expected that the support services organisations would operate independently. A not for profit social enterprise model was expected, but they would have to compete in an open market and aspects such as informatics might also be purchased from different providers. When the CCG's became statutory bodies, they would have three options open to them, they could buy in all commissioning support; provide some or all support in house; or buy services from the open market. The CCG's would have restrictions when considering what option to choose, as the incentive funding allocations to the CCGs to buy support were estimated at £25 per head of population served by the group, which was the same allocation in London as in the North of England. To date, none of the clusters in London were able to provide services for less than £25 per head.

Further discussion took place regarding commissioning services across organisations. It was noted that discussions were taking place between councils and strategic health authorities on an integrated commissioning approach.

Concerns were raised regarding the transparency of the commissioning process, especially when a decision had to be taken on choosing a provider for services. The Committee highlighted the importance scrutiny added to the process and how it would have an enhanced role in bringing transparency to the process in the future.

In response to questions Martin Machray made the following points:-

- Budget figures, when allocations were confirmed, for the five CCGs would be circulated to the Committee. **ACTION BY: Martin Machray**;
- In terms of accountability, there would be a clear channel of responsibility to Caroline Taylor, Chief Executive NHS North Central London, until the CCG's became a statutory body;
- NHS NCL had expressed an interest in providing commissioning support for all the NCL clusters, but it would need to operate over a much larger area

including Outer North East and East London and include up to 19 CCG's to be financially viable at that price. Three commissioning support agencies for London were being proposed, with another one covering North West London, and a third covering South and South west London. ;

- Guidelines have been published from the Department of Health regarding conflicts of interests in relation to GPs on CCGs, this information would be shared with the Committee. **ACTION BY: Martin Machray**.

The Committee were concerned that the indicative funding of £25 per head of population would not be sufficient for London. The Committee felt that for London the funding should also have a London premium attached. It was agreed that a letter should be sent to London Councils asking them to take up this concern.

ACTION BY: Rob Mack (Scrutiny Officer)

Following discussion, it was

RESOLVED –

THAT the report and recommendations be noted.

TO NOTE: All

8. TUBERCULOSIS: DEVELOPING SERVICES FOR THE FUTURE FOR NORTH CENTRAL LONDON

The Committee gave its consideration to a report of NHS North Central London. Jenny Gough, NHS North Central London introduced the report which detailed the current tuberculosis (TB) service provision, and gave an update on the review and development of services for TB across North Central London cluster. TB was spread through prolonged contact with an infected person, but was preventable and treatable. It could be incubated from two to five years. Hospital treatment of TB was offered even to people who were not entitled to free NHS treatment in primary care including illegal immigrants and visa overstayers. Despite targeted outreach, the Somali community has not engaged with TB treatment and more needed to be done to break down stigma and promote that TB was treatable.

Terence Joe, NHS North Central London, gave a presentation to the Committee which outlined the proposed TB services model of care across North Central London, and, the process of service development adopted to date. The Committee noted that the change in service model would see the creation of two key TB hubs. The North hub would be located at North Middlesex Hospital, the South hub location was still to be confirmed, but a recommendation had been made to the project group that the Whittington Hospital would be the best site. The changes based on research would increase opening hours, offer greater flexibility and reduce waiting times.

A concern was made by a Member of the Committee regarding travelling to the Whittington Hospital by residents who were living in the west part of Camden.

The Committee also recommended that translation services would be important in the new model.

The Committee thanked the officers for the report and Terence Joe for a very good presentation

RESOLVED –

THAT the report and presentation be noted, and they supported the recommendations.

TO NOTE: All

9. FUTURE WORK PLAN

The Committee gave its consideration to a report outlining its future work plan.

The Committee requested that it receives copies of the letters sent to North Central London regarding the QIPP. **ACTION BY: Rob Mack, Scrutiny Officer**

The Committee were informed that there was a meeting taking place with NCL London at Stevenson House on 30th January 2012 regarding CAMIDOC.

The future meeting dates were as follows;

27th February - Islington

16th April – Haringey

28 May - Enfield

9th July (moved from 16th July) - Barnet

RESOLVED -

THAT subject to the above amendments, the report be agreed.

TO NOTE: All

The meeting ended at 1.14pm

CHAIR: Councillor Gideon Bull

MINUTES END

Agenda Item 5

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: NHS North Central London Primary Care Strategy 2012 to 2016	
REPORT OF: Dr Douglas Russell Medical Director (Primary Care) NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 12/02/2012**

SUMMARY:
The NHS North Central London Primary Care Strategy item will provide members with an update on the development of the primary care strategy across the five boroughs and focus on its implementation.

CONTACT OFFICER:
Elizabeth Stimson
Senior Communications and Engagement Officer
NHS North Central London

RECOMMENDATIONS: The Committee is asked to note the information provided and comment.

Dr Douglas Russell
Medical Director (Primary Care)
NHS North Central London

DATE: 10/01/12

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NHS
North Central London

Transforming the primary care landscape in North Central London

January 2012

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Foreword

Dr Douglas Russell, Medical Director (Primary Care)

This is the underpinning Primary Care Strategy that has been developed since August 2011 in NHS North Central London. The strategy has been shaped by our aspirational vision "The Future Landscape of Primary Care – A patient's perspective". While many practices are already delivering some of that vision, we want to raise the standard across the board so that all patients have access to the very best in primary care.

Addressing quality, safety, and improving patient experience are the key aims in our primary care strategy. The strategy recognises that transformational changes are needed to support the development and capacity of primary care, and describes the steps towards implementing that transformation, but it will take time and resource.

We have therefore devised a major programme of transformational change requiring commitment and/or investment by all parties involved in the commissioning and delivery of primary care services, in order to make our vision a reality by 2016.

The process of developing the strategy has already included borough-based stakeholder workshops and direct engagement of GP and other independent contractor representatives. This is a co-production by many of the people directly involved in delivering primary care services.

Although it is strongly focused on the role of general practice in primary care, the implementation of the strategy will require the support of all independent contractors, nurses, therapists, hospital doctors and all other clinicians and managers involved in the delivery of primary and community care.

Currently, the quality and accessibility of primary care is variable across North Central London as a whole, and within individual boroughs. Allied to this, there is too much hospital activity in terms of Accident and Emergency attendances and unscheduled care admissions.

Primary Care has a pivotal role to play in reducing use of secondary care for basic healthcare provision and in improving population health. Radical change is required to improve quality, capability and productivity further, and to create capacity within primary care.

In this document we start by exploring what the primary care environment is in each borough, and acknowledge the legacy created in some areas by previous strategies and the extent to which they have been implemented. We then describe aspects of the care we aspire to provide, the vehicles for change that each borough will be able to draw upon as they set out their devolved implementation plans, and ultimately, what are the outcomes by which we will measure the success of this strategy in our future delivery of care.

It is my belief, shared by many primary care colleagues, that the high quality primary care we want to provide requires resourcing through upfront investment. Therefore this strategy is predicated on a substantial investment of pump-priming investment in the primary care strategy in Barnet, Camden, Enfield, Haringey and Islington. At the end of three years, we anticipate that the net savings of this strategy will more than cover any major investment.

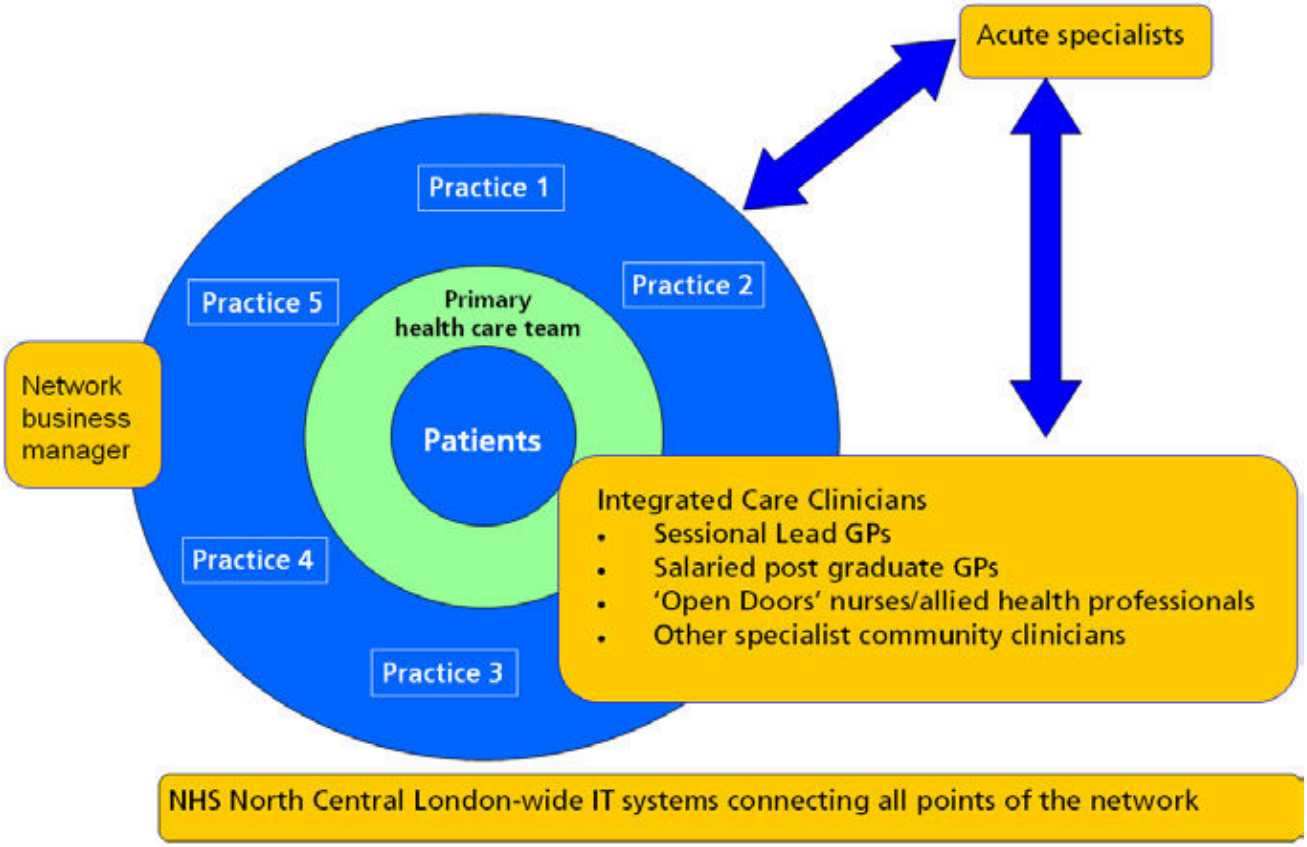
We are proposing nine strategic investment domains, of which the first three will form the Integrated Care Network (ICN) which is the heart of our new care delivery model.

We are asking practices to work together in local natural communities (of varying sizes) to create Integrated Care Networks, all the time retaining their autonomy as independent contractors. We will then provide funding for integrated care packages with community-based clinicians working along patient pathways from primary, through community and reaching into secondary care, where our hospital colleagues will provide professional clinical support to the networks and less hands-on care to those patients who can, and should, be seen in primary care.

Each network will be supported by an interactive, web-based, clinical information management network across NHS North Central London which will enable all healthcare providers to share patient records and to communicate electronically directly with each other to ensure that individual patient needs are met.

We are offering an example of what an Integrated Care Network may look like, but the actual design will be determined by each network.

WHAT MIGHT AN INTEGRATED CARE NETWORK LOOK LIKE?



The Integrated Care Network is not merely a theoretical construct. It is based on solid evidence (The King's Fund Report "Improving the Quality of Care in General Practice" March 2010), including demonstrable results from other London boroughs. But the success will come from the primary care community embracing both the concept of integrated care and

the investment to create locally-based effective networks. It is a framework and we have not set out the micro-detail of how the networks should operate because we want those decisions to be made at a local level. This is the next stage of development.

Having provided the investment and devolved authority to the networks, NHS North Central London has a duty to ensure that it is spent as intended and that it delivers the desired results. We will work with our independent contractors to motivate, incentivise and support them on the transformational journey. But we will also monitor their performance to ensure that our contractors do deliver those higher standards of quality, safety and patient experience.

Our intention is not to create any contractual changes. We are seeking to promote a change in "how things are done" rather than "what is done". We are therefore proposing a mutually beneficial investment in primary care which requires independent contractor practices to achieve explicit quality standards of inputs and outcomes in return for the financial investment. Our message to our independent contractors is "If you do these things well with our investment, then together we will achieve the desired outcomes".

Those outcomes, will have explicit quality markers by GP practice and network, agreed with GPs, whereby in return for the investment we can expect to achieve improvements in:

- Patient safety
- Clinical effectiveness

} Health outcomes

- The experience of patients.

I recognise that this primary care strategy is but one of many such initiatives in the current environment and that there is a real danger of change fatigue. Clinical leadership has never been more in demand, particularly from, and for, GPs. We need to separate our new role and responsibilities as commissioners from our traditional role as providers.

This strategy is about GPs in North Central London taking the opportunity to lead change in that traditional role. I am confident that secondary care colleagues, local authority colleagues, patients and the public will all respond positively to the successful implementation of this strategy.

In his foreword to The King's Fund Report "Improving the Quality of Care in General Practice", Chief Executive Chris Ham states:

> "The gauntlet thrown down by this report is to accelerate the pace of improvement in general practice and to develop a system that is fit for the future".

I invite all independent contractors, other clinicians and managers in both health and social care to join me and rise to this challenge in North Central London over the next three to five years.

Dr Douglas Russell

1. Introduction

In August 2011, NHS North Central London set up a project to develop a North Central London-wide Primary Care Strategy. This document describes a major programme of transformational change which will require commitment and/or investment by all parties involved in the commissioning and delivery of primary health care services. Its aim is to improve quality, capability and productivity further, and to create capacity within primary care.

The need for a strategy is in recognition that primary care services across North Central London are currently so variable in so many aspects that we need to transform our primary care services to raise the standard across the board so that all patients have access to the very best in primary care.

Through working with local people and partners we will improve the health and wellbeing of our population, reduce inequalities and maximise value in terms of outcomes, quality and efficiency from services provided to patients. We will:

- Enable our population to live longer, healthier lives, in particular tackling the significant health inequalities that exist between communities
- Provide children with the best start in life
- Ensure patients receive the right care, in the right place, first time
- Deliver the greatest value from every NHS pound invested.

We will achieve this:

- By actively engaging local people in decisions about their own and their community's health and wellbeing
- Through working collaboratively with partners to deliver seamless care.

This strategy underpins the development of our five borough-based implementation plans by defining the medium/long term goals, priorities, principles, investment criteria and performance expectations. It is a strategic shift from the previous premises-led agenda to one that is quality-led, and which focuses on:

- Promoting health, wellbeing and illness prevention
- Addressing health inequalities
- Further improving the quality of primary care services, particularly in General Practice, to enhance the patient experience with better outcomes.

The combined strategy and implementation plans will determine how the NHS in north central London will invest in primary care in each of the five boroughs over the coming years. The payback will be in the improvement in clinical and service quality and in a reduction in hospital usage and costs.

The strategy has been developed using, amongst others, the following inputs:

- The case for change in primary care in north central London
- The Barnet, Enfield and Haringey Clinical Strategy
- The King's Fund Report "Improving the Quality of Care in General Practice" (March 2011), which includes best practice examples in similar health economies, including Tower Hamlets
- "Value-Based Health Care Delivery", Michael Porter, Harvard (UCLP January 2011)
- "Improving access, responding to patients - A 'how-to' guide for GP practices" (Practice Management Network- August 2009).

The process of developing the strategy has already included borough-based stakeholder workshops and direct engagement of GP and other independent contractor representatives. This is not a top down imposition, but rather a co-production by many of the people directly involved in delivering primary care services.

Throughout the strategy, the definition of primary care should be assumed to be the independent contractor groups of GPs, dentists, pharmacists and optometrists, who all form a vital part of our primary care services. Community-based services such as district nursing, health visiting and therapy services are partners with the primary care independent contractors as members of the Extended Primary Care Team. This strategy describes how the partnership will work within an integrated network model.

The aspirational "vision" is set out from a patient perspective in the section "The future landscape of primary care - A patient's view of primary care in North Central London in the boroughs of Barnet, Camden, Enfield, Haringey and Islington in the year 2016". This is a deliberately challenging way of creating a vision, by starting from a single patient's view of the local healthcare system. It concludes with the following statement of purpose:

> **"Our aim, and that of all our practices, is to offer you a high quality primary care team service, linked, when necessary, to more specialist services; all of which will enable you to live the best possible lifestyle in respect of your personal health and wellbeing."**

2. Background

"This is how it was and how it is"

In our first NHS North Central London-wide strategy document Commissioning Strategy Plan 2010/14 (CSP) dated January 2010, we noted that:

> "The primary care landscape in North Central London is characterised by a significant variation in general practice size. There are a significant number of single handed GPs and many are in old buildings and estate that is not fit for purpose." (Page 35)

There were then 269 practices serving a registered population size of 1,374,253, at an average of 5,109 patients per practice.

The central theme of the plan was to implement the London-wide strategy set out in "Healthcare for London - A Framework for Action" (2007) and to support our PCTs in developing polysystems. This was a major investment in a premises-led strategy.

In January 2011, we published the first version of the NHS North Central London cluster Commissioning Strategy and QIPP Plan 2011/12 – 2014/15. This was subsequently issued as an updated version 30 June 2011. The foreword to the plan reflects a move away from the emphasis on the premises-led polysystems approach towards a more qualitative approach based on patient research:

> "The plan builds on our previous Commissioning Strategy Plan (CSP) published in January 2010 and retains the key themes of that plan of transferring care, where appropriate, from hospitals to community and primary care settings. Our discussions with General Practitioner (GP) commissioners as part of the planning process highlighted this as a key priority for them, along with improving services for mental health patients. Other priorities in the plan reflect work undertaken across London to improve patient outcomes in specialist services such as cancer and cardiovascular, local services such as maternity, and areas where we have benchmarked our performance against others and identified improvement opportunities.
>
> "Our plan takes account of the approval of the Barnet, Enfield and Haringey (BEH) Clinical Strategy in January 2011 and assumes that the consultation on the reduction of mental health bed capacity with Camden and Islington NHS Foundation Trust leads to bed closures taking place. At this point, our plan does not include other major service or provider reconfigurations other than those agreed across London in specialist services. Throughout the course of our planning we have continued to discuss and review with providers the implications of our plan on them both in the short and longer terms. Potentially, these discussions may conclude that there is a need for further changes to the pattern of services within North Central London."

The plan included a number of initiatives within primary care including list maintenance, reviewing enhanced services, pan-London performance management and review of the personal medical services. The 2011/12 programme of work has been focused on delivery of these initiatives.

By mid-2011, there were a total of 258 general practices with 1,413,086 registered patients, excluding the three GP-led health centres and PCT Special Practice.

FIGURE 1 - NUMBER OF PRACTICES, BY LIST SIZE, BY BOROUGH, AT JULY 2011

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9	2	4	7	2	24
2-5,000	27	19	35	28	14	123
5-10,000	23	9	16	12	17	77
10,000-15,000	7	8	5	4	4	28
>15,000	2	1	0	3	0	6
Number of practices	68	39	60	54	37	258
Total registered patients	373,715	251,016	299,119	272,236	217,000	1,413,086

FIGURE 2 - THE AVERAGE NUMBER OF PATIENTS PER PRACTICE VARIES FROM UNDER 5,000 IN ENFIELD TO ALMOST 6,500 IN CAMDEN:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

FIGURE 3 - A MORE DETAILED ANALYSIS SHOWS THE VARYING NUMBER OF PATIENTS REGISTERED BY SIZE OF PRACTICE:

Number of patients by practice Size at 1 July 2011	Barnet	Camden	Enfield	Haringey	Islington	Totals
Practices <2,000	16,148	4,541	6,878	8,424	3,959	39,950
% of total patients	4%	2%	2%	3%	2%	3%
Practices 2-5,000	89,126	63,356	121,098	87,331	44,714	405,625
% of total patients	24%	25%	40%	32%	21%	29%
Cumulative	28%	27%	43%	35%	22%	32%
Practices 5-10,000	158,129	68,078	112,386	82,142	120,588	541,323
% of total patients	42%	27%	38%	30%	56%	38%
Cumulative	70%	54%	80%	65%	78%	70%
Practices 10-15,000	76,949	96,759	58,757	45,843	47,739	326,047
% of total patients	21%	39%	20%	17%	22%	23%
Cumulative	91%	93%	100%	82%	100%	93%
Practices >15,000	33,363	18,282	0	48,496	0	100,141
% of total patients	9%	7%	0	18%	0	7%
Cumulative	100%	100%	100%	100%	100%	100%
Total registered patients	373,715	251,016	299,119	272,236	217,000	1,413,086

From Figure 3 we can see that:

- Fewer than 40,000 patients (ie 3%) in North Central London are registered in practices which have fewer than 2,000 patients, with the largest number (16,000) in Barnet (but still only 4% of Barnet total)
- 43% of Enfield patients are registered in practices with fewer than 5,000
- In Islington, the comparable figure is 22%
- In Camden, 46% of patients are registered in the larger practices with over 10,000, compared with the North Central London average of 30%
- Across North Central London there are six practices with over 15,000 registered patients and three of those are in Haringey, accounting for 18% of their total patients.

FIGURE 4 - NUMBERS OF DENTISTS, OPTOMETRISTS AND PHARMACISTS

April 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Dental Practices	70	42	44	51	23	230
Optometrists	88	77	72	33	53	323
Pharmacies	71	65	61	56	46	299

3. The case for change

"Why do we need to change?"

In July 2011, recognising the need for more fundamental and transformational change, Dr Douglas Russell, NHS North Central London Medical Director of primary care, produced a discussion paper titled "Starter for 10 - NHS North Central London case for a primary care strategy" to frame a further discussion about the need to develop a new primary care strategy for the five boroughs of north central London. He set out the argument for the definition and measurement of both activity and quality before engaging in a developmental programme with primary care contractors and concluded:

> "We need to engage the clinical leadership with a new vision of a transformed, supported and developed high quality GP and primary care landscape across the whole cluster attracting and retaining the highest quality staff, both clinical and support. There are a set of core documents published recently that fill out a lot of background detail and evidence of the vision of what we would like to achieve over the next five years, from sources such as the Royal College of General Practitioners, Kings Fund, Information Centre, Primary Care Commissioning. The King's Fund report on "Improving quality in general practice" is a key resource document."

There is a common theme that five years ago most strategies were looking to develop care pathways based on hub and spoke models. Healthcare for London led to most plans being re-packaged as polysystems, including new-build locality centres. Over the past year, without any new build financing, plans have been modified to take account of the original hub and spoke model plus any polysystem developments that were approved.

Undoubtedly, the strategic focus and planning over the past five years has been premises-led. However, despite the elaborate planning, implementation has been slow. Strategically the picture across NHS North Central London has not changed dramatically.

Everything in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy. First developed in 2006, it has now been ratified by the Secretary of State and implementation has recommenced. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

Any new developments in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy, which was given the green light for implementation by the Secretary of State for Health in September 2011. We are in the process of developing an integrated implementation plan which will recognise the close relationship between the two strategies and bring together the work to implement each.

The Primary Care Strategy supports delivery of better services in Camden and Islington as well as Barnet, Enfield and Haringey and, while there have been many recent developments in primary care in each of the five boroughs, many more are being developed or are planned. We will make the changes in hospitals when clinicians tell us that the primary care system is sufficiently developed to provide better and safer care than in hospitals.

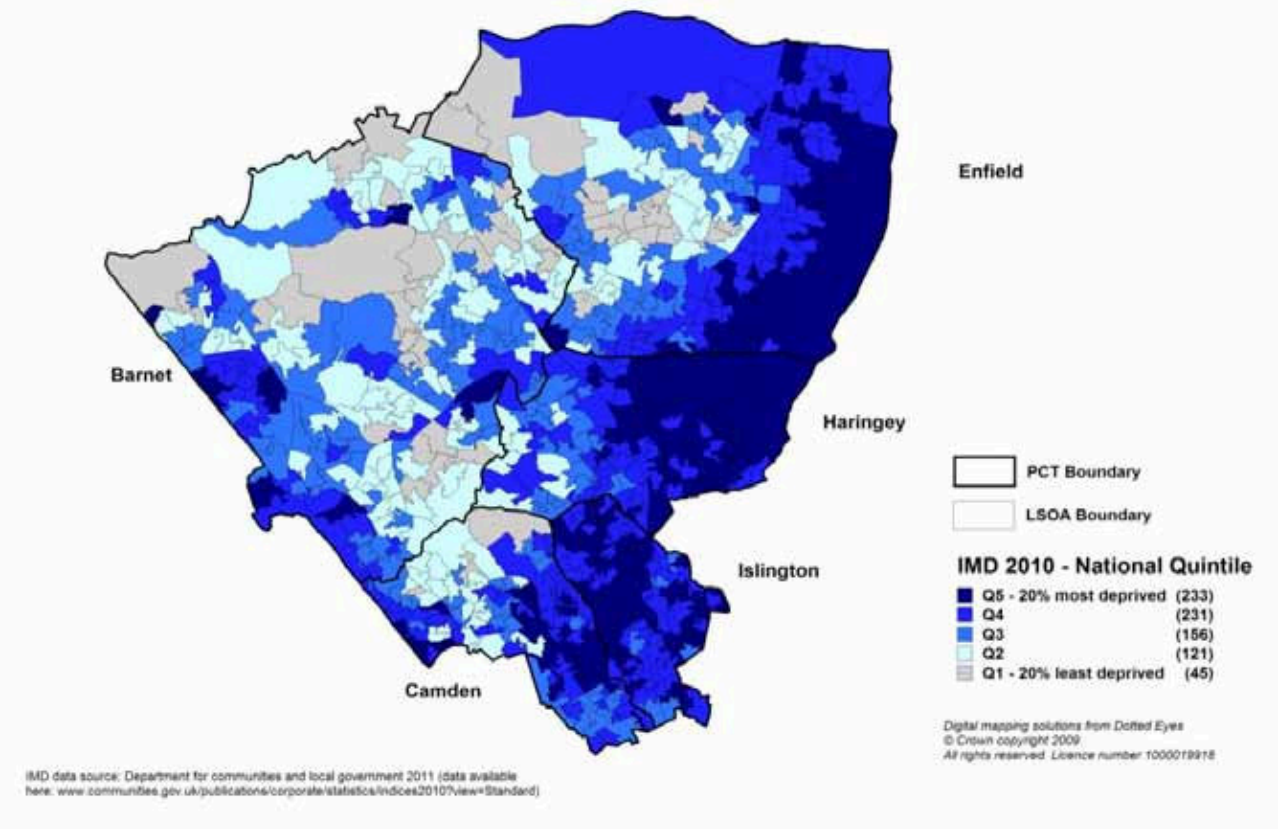
At its best, Practice Based Commissioning has tended to focus on pathway redesigns and has delivered improvements in some areas, but it has been variable across North Central London.

DEPRIVATION

There are significant differences in levels of deprivation between NHS North Central London's boroughs as well as marked differences within the boroughs.

In general, deprivation in North Central London increases as one goes from west to east, with the greatest concentrations of deprivation across most of Islington, the eastern half of Haringey, eastern edge of Enfield and parts of Camden.

IMD 2010 national quintile of overall deprivation score by North Central London sector LSOAs



LIFE EXPECTANCY

At 76.0 years, the male life expectancy at birth in Islington was the lowest in London, and in Haringey (at 77.4) was also significantly below the national and London averages. Enfield (79.5) and Barnet (80.4) were significantly above. The rate in Camden (78.5) was in line with the national and London rates, however there is a 10-year difference in male life expectancy between the south and north of the Borough.

Female life expectancy is generally higher than that for males. Whilst Islington's female life expectancy of 81.4 is significantly below the London average, Enfield's of 83.0 is not. Barnet's life expectancy of 84.4 is above both London and national averages, whilst Camden (83.8) and Haringey (83.7) are in line with London but significantly above the England average.

For both men and women, deprivation and lifestyle factors account for much of the difference in life expectancy between and within boroughs.

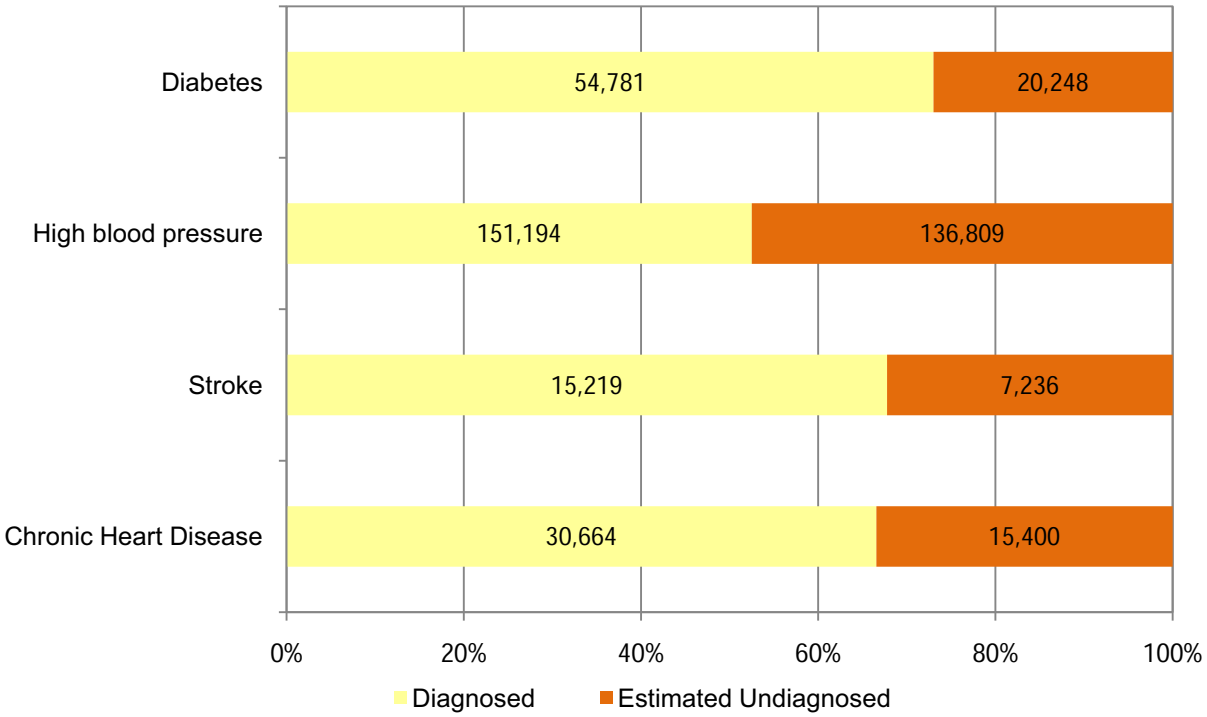
MORTALITY

There are approximately 8,000 deaths per year in North Central London. The three leading causes of death - cardiovascular disease (CVD), cancer, and respiratory disease - account for approximately 75% of all deaths, including 70% of all premature deaths (deaths under the age of 75).

PREVALENCE OF LONG-TERM CONDITIONS

There is significant under-diagnosis of long-term conditions across NHS North Central London, therefore many individuals cannot benefit from prevention and early intervention, resulting in poorer long term outcomes, higher use secondary care (including for emergency care). This includes cancer, chronic obstructive pulmonary disease (COPD), HIV and the following estimates of undiagnosed cases of diabetes, high blood pressure, stroke and coronary heart disease (CHD).

NUMBERS WITH LONG-TERM CONDITIONS – DIAGNOSED AND ESTIMATED UNDIAGNOSED. NORTH CENTRAL LONDON 2009/10



LIFESTYLES AND PREVENTION

There is some evidence to show that those living in the most deprived areas of London are likely to have a concentration of people with lifestyle choices which can be changed such as alcohol intake or smoking.

- Smoking is responsible for 20% of deaths in the sector
- Obesity is strongly linked to diabetes, cardiovascular disease and cancer. Over 200,000 adults are estimated to be obese (estimated to be below national levels)
- Physical activity. Nearly a million people across North Central London are considered not to be engaging in sufficient physical activity. Adult physical activity levels are above the London average in Camden and Haringey, but lower in Barnet, Enfield and Islington
- Alcohol. Across North Central London, less than 5% of the 54,000 estimated harmful drinkers are in treatment, ranging from 2.2% in Enfield to 8.7% in Islington
- Health Checks. Across North Central London, 16,744 people received a health check in 2010/11, 4.2% of the eligible population (though 13% was achieved in Islington).

Quality in NHS North Central London Primary Care - How can we really measure true quality?

> "Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice" (Improving the quality of care in general practice The King's Fund March 2011)

We have had Balanced Scorecards (five very different), Quality and Outcomes Framework (generally good), MORI Survey (not so good) and prescribing data. We have trialled and will be implementing the London-wide GP Outcomes Framework from April 2012.

OVERALL QUALITY AND OUTCOMES FRAMEWORK ACHIEVEMENT SCORES BY BOROUGH PCT 2010/11

Borough PCT	Number Practices	Exception Reporting	Number of Practices by overall QOF scores 2010/11 and % of total practices								PCT Ave
			<50%	50-80%	80-90%	90-93.3%		93.4-94.6%		>94.7%	
Barnet	69	4.5%	0	2	6	7		12		42	93.7%
			22%					17%		61%	
Camden	40	5.4%	0	1	3	6		8		22	93.8%
			28%					20%		55%	
Enfield	62	4.0%	1	5	12	15	93.3 London Ave.	8	94.7 England Ave.	21	90.4%
			53%					13%		34%	
Haringey	53	5.2%	0	5	6	11		6		25	92.0%
			42%					11%		47%	
Islington	38	6.0%	0	0	2	4		7		25	95.0%
			16%					18%		66%	
NHS North Central London	262		1	13	29	43		41		135	
			33%					16%		52%	
London		4.9%									
England		5.4%									

Better than London and England Averages

Better than London / Worse than England Averages

Worse than London and England Averages

Key points to note:

- 52% of NHS North Central London practices score higher than London and England averages
- Islington overall score higher than London and England averages
- Enfield and Barnet have low Exception Reporting

- 67% score higher than London average
- Barnet and Camden overall score higher than London

- One in three practices (86) score less than London average
- Of those 86 practices, 33 are in Enfield, equating to over half of the Enfield practices
- Enfield and Haringey overall score less than London average
- Islington has the highest Exception Reporting at 6%

MORI PATIENT SURVEY MARCH 2011

Overall Satisfaction Levels by Borough PCT

MORI 2010/2011 Scores	Satisfaction with care received	Recommending a GP surgery to someone moved into area
Results – England as a whole	89%	84%
London SHA	85%	77%
Barnet	85%	80%
Camden	83%	79%
Enfield	85%	77%
Haringey	81%	74%
Islington	85%	79%

Worse than England but better than London average	Worse than both England and London Average

On the two overall satisfaction questions, none of the boroughs achieve the England average, but Barnet, Enfield and Islington all equal or better the London average. Haringey fails to achieve the London average in both areas.

ACCESS

	Barnet	Camden	Enfield	Haringey	Islington	London	England
Ease of getting through on the phone	62%	63%	66%	65%	66%	67%	**69%**
No appointments available	84%	81%	84%	80%	83%	82%	**84%**
Times didn't suit	19%	20%	16%	17%	18%	18%	**15%**
Satisfied with opening hours	74%	74%	79%	76%	74%	78%	**80%**
Know how to access out of hours care	**56%**	**52%**	**55%**	**52%**	**52%**	**54%**	**62%**

Source: GP Survey 2010/11

PRIMARY CARE CONTRACT COSTS (SEE APPENDIX A FOR FULL ANALYSIS)

These costs are provided to illustrate the variations across NHS North Central London. A key issue from this data is that there seems to be no direct correlation between costs and outcomes.

General Practice

- Total GP costs range from £119 per capita (Barnet) to £140 (Camden).
- Total costs per practice range from £606k (Haringey) to £898k (Camden)
- General Medical Services contract costs are from £104 per capita (Haringey) to £124 (Camden)
- Ignoring Islington with only two PMS practices, PMS contract costs are from £128 (Haringey) per capita to £168 (Barnet)
- Barnet GMS contract costs are £109 compared to PMS contract costs of £168 per capita.

Dental, optometrists and pharmacists contractor costs:

- Total dental, optometrist and pharmacist contractor costs per capita:
    - Dental from £38 (Islington) to £56 (Haringey)
    - Optometrists from £6 (Islington) to £10 (Barnet)
    - Pharmacists from £19 (Camden) to £26 (Barnet).

- Number of dental contractors varies from 23 (Islington) to 70 (Barnet)
- Haringey dental costs are an outlier at £56
- Number of optometrists in Haringey is only 33
- Optometrist costs per capita from £6 (Islington) to £10 (Barnet).

Total costs of all independent contractors range from £184 (Islington) to £215 (Enfield), while prescribing costs range from £101 (Camden) to £160 (Barnet). The data on Astro PU costs indicates a range from £21.94 (Camden) to £25.47 (Barnet).

In summary, the quality and accessibility of primary care is variable across North Central London as a whole and within borough PCTs. Primary care has a pivotal role to play in reducing use of secondary care for basic healthcare provision, as well as improving population health. Radical change is required to develop primary care capacity and capability and ensure higher quality and productivity in primary care.

4. The future landscape of primary care - A patient's perspective

"This is how we want it to be"

North Central London

A patient's view of what primary care in North Central London will be like in the year 2016 in the boroughs of Barnet, Camden, Enfield, Haringey, and Islington.

Hi - I've just moved into the area and I'd like to find out about what's available to me from the local NHS. I've got friends who used to live in North Central London back in 2011 and they've told me some worrying stories about how variable the availability and quality of primary care used to be. Apparently it was something of a lottery with many really good general practices and some, allegedly, barely fit for purpose. At its very best it was fantastic and compared well with anywhere in the country. At its very worst, you could experience any or all of the following:

- Great difficulty in finding a practice with which to register
- Not being able to get through on the phone to make an appointment
- Very difficult to get an appointment suited to your lifestyle
- Unwelcoming reception staff
- Premises in poor condition, not clean and very uncomfortable
- Despite having an appointment, you often had to wait ages to see the doctor
- When you did get to see a doctor, apparently some of them didn't know anything about you as a person, didn't seem to have relevant history notes and didn't really sort out the problem.

I understand at that time too many patients took the easy option of going to the urgent care services – A&E, Walk in Centres and Urgent Care Centres. That can't have been the best solution for them or the NHS.

So my first question is – has anything actually changed since 2011?

Welcome to North Central London from the primary care part of the NHS. Yes things have changed greatly for the better. You're right – back in 2011 it was a very variable quality service with some excellent practices side by side with some not-so-good. In those days the "better" practices (as perceived by patients) were sought after and couldn't cope with the rising demand.

Then in 2011/12 we introduced a primary care strategy and development plan to improve poor performance and to ensure that all of our practices now meet explicit high quality standards. It is only fair to say that many of them already did meet those standards back in 2011 and what we have done is to ensure that all patients can now get that high quality service.

So, firstly, we want to get you registered as a patient in our area, and we don't want you to wait until you actually need our services. We aim to make it as easy as possible. You may already have had an information pack from your estate agent or letting landlord, giving you details of our services and a range of different ways to register with us.

For online registration, go to our website and click on the "I want to register as a new patient" link and just follow the on-screen instructions on the application form if you want to send us your details in that way (please read the internet security caution).

If you don't want to register online, call in at any of our NHS-signed premises – doctors, pharmacies, optometrists, dentists, community-based health services or clinics - or at any of your local council offices, Job Centre Plus, Citizens Advice Bureau, Libraries, and some local estate agents. You do not need to bring anything with you and we'll get you signed up straight away. When you arrive at the practice we will ask you to sign the form as a legal requirement and that is it – you will be registered. At the surgery you will be able to find a complete list of all of the services available both at your base surgery and in the NHS and social care network locally. (All of this information will also be available via our website as well and is available in different languages). This will include:

A. NAMES AND ADDRESSES AND FULL INFORMATION ABOUT LOCAL GENERAL PRACTICES WITH THEIR RANGE OF SERVICES AND DETAILS OF THEIR STAFF AND OPENING TIMES

Generally speaking, you should be able to find a choice of practices within 20 to 30 minutes travel time from wherever you live in Barnet, Camden, Enfield, Haringey, or Islington. You can then choose the one that best meets your personal lifestyle preferences. Be assured that the quality of care is uniformly high at all of our practices, and that the differences in location, premises, size, opening hours, languages and/or translation service and the range of clinical services available on-site are the criteria by which we want you to choose, according to what suits you.

We know that many patients prefer a small practice where they will know, and be known by, all the staff. Because there are fewer clinicians it should be easy to get personalised continuity of care. But, depending on the range of services offered by that practice, sometimes it may mean that patients have to go to another nearby practice for care that cannot be delivered safely and effectively in every practice. We also know that other patients do prefer a larger "one stop" centre where they may not always know, or be known by, all the staff but a wider range of services may be available. It's really your choice!

B. AN OPPORTUNITY FOR YOU TO GET A CHECK-UP BY BOOKING A NEW PATIENT HEALTH CHECK AT THE PRACTICE OF YOUR CHOICE

We want to ensure that the practice gets to know about you so that it can work with you on your total health service. This opportunity will also be extended to your family members if you are also registering them. We understand that your time is valuable so as much detail as possible can be filled in online through a health questionnaire, and some of the detail can be filled in later, possibly at a self-check station in one of our community pharmacies or other NHS premises. If there are any gaps we will fill them in next time you come in. You will be able to access care straight away, but the more we know about you from the outset the better and safer it will be for you.

C. A LIST OF PHARMACIES IN YOUR AREA, WITH OPENING TIMES AND ADDITIONAL SERVICES

Our practices operate a "standing order" system of repeat dispensing of many medications, (with some exceptions) which means that you may not have to get a repeat prescription from your GP every time you need your regular medication. Do note that our pharmacists are able to provide advice and a wide range of services which could save you having to go to your doctor at all. These include general health promotion, dealing with minor illnesses such as colds, hay fever, allergies, tummy upsets, emergency contraception, travel advice, medicines advice, NHS Health Checks and some immunisations and smoking cessation. Plus lots more – it's all in the leaflet.

D. AN INFORMATION PACK ON THE FULL RANGE OF SERVICES AVAILABLE AND HOW TO ACCESS THEM, FROM DENTISTS AND OPTOMETRISTS

Dentists can provide advice on oral health, nutrition and smoking cessation. Optometrists can advise you on colour blindness, cataracts, glaucoma, "acute red eye" and early eye disease signs of some long term conditions. Again, full details of these and other services are in the leaflet.

E. ALSO THE INFORMATION LEAFLET WILL EXPLAIN HOW TO FIND YOUR WAY THROUGH THE LOCAL NHS WHEN YOU NEED US URGENTLY

We offer a range of urgent care services. The hospital accident and emergency department is reserved for the most serious cases. The majority of urgent care can be delivered by your doctor, pharmacist, dentist or optometrist. If you're not sure you can always phone us on 111, the NHS one stop phone number service, who will help you access the right people for your care.

Do be aware that if you do go straight to the hospital A&E, they may re-direct you back to your local primary care service for the type of care that you need. If you are unwell out of normal working hours, many of our surgeries offer extended opening hours including evenings and weekends. We have the 24 hour 111 telephone helpline and you can visit an urgent out of hours centre or, if housebound, a home visit is available for those who really need it. Remember, patients attending in person can be seen much more quickly than those on home visits.

F. DETAILS OF THE SOCIAL SERVICES AVAILABLE FROM YOUR LOCAL COUNCIL ARE ALSO IN THE PACK

This will include guidance on how to access those services and how they work in an integrated way with our primary health care teams and the voluntary sector.

SO, AS A NEW PATIENT, WHAT CAN I EXPECT FROM MY GENERAL PRACTICE?

Firstly, we can assure you that the premises will be fit for purpose, irrespective of the age and type of building. We have a mix of new and old, large, and small buildings; but they are all clean, bright, and tidy and will display only current relevant information about our services. The building will be accessible for all, including the disabled, and will conform to all health and safety requirements and be a safe environment. There will be a comfortable waiting area and all of our practices are child friendly, understanding the needs of both parents and children, at what may be a stressful time. All consulting and treatment rooms will be appropriate for their use, and there will be decent toilet facilities should you need them.

All practice premises are open and staffed, as a minimum, all day from 8am to 6.30pm Monday to Friday and some are open in the evenings and at weekends. When you contact them, you will be offered an appointment or telephone consultation with a healthcare professional relevant to your needs, which, depending on clinical urgency, may include same day access. From the information we sent you, you will already be aware of your choice of clinician, including gender and language preferences.

On arrival, the practice reception staff will be welcoming and you will be able to check-in confidentially, either face to face, or electronically. As a new patient, you will be introduced to our "Self care management and co-creating health programme" either face-to-face or electronically, to guide you through the things that you may find useful including:

- How to get your personal health profile
- Self-care and lifestyle advice
- Exercise on prescription
- Housing, benefits, employment, healthy foods and cookery advice
- Specialist advice on drugs and alcohol abuse
- Details of how to access all our services.

Your practice healthcare team will view you as a member of the local health community and will provide you with public health information about disease patterns, likelihood and symptoms. We know the expected patterns of ill-health in a community and can advise you on healthy living, prevention and early diagnosis. Health promotion and illness prevention is as much a part of our service as care and treatment.

AFTER MY INITIAL VISIT, HOW WILL I BE ABLE TO CONTACT THE PRACTICE?

Weekdays between 8am and 6.30pm, you can contact any of our practices by phone, online appointment booking or in person. Some of our practices are open until 8pm and at weekends. Occasionally, a practice may close for a half-day staff training session, but they will have arranged for a nearby practice or an urgent care provider to cover any patient needs.

We offer consultations with doctors and nurses face to face, by phone and sometimes by e-mail. When you enquire about making an appointment the practice will agree with you which is the most suitable option for you, or you can just book online, if you know which clinician you need to see.

If you prefer continuity of care, then practices will always try to offer you an appointment with the clinician of your choice. Sometimes, particularly if you require an urgent consultation, they will offer you an appointment with the first available clinician. If you sign up for our "Reminder" service, the practice will always send you a text message to your mobile phone 24 hours before your appointment. If you are unable to attend, please let us know immediately so that we can offer your slot to another patient.

Outside these surgery hours, please ring 111 for the Out-of-Hours Doctor Service.

Whichever type of consultation you have, and whatever the time of day or night, with your permission, we can arrange for your medical records to be available to the clinician so that they can see all relevant information. If you have an out-of-hours consultation, we will ensure that your registered practice is aware of it, and they will update your records accordingly within 12 hours.

WHAT SERVICES DO YOU OFFER THROUGH YOUR PRACTICES?

All our practices work within a local primary care network across a number of practices in a "natural community". The network principle is that you will always be able to access, within the network, all of the services that we offer as part of our guaranteed standard services list (see enclosed).

Every practice offers on-site, as a minimum, the range of core services that you would expect from any general practice. Some practices offer a wider and growing range of additional services. If you are registered with a practice that does not offer the full range of guaranteed services, you may have to attend another nearby practice in the local network for some of those services. Here are some examples of how the network functions:

- All practices offer a range of patient diagnostic tests in-house. If you need a blood test, then the sample may be taken in your own or a nearby network practice, and the samples sent away for analysis. You will then be able to contact the practice for your results within 72 hours and they will be available to you online on your health record
- Some practices offer more specialised testing, such as ultrasound scanning, for their own patients, and for those from nearby practices in the network
- If you require more specialist support and advice for a condition such as diabetes, your GP may refer you to attend an appointment with a diabetes GP or nurse locally in the network
- If you need more specialised diagnostics, such as an x-ray, your GP has direct access to order tests as required, usually within the borough.

The local primary care network includes a wide range of community–based clinicians known as the Extended Primary Health Care Team. The team will service the network patients across a number of practices. The services include:

- District nursing, including community matrons to help you plan and support you in your care
- Specialist nursing including school nurses, paediatric nurses and other clinical specialties
- Health visiting
- Midwifery
- Physiotherapy
- Podiatry
- Speech and language therapy
- Occupational therapy
- Primary mental health services, including psychology and a range of counselling and therapy services
- Social services care.

The local network includes a team of Integrated Care Clinicians who manage the care pathways, (how you move through the NHS during your treatment) liaising with the hospital specialists, community services and the network GPs to ensure rapid and effective delivery of the services along those pathways. Each network has differently skilled and specialised Integrated Care Clinicians according to local needs.

Communication between practices is usually electronic. Most practices use the same computer system, but those few who have a different system can still communicate with each other across the IT network. Practices are also able to communicate directly with other community-based clinicians and hospitals to ensure effective transfer of relevant patient information across organisational boundaries.

In line with national policy, you will also be able to log on to the same system to check your own health summary care record at any time. If you don't have a computer or smart phone available to you, you can use the surgery patient computer to check your records, make future appointments or re-order your medication.

In addition to the above services, all practices provide home visits for housebound patients. When appropriate, we can also offer some patients self-monitoring equipment to measure blood pressure, blood sugar levels and other routine regular monitoring tests. The clinicians will teach you how to use the equipment, what the results mean, how to care for yourself if your condition changes, and when to contact your healthcare team. Supported self-care is a key part of our total healthcare service. If you are a patient who has a full or part-time carer, this also includes support for your carer.

We are very pleased that children in North Central London rarely get measles. GPs have been working closely with the community in ensuring that over 90% of the children in our area have received their childhood immunisations. With this excellent coverage we have minimised the risk of children developing measles, mumps, rubella or tetanus, diphtheria, whooping cough and polio. You are no longer restricted to a specific clinic on a specific day as immunisations are offered in a range of settings.
We have also have excellent flu vaccination rates amongst our elderly and people with long term conditions, meaning there are less complications as a result of the flu.

Dentists, pharmacists and optometrists are all an important part of our primary care services and you can contact them directly. Our information pack will give you full details of your nearest practitioners and how to access them both routinely and in an emergency. Sometimes they will be co-located with our general practices or will be in nearby premises, offering a range of services to support your health and wellbeing.

Our GPs will only ever do what they know they can do safely in their own practice, and sometimes it will be necessary to refer you for further diagnostic tests and/or treatment. Your GP will be able to offer you a consultation locally, often with a specialist community-based service, or will arrange a hospital appointment for you. Our integrated care pathways mean that your GP, the community services and the hospital consultants can communicate electronically to share information and agree on the best course of action to meet your particular needs.

In addition to their role as specialist clinicians in the primary care team, our GPs are also the skilled navigators to guide you through the care system to ensure that you receive the right care, in the right place, first time.

WHAT IF I NEED TO GO IN TO HOSPITAL FOR AN OPERATION?

Our GPs will do as much as they can in primary care to avoid unnecessary hospital admissions. However, following your consultation with the specialist, if you and they decide that an operation is necessary, your GP will:

- Advise you on what to expect
- Offer you a choice of hospitals, if you wish to go elsewhere
- Have the technology to place you on the appropriate waiting list and be able to update you on your list status, as hospital waiting lists are now fully accessible by our GPs
- Increasingly, arrange for you to be a day case patient without any overnight stay
- Liaise with the hospital to ensure that, if you do stay in, it will only be for the minimum time and that they get you discharged as soon as it is safe to do so
- Have access to information to confirm that the hospital makes all parties aware of your discharge arrangements and discharge plan details
- Support your rehabilitation and convalescence at home or in a community setting
- Work with the hospital to arrange any follow up consultations with the most appropriate clinician, who may be the GP, the hospital consultant or another specialist clinician.

WHAT ABOUT PATIENTS LIVING WITH A LONG TERM CONDITION – HOW DO YOU MANAGE THAT?

A long term condition is one that will require monitoring and treatment over a long time such as asthma or diabetes. Firstly, we aim to achieve an early diagnosis of any such condition so that we can start treating it as soon as possible.

When a patient is first diagnosed with a long term condition, our practices will:

- Provide you with full educational information about your condition soon after diagnosis
- Introduce you to our nursing team who lead much of our long term conditions management
- Advise you of additional support services, which will often be patient groups or charities, who are expert in the management of your condition
- Agree a package of care with you based on your needs. This will include a written Care Plan with mutually agreed goals and periodic and annual reviews.
- Agree with you what you can do for yourself as supported self-care and when to seek the help of your healthcare team. We want you to become confident in managing your own condition as much as possible.

If you have a complex condition, or set of conditions, our team will appoint a named care co-ordinator, to work with you and the rest of the team. They will then help you to implement your Care Plan; you will have one integrated plan, not many disconnected ones.

All community members of our teams have modern technology, including telephones with GPS navigation, so that colleagues can locate them and they can locate you as quickly as is necessary. You will also be able to e-mail and text them whenever you need to do so. Our staff will respond as soon as they can within time periods that we will publish and on which we will be monitored on.

The primary care team is professionally integrated with specialist hospital consultants, who can advise the team, and you, on your individual case management as well as providing ongoing education, training and clinical supervision. Occasionally, the team may decide that you need a review with the consultant and will offer you an appointment. The team will aim to provide you with as much of your routine care as close to home as possible.

WHAT SERVICES DO YOUR PRACTICES OFFER TO PREGNANT WOMEN?

Hopefully, your practice will already know you and have offered you pre-conception advice as part of our normal service. The practice will want you to confirm your pregnancy as early as possible and can advise you on locally available pregnancy testing. Then, at no later than 12 weeks, they will offer you, and your partner, a range of ante-natal services including exercise and parenting classes. Our team of midwives will work closely with you and your GP to monitor your pregnancy and to support you in a safe birth including your choice of birth settings.

After the birth, the practice team of doctors, nurses, midwives and health visitors will provide additional support services for the first two years. This will include:

- Post-natal classes

- Immunisations
- Child development monitoring
- Parenting skills support
- Ongoing conception advice.

WHAT IF I HAVE FAMILY MEMBERS WITH SPECIAL NEEDS?

The specific needs of the patient groups concerned are reviewed against the latest evidence and take advantage of shared knowledge from consultants, specialist nurses and therapists across the wider primary care team based in a highly integrated way rather than in a purely reactive way.

For example with patients with learning disabilities, who as a group have significantly reduced life expectancy, the network and each individual practice are fully up to date with the special needs of each registered group with ready access to the appropriate expertise and advice. They also identify individuals at increased risk and agree individual care plans with the patients, and where appropriate, their carers.

WHAT SUPPORT CAN YOU OFFER ME IF I AM DIAGNOSED WITH A TERMINAL ILLNESS?

It is important that your GP knows your wishes for your care soon after your diagnosis. They will then develop a Care Plan with you based on the Macmillan Gold Standard Framework (GSF) for end-of-life care. In addition to your GP, our extended primary health care team will help to look after you and support and advise you on your options requiring decisions.

Through the team you will have direct and speedy access to specialist clinicians most qualified to advise on your care.

WHAT ABOUT THE RISKS OF CANCER?

In spite of significant advanced of treatment in cancer, UK survival rates remain disappointing compared to Europe. But we know that much of this difference is accounted for by the differences in one-year survival and that strongly suggests that delayed diagnosis is a significant contributory factor.

Therefore, all our practices take a multi-strand approach, firstly to prevent, and secondly to diagnose as early as possible through:

- Continued emphasis on prevention (smoking cessation, reducing obesity, healthy diet, regular exercise)
- Improving the uptake of screening
- Targeted social marketing to increase awareness and encourage earlier presentation by patients
- Clinician awareness of early presenting features suggesting possible cancer.

WILL I STILL HAVE A GP IF I HAVE TO GO INTO A NURSING/RESIDENTIAL HOME?

You'll certainly have access to the full range of services that we've described. We have contracts with selected practices to provide primary care services to the nursing/residential homes in our area and they have particular knowledge and experience in meeting the needs of those residents. So you'll be able to choose whether to stay registered with your existing practice or whether to transfer to one of those other practices.

WHAT ABOUT PRESCRIPTIONS AND MEDICINES – HOW DOES THAT WORK?

For those patients who need repeat prescriptions such as those for long term conditions or oral contraception, our practices operate a "standing order" system of repeat dispensing of prescriptions (with some exceptions), from your named pharmacy, without the need to request a repeat prescription from your GP. The pharmacist is an expert in medicines management and will advise when you need to see your doctor again for a review of your clinical condition.

Your pharmacist runs a New Medicines Service. When you are prescribed new medications, they will spend time with you teaching you about the new medicine. Many patients say that they find this service really helpful in understanding their new medicines.

Your pharmacist is also available to advise you on any side-effects or concerns that you have arising from your medication and will consult with your doctor about any recommended changes.

HOW DO YOU ASSURE THE QUALITY OF YOUR GPS TO KNOW WHETHER THEY ARE DOING A GOOD JOB FOR THEIR PATIENTS?

In accordance with best practice, we define and monitor the quality of primary care under three headings - patient safety, clinical effectiveness and the experience of patients.

The NHS in London, working with GPs, has developed a set of standards, often known as indicators, for GP practices which give you the information you need to make decisions about your healthcare.

There are 22 standards, covering areas like diagnosis, screening, vaccinations for children, and ease of getting appointments, making it easier for you to:

- See how effective your GP services are in areas of healthcare that matter to you
- Understand what your practice is doing to meet the healthcare standards required by you and your family
- Make a decision about registering with a practice that best suits your particular needs.

You can compare the performance of individual practices on the Myhealthlondon website.

All practices have to be registered with the Care Quality Commission (CQC).

All our GPs are committed to ongoing professional development. They all have written personal development plans, and take part in an annual appraisal of their performance with a qualified GP appraiser. They attend regular education and development programmes on key GP skills. Since 2012/13, all GPs have been required to apply for professional revalidation every five years. Many of our practices are also qualified to train new GPs.

In addition, GPs arrange for their practice staff to attend regular professional development training and education programmes suitable to their role. In addition to professional clinical training for our clinicians, this includes customer service training for our reception teams. Our practices aim to build a culture of high standards of clinical care and service.

As part of all of the above there are a number of contractual measures by which we assess the overall quality of service provision by our primary care colleagues.

We encourage a culture of incident reporting and group learning. Our practices actively seek and welcome feedback from patients on their experience of services, and view complaints as an opportunity to improve services. For that reason ask you to speak directly to, or send any complaints to, the Practice Manager at your registered practice. They will acknowledge your complaint within 48 hours and keep you advised of progress.

If you are unhappy with any aspect of the service that you have received, but don't want to engage directly with the practice then please contact our Patient Advice and Complains Service (PALS).

We undertake regular patient surveys at all practices and the results are published on our website. In addition, patients can go on to the NHS Choices website practice page and leave comments about their experience. Practices are required to develop action plans to address any areas where potential improvements have been identified.

Many of our practices engage directly with their patients through Patient Participation Groups. These provide a forum for local feedback and improvements by practice users.

We also engage in more formal public involvement through Local Involvement Networks (LINks, or their successor HealthWatch), the independent consumer organisation. They have the statutory right of entry to visit the premises of service providers and to report their findings.

Our aim, and that of all our practices, is to offer you a high quality primary care team service, linked, when necessary to more specialist services; all of which will enable you to live the best possible lifestyle in respect of your personal health and wellbeing.

5. Transformation Strategy

"This is what we're planning to do to make it happen"

The "Future landscape of primary care – a patient's perspective" in the previous chapter is our aspiration for the future. Many practices are already delivering some of that vision. We want to raise the standard across the board so that all patients have access to the very best in primary care.

The rest of this document describes our plans to transform primary care over the next five years to make the aspirational future landscape a reality. This section sets out our transformation strategy, explains our thinking and identifies specific areas for investment.

Addressing quality, safety and improving patient experience are key aims in the North Central London primary care strategy. This strategy recognises that transformational changes are needed to support the development and capacity of primary care, and describes the steps towards implementing that transformation. It will take time and resource. We want to work with our independent contractors to motivate, incentivise and support them on the transformational journey. But we will also manage their performance to ensure that our contractors do deliver those higher standards of quality, safety and patient experience.

The strategy aims to improve the quality, capability, capacity and productivity in primary care. The focus will be on promoting health, wellbeing and illness prevention and addressing our health inequalities. It will enhance patient experience and outcomes by improving clinical and service quality and life expectancy. Operating across the traditional boundaries it will begin to integrate the delivery of care, reduce the variation between practices, and increase the number of people registered with a GP in a way that is culturally appropriate.

We recognise this will need upfront investment. As part of this strategy, we are submitting a Business Case to NHS London for three years of pump-priming financial investment to cover additional and/or double running costs. At the end of three years, we anticipate that the savings in acute care will more than cover the then ongoing recurrent higher costs of primary care. This is set out in the strategic cost/benefit analysis in Section 9. We are proposing nine strategic investment domains:

1. Integration
2. Clinical services
3. Information technology

} = Integrated Care Network

4. Public Health
5. Premises
6. Productivity
7. Workforce, leadership and team development
8. Commissioning
9. Communications.

STRATEGIC DOMAIN 1 - INTEGRATION

The long term aim is to overcome organisational boundaries and to replace them with networks of service delivery along care pathways. There are five identified levels of integration:

1. PRACTICE TO PRACTICE.

Individual GP practices grouped geographically into networks of natural communities of registered patients. Each practice will retain its own GMS/PMS contract for delivery of core services. The network (or a nominated lead practice) will contract by "Super local enhanced service" (or possibly alternative provider of medical services) to provide all additional services on a guaranteed list, and decide at which locations the services will be available. In some networks, all practices may choose to provide all services. The patient guarantee is that all patients within all networks will be able to access the same guaranteed primary care services, which will address the previous issues of inequity of provision.

2. EXTENDED PRIMARY HEALTH CARE TEAMS ATTACHED TO THE GP NETWORKS PROVIDING THE STANDARD RANGE OF COMMUNITY SERVICES.

This can be facilitated by Clinical Commissioning Groups specifying and commissioning community services as complete teams.

3. INTEGRATION AT APPROPRIATE POPULATION LEVEL (BASED ON DISEASE PREVALENCE), OF ALL SERVICES – AND INCREASINGLY MOVING TO NON PAYMENT BY RESULTS (PBR) TARIFF "WHOLE PATHWAY" FUNDING.

The integrated pathway will include specialists and additional clinical resources drawn from a local Clinical Pathway Pool comprising:

- Lead experienced GPs working on a part-time sessional basis (replacing the current sessional lead GP arrangements)
- "Open doors" specialist long term conditions nurses/allied health professionals recruited from secondary care to liaise with the hospital specialists, community services, GPs and practice nurses to ensure rapid and effective delivery of the services along those pathways
- Recent post-graduate GPs to provide flexible, additional capacity in the network
- Other community specialist clinicians as required.

The Pool will be borough-wide and will be designed by the network practices. It could be populated by clinicians from practices, community services, acute services, voluntary sector and other expert organisations. Each network will have a budget to buy in resources as required from the Clinical Pathway Pool on a not-for-profit basis.

The combined network budgets in a borough will pay for the total resources in the pool. Payment will be made to the employing organisation who will informally lend clinicians into the pool, either full or part time in line with demand. If, as expected, local practice GPs wish to become part of the pool, their practices will be reimbursed from the pool budget.

The design and operation of the networks and Clinical Pathway Pools will require more development. We want to work with GP colleagues to create the most effective models for each network.

4. INTEGRATION BETWEEN HEALTH AND ENHANCED SELF CARE AND SOCIAL CARE.

We want to build the a personal network around individual patients, combining the right level of professional input from both health and social care, with pro-active support for the highest level of self care suitable to individual circumstances.

5. INTEGRATION WITH ACUTE SPECIALIST

Input may include:

- Fewer and highly selective face-to-face individual patient consultations (might still be in a hospital setting or a community based consultation)
- Case based discussion of selected individual cases using records and data in multi-disciplinary teams occurring on a regular basis
- Sharing of knowledge, teaching, research findings, new drugs, new interventions and new technologies
- Clinical governance, clinical audit, clinical supervision of network clinical leads
- Outcomes /metrics management of one network compared with another using dashboards data, and within networks with outlier individual practice(s)
- Outreach to support poorly performing networks.

STRATEGIC DOMAIN 2 - CLINICAL SERVICES

People are living longer, but rather than being healthy for longer with the same health issues and costs concentrated at the end of life, they are tending to develop long term conditions earlier in life and live with them for longer, with physical and mental health problems for many years consuming ever escalating costs of health resources.

It is unusual to have a single long term condition, the majority of patients have more than one, often inter-related conditions most of which are linked to or exacerbated by lifestyle choices, which in turn are linked to deprivation and lower income. These lifestyle factors include smoking, obesity, physical inactivity, excessive alcohol intake and poor diet.

Diseases include diabetes (type 2), coronary heart disease, hypertension, stroke, COPD, heart failure, renal impairment, liver disease, muscular-skeletal problems, degenerative joint disease, chronic pain, depression and anxiety. Traditional primary care has tended to address these problems at the level of the individual in a reactive way that has often been centred on the clinician rather than the patient and certainly not on the population.

Our ambition is to transform this to a much more proactive, population view, patient centred service based on a transformed approach to health status monitoring of the population and

much earlier and more patient friendly interventions. The Kings Fund Report describes the required change:

> "The required modernisation agenda for general practice has been described in the United States as 'the transformation from cottage industry to post-industrial care'. This is because it combines three key elements – standardising care, measuring performance, and transparent reporting – and eliminates unwarranted clinical variation, waste, and defects.
>
> "At its heart, general practice in much of England remains a cottage industry, and we believe that this must change radically."

The King's Fund Report also describes the changing role of the GP:

> "General practice needs to see itself at the hub of a wider system of care, and must take responsibility for co-ordination and signposting to services beyond health care – in particular, social care, housing and benefits.
>
> "General practice needs to move from being the gatekeeper to specialist care to being the navigator that helps steer patients to the most appropriate care and support.

Combining this redefinition with all the other component parts of this strategy, it all adds up to what may be a significant culture change for many GPs. However, our intention is not to create any contractual changes. We are seeking to promote a change in "how things are done" rather than "what is done".

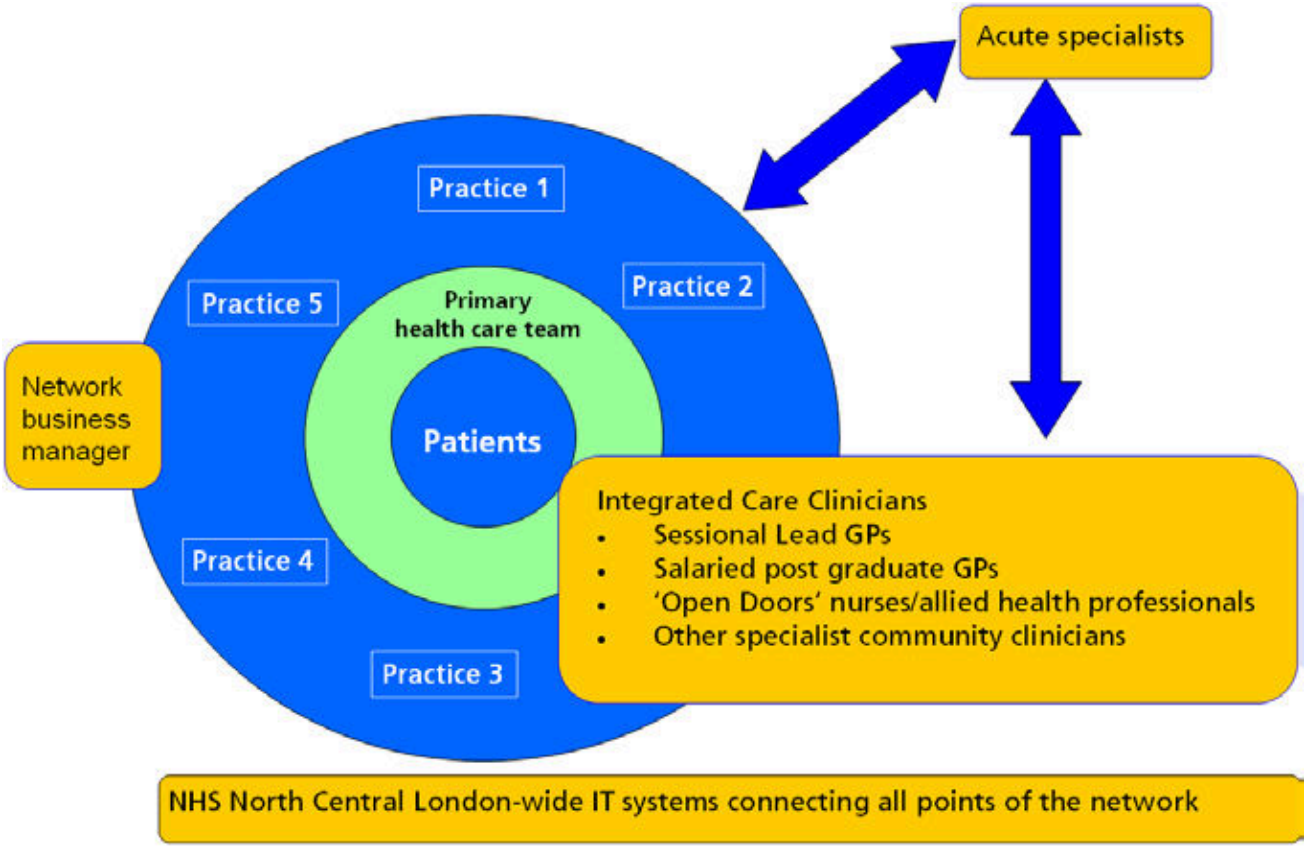
This will be achieved through an education programme, based on the King's Fund Report, designed to support GPs in becoming system navigators whilst retaining the essential parts of their traditional role as gatekeeper.

STRATEGIC DOMAIN 3 – INFORMATION TECHNOLOGY

This is a major theme which will require significant investment. The ideal end state will be to have all health care providers able to share patient records and to communicate electronically directly with each other to ensure that individual patient needs are met. We intend to commission an interactive web-based clinical information management network across NHS North Central London.

The first three domains, as described above, are combined together to create an Integrated Care Network (ICN). We are offering an example of what an ICN may look like but the actual design will be determined by each network.

WHAT MIGHT AN INTEGRATED CARE NETWORK LOOK LIKE?



STRATEGIC DOMAIN 4 - PUBLIC HEALTH

Public health intelligence is vital to health care planning. We want each network service delivery unit to have tailored disease-specific prevalence data by practice for their area. Each network will then be able to take a more proactive population view, using public health status monitoring of the population. The target will be to address health inequalities by closing the gap between expected and actual prevalence.

STRATEGIC DOMAIN 5 - PREMISES

Rather than focusing on premises-led strategies, primary care providers must now focus on the quality of clinical care, patient pathways or packages of care, and patient experience, where premises will be an essential enabler. Practice size will not be an issue but delivery of high quality care and patient experience will be.

Traditionally there has been an overlapping relationship between PCTs as both commissioners and often as landlords, and GPs as both service providers and as tenants. This dual role for PCTs will end when PCT-owned premises are transferred to providers, leaving the NHS North Central London cluster PCTs as purely primary care commissioners and

contractors. It is this role that will then transfer to the NHS Commissioning Board in April 2013.

NHS North Central London intends to commission only high quality primary care as defined in the strategy. In support of this aim, the primary care strategy will include the following principles relating to practice premises:

- If any practices in unsuitable premises are unable to achieve the premises quality standards, but wish to remain as contracted providers, NHS North Central London may require, and will support them, to relocate within a given time period. If they are unable to improve or find suitable alternative premises, NHS North Central London may require them to move into NHS-owned premises on a resource-sharing basis, subject to NHS landlord approval.

- If any practices in unsuitable premises are unable to achieve the required quality standards and decide to exit from provision, NHS North Central London will not necessarily replace them like for like.

- If any practice wishes to relocate and the relocation will impact on the GMS cost/rent reimbursement, then NHS North Central London will require a business case to be submitted before the relocation occurs. Providing the business case meets the required quality delivery markers, NHS North Central London will approve the financial reimbursement.

- NHS North Central London, in the role of primary care commissioners, is not responsible for providing or maintaining premises for independent contractors. However, after many years of supporting general practice through primary care premises development programmes, NHS North Central London recognises the mutual benefit to be gained from premises improvements. We intend to invest in additional premises management expertise to work with GPs who are proactively seeking renovation or relocation. We will seek to appoint and/or contract with entrepreneurial business development specialists who can work with GPs to put together innovative commercial development projects.

- Premises developments have both capital and revenue implications. It must be assumed that there will some, but limited, NHS capital for new premises. NHS North Central London will welcome innovative schemes from stakeholders to create new and/or modernised premises for GPs and primary care teams. This could include third party developers, GPs, other independent contractor groups, local authorities and not-for-profit organisations. Development planning gain may present opportunities. Normal NHS rent reimbursement arrangements will apply, but in order to manage the cost pressures on revenue, all such developments must demonstrate value for money and will be subject to the prior approval of business cases by NHS North Central London.

STRATEGIC DOMAIN 6 – PRODUCTIVITY

Access is always reported as a key issue for patients, although they are often prepared to trade-off immediate availability in order to receive continuity of care, particularly with long term conditions management. The reality is that both access and continuity are dependent on the ability of a practice to balance demand and supply. Some years ago much work was done on balancing through programmes such as Advanced Access. But it is not a one-off adjustment – it must be continuously refreshed.

We propose to undertake a programme to audit access and create improvements by supporting system redesign where necessary. This will include defining the number of GP and nurse appointments that should be available in every practice to meet the reasonable needs of their registered population – in line with the national GP contract.

We also propose to invest in general practice productivity improvement programmes and we will encourage and incentivise practices to take part in, for example:

- "Improving access, responding to patients - A 'how-to' guide for GP practices" (Practice Management Network- August 2009)
- The RCGP Practice Accreditation award
- The Productive General Practice programme "Releasing Time" from the NHS Institute for Innovation and Improvement
- "Doctor 1st" Telephone Access.

STRATEGIC DOMAIN 7 - WORKFORCE, LEADERSHIP AND TEAM DEVELOPMENT

The (re)establishment of the extended primary health care team will require leadership and team development to focus on:

- Agreeing roles and responsibilities
- Sharing clinical skill sets
- Understanding network accountability
- Defining the challenges and opportunities in the network
- Creating a shared vision for the network
- Agreeing on who will deliver what, where and when
- Metrics reporting.

In addition there will be topic-specific development programmes for GPs, practice nurses, practice managers and reception staff, covering clinical and non-clinical skills development.

STRATEGIC DOMAIN 8 – COMMISSIONING

It is clearly understood that primary care contracting and performance management will be the responsibility of the new NHS Commissioning Board. However, Clinical Commissioning Groups (CCGs) will have a role to play in primary care commissioning, when as the strategic commissioners, they will want to define their expectations of primary care services. This will include decisions on specifying Local Enhanced Services (LES) to be contracted by the NHS Commissioning Board. This primary care strategy also requires CCGs to commission

community services on a network team basis. It is also likely that CCGs will want to shift the provision of some services from hospital to a community setting and will seek bids from primary care contractors to provide parts of, or whole, new pathways.

In this way, with CCG leadership, investment will be redirected from secondary to primary care.

STRATEGIC DOMAIN 9 – COMMUNICATIONS

We will invest in a communications programme designed to inform the public about primary care services available to the population and how to access them as easily as possible. This will be combined with self-care and healthy living advice.

6. Managing the Transformation

"Making sure that the right things are done well"

Having provided the investment to create the transformation, for implementation, NHS North Central London has a duty to ensure that the investment is spent as intended and that it delivers the desired results. We have already stated that our intention is not to create any contractual changes. We are seeking to promote a change in "how things are done" rather than "what is done".

We are therefore proposing a mutually beneficial investment in primary care which requires independent contractor practices to achieve explicit quality standards of inputs and outcomes in return for the financial investment. Our message to our independent contractors is "If you do these things well with our investment, then together we will achieve the desired outcomes". This section now focuses on defining and monitoring the inputs and actions that are required to implement the strategy.

STANDARDS BY STRATEGIC DOMAIN

DOMAIN 1 - INTEGRATION

- To be signed-up member of the local practices network
- Explicitly connected into the local Integrated Care Network
- Full participation in a Primary Health Care Team development programme.

DOMAIN 2 - CLINICAL SERVICES

- To provide as a practice, or jointly provide within the network through a Super LES, the full range of additional services in line with the patient guaranteed list
- Set up repeat dispensing arrangements with pharmacies
- Produce and manage long term conditions care plans, including self-care
- Produce and manage MacMillan GSF Plans
- Participation in patient surveys and development of improvement plans based on those surveys.

DOMAIN 3 – INFORMATION TECHNOLOGY

- Switch over to the NHS North Central London web-based system within the required timescale
- Install patient self check-in system
- Provide a designated patient computer terminal
- Have a practice website with online appointment booking and electronic repeat prescribing
- Patient access to health care records in line with national policy.

DOMAIN 4 - PUBLIC HEALTH

- Proactively use the network/practice disease profiles to case find and maintain practice disease registers
- Plan services as part of the network based on the disease profiles and create plans to improve population health including measurement of outcomes.

DOMAIN 5 - PREMISES

- Health and safety compliant
- Disability Discrimination Act compliant
- Care Quality Commission ready
- NHS external signage
- Internal cleanliness and patient friendly
- Patient toilet facilities.

DOMAIN 6 – PRODUCTIVITY

- Undertake access audit/improvement programme
- Offer agreed number of appointment slots per week/month/year based on access audit calculations *
- Take part in a productivity improvement programme
- Practice opening hours minimum 8am to 6.30pm *
- Same day urgent access available *
- SMS text reminder service.

* There will be no additional funding for these elements, which are already funded as part of the GP contract.

DOMAIN 7 - WORKFORCE, LEADERSHIP AND TEAM DEVELOPMENT

- Full participation in all GP/practice manager/practice nurse/receptionist training and development programmes
- Undertake appraisals
- Achieve revalidation.

DOMAIN 8 - COMMISSIONING

- To be a signed-up member of the Clinical Commissioning Group.

DOMAIN 9 – COMMUNICATIONS

- To display and distribute all NHS North Central London patient literature.

CONTRACT PERFORMANCE MANAGEMENT

All independent contractors are subject to routine contract performance management of their practices against national/local contracts. It is this function that will transfer from NHS North Central London to the new NHS Commissioning Board. This strategy does not propose any changes to the agreed national contract and performance management requirements.

In addition to existing contracts, and where required, Integrated Care Networks will be held accountable by Super LES contracts for their delivery of the guaranteed services in their network. Borough teams will be involved in the setting up of non-core contract elements (i.e. those wrapped into the super LES contracts) and it is expected that the performance management aspect will then be carried out by NHS North Central London primary care contracting and performance staff, although future management arrangements are not yet finalised.

NHS North Central London has a comprehensive performance management process to support GPs in improving their care. This is key to supporting the transformational change. NHS North Central London will invest in additional staff, including clinicians and managers, to provide additional capacity for the performance management of core contracts and individual performer concerns.

PERFORMANCE MANAGEMENT OF THE PRIMARY CARE STRATEGY

Performance management and the implementation of the strategy will be the responsibility of NHS North Central London primary care contracting and performance staff. Clear programme governance arrangements will be put in place to ensure that the primary care strategy is delivered to time and provides the inputs/actions set out above in return for the investment in each strategic domain in order to deliver the outcomes listed in the next section.

7. Outcomes

"Getting the right results"

> "Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice" (Improving the quality of care in general practice - The King's Fund, March 2011)

There will be explicit quality markers by practice and network, agreed with GPs, whereby in return for the investment, we can expect to achieve improvements in:

- Patient safety
- Clinical effectiveness
- The experience of patients.

} Health Outcomes

HEALTH OUTCOMES

A full list of target outcomes will be developed within each borough's implementation plan and based on local practice population profiles. It should include:

MEDIUM TERM:

- Improved early detection and management of long term conditions leading to improved outcomes, in particular: diabetes, HIV, hypertension, COPD and CVD
- Improved cancer early detection and survival rates
- Increased smoking cessation
- Reduced obesity
- Improved self-care management, e.g. COPD Pulmonary Rehabilitation.

LONG TERM:

- Sustained top quartile performance against national quality metrics
- Improved life expectancy
- Closed gap for observed and predicted disease
- Herd immunity immunisation levels leading to reduced incidence
- Improved quality of dental care.

INNOVATIONS IN PATIENT CARE

SHORT TERM:

- Defined care packages for different stratification of disease risk.

MEDIUM TERM:

- Network of practices delivering comprehensive primary care.

LONG TERM:

- Integration across all providers of health system
- Transformation of the primary care brand in north central London – a demonstration to local stakeholders that we are serious about improving primary care.

PRODUCTIVITY

MEDIUM TERM

- GPs as systems navigators increasing both General Practice and system productivity
- Reduction in A&E attendances
- Fewer non-elective admissions for patients with long term conditions
- Improving biological measures for long term conditions e.g. HBA1C, Blood pressure control.

PATIENT EXPERIENCE

This could be described as customer care, but that label does not represent the true nature of the relationship between GP and patient. Traditional models of customer care imply that the onus and obligations are all exclusively on the service provider and that the customer has full rights and no responsibilities.

In order to work to its fullest potential, the GP/patient relationship needs to be more collaborative and to recognise the mutual benefits to be gained from working together with explicitly agreed rights and responsibilities for both parties. However, GPs must accept that the ultimate verdict on the total experience will be delivered by the patient based on their perception and as reported in:

- High scores on MORI and GPAQ surveys
- Positive feedback on NHS Choices website
- Positive performance as reported on the Myhealthlondon website
- Positive feedback from PPG/LINKs/HealthWatch/Local Health and Wellbeing Board
- Increase in access through core minimum hours of offering appointments using existing contract
- Fit for purpose premises – improving patient experience, quality and productivity
- Increased proportion of the population of North Central London registered with a GP practice
- Management of complaints.

8. Local borough implementation plans

"This is how we are going to do it in each borough"

BARNET

BACKGROUND

Barnet has by far the largest registered patient population number (373,715 at July 2011) in North Central London, but a much lower capitation funding of 327,404. Much of the demography of Barnet is closer to that of the Home Counties than to inner London boroughs, although there are pockets of significant deprivation. This mixed profile introduces different challenges.

GPs report that their health-aware residents are very high consumers of any/all services offered. Additionally, there is anecdotal evidence to suggest that, with a generally older age profile, many retired residents have switched from using private insurance provision to NHS services, and that much of this workload is in general practice supporting long term conditions management.

Like Enfield and Haringey, primary care in Barnet, must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State and is being implemented. The implications for primary care have been emphasised in many documents.

Any new developments in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy, which was given the green light for implementation by the Secretary of State for Health in September 2011. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

The Primary Care Strategy supports delivery of better services in Camden and Islington as well as Barnet, Enfield and Haringey and, while there have been many recent developments in primary care in each of the five boroughs, many more are being developed or are planned. We will make the changes in hospitals when clinicians tell us that the primary care system is sufficiently developed to provide better and safer care than in hospitals.

In 2007, the primary care strategy stated that there were too many (then 73), and too small, practices, operating from unsatisfactory premises. The strategy set out plans to move to a "hub and spoke" model and to reduce both practices and premises. Most of the focus has been on the health system infrastructure, yet little seems to have actually changed for most practices. The re-building of Finchley Memorial Hospital (due to open in 2012) is the most significant and tangible achievement. Along with the existing Edgware Community Hospital, the health economy will be unusual in London by having two community hospitals.

The key challenges now facing primary care in Barnet would seem to be:

- To rise to the BEH Clinical Strategy challenge, particularly given the high number of smaller practices which lack the capacity to expand their services
- To ensure that all practices are capable of achieving the highest quality standards
- As part of that quality drive, to improve the overall premises standard
- To establish the re-built Finchley Memorial Hospital as a fully functioning community hospital
- The need to get into financial balance.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

CAMDEN

BACKGROUND

Previous Camden strategy documents refer to a strong reputation for innovation and for delivering continuous performance improvement. The April 2010 CSP reflects broader whole system thinking and it introduces QIPP and robust performance management measurement. In terms of general practice, the PCT always maintained that:

> "NHS Camden is committed to supporting and developing a diverse provider landscape for general practice and believes that patients want to see a mixed economy of small, medium and large practices."

However, with just 39 practices, it is interesting to note that Camden has the highest number of registered patients per practice at almost 6,500 compared with Enfield, below 5,000, and the North Central London average of 5,500.

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

The CSP notes that 80% of practices have received investment to improve premises over recent years, and that, although there are a few problem sites, the overall state of GP premises has been improved considerably.

Camden, along with Islington, is one of the few PCTs in the country to have published a GP balanced scorecard on its website. It is set out as a RAG-rated league table and is perceived by practices themselves to have been a very effective performance improvement driver for all practices.

Camden GPs are considered to be among the most cost-effective prescribers in England and will continue to maintain this by working with their strong Medicines Management Team.

Camden is also one of the few PCTs who agreed (three) APMS contracts with new providers, but these contracts have not been without their problems which has included a change of provider.

The growth of Haverstock Healthcare, the Camden GP Provider Federation, means that there is now a single provider organisation through which NHS North Central London can communicate directly with most of their GP practices.

Camden is projecting a financial surplus at the end of 2011/12.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

ENFIELD

BACKGROUND

Enfield has the second largest registered patient population number (292,819 at July 2011) in North Central London. The demography of Enfield is similar to much of Barnet in the west and significantly more like the most deprived inner London Boroughs to the east. Both demographically and in terms of service provision it is a two-tier health economy.

With 60 practices, Enfield has the lowest average number of registered patients per practice in NHS North Central London:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

43% of Enfield patients are registered in the 39 practices which have fewer than 5,000 patients. Many of these smaller practices are in sub-standard premises. This is an issue that is mentioned in all of the previous strategic planning documents and one that those strategies have sought to address, but little seems to have changed in terms of numbers or premises conditions. As a result, the primary care scene in Enfield seems to be the most under-developed in North Central London.

Like Barnet, primary care in Enfield must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

The challenges facing primary care in Enfield seem to be:

- The ongoing issues arising from previous failed primary care premises strategies

- To rise to the BEH Clinical Strategy challenge, particularly given the high number of very small practices which lack the capacity to expand their services and are working in totally unsuitable premises
- To ensure that the high number of PMS contracts (31) and the high cost (£143 unified weighted population) are delivering commensurate value
- To ensure that all practices are capable of achieving the highest quality standards.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

HARINGEY

BACKGROUND

Haringey is unusual in London in that it does not have a District General Hospital site within the borough boundary. North Middlesex University Hospital NHS Trust lies to the north east and Whittington Health to the south west. The demography places Haringey on the cusp of outer and inner London. The relatively well and wealthy west gives way to more areas of deprivation and inequality as you move eastwards, and the hospital landscape means the two trusts cater for two very different Haringey populations.

Having been one of the early implementers of polysystems, Haringey does benefit from new and modern estate - Hornsey Central, The Laurels and Lordship Lane. All are now becoming fully operational but there is more opportunity and there is potential for some major investment decisions to be made about upcoming developments in Tottenham and on the St Ann's site.

As with Barnet and Enfield, Haringey must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

General practice in Haringey is still characterised by large numbers of small practices. The registered practice population has reduced by 7,500 (-3.2%) over the past year, mainly as a result of list cleaning. Average list size is just over 5,000.

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

This extract from the overview in the January 2010 CSP provides a good description of the primary care scene in Haringey:

"Haringey has a diverse provider base with a large number of both GP and dental practitioners but the number and size of practices means this is a potentially fragmented system.

CHARACTERISTICS

- There are a large number of single handed GPs
- Despite the introduction of the polysystem model there is a fragmented provider base
- There are 270,000 GP registrations in Haringey, higher than the estimated population figures of 226,000. This could mean that patients are registering from neighbouring boroughs
- GP services vary significantly depending on the practice in terms of access, quality, and condition of premises and range of services available.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

ISLINGTON

BACKGROUND

The growing population combined with the low number of practices means Islington has the second highest average patient population per practice in north central London:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

The Primary Care SWOT analysis in the January 2010 CSP still provides a good description of the primary care scene in Islington:

- General Practitioners account for approximately 50% of the PCT primary care budget. The majority of the 38 GP practices provide services in core hours. 12 single handed practices, five of which are within the central locality. Out of hours care is provided by CAMIDOC. (Now provided by Harmoni)

- Pharmacy and prescribing accounts for 38% of the total budget and operates from 45 locations spread across the borough

- Dental practices offer NHS treatment to Islington residents from 25 locations accounting for 13% of the overall primary care budget. 49% of residents access an NHS dentist

- There are 49 contracted optometrists operating in Islington operating from 27 practices. Services are centrally purchased.

CHALLENGES

- Providing accessible and modern facilities given some of the primary care estate
- Lower than anticipated poor outcomes on patient experience
- Inequitable access to enhanced services for the population
- Supporting a high proportion of single handed GP practices - 10 out of 38
- Disparities in the quality of care across some of our practices
- Limited capacity to respond to urgent care needs in and out of hours
- Multiple demands to respond to enhanced service requirements
- Attaining CQC registration status
- Improving the oral health of children
- Differentials in expected and recorded numbers on disease registers.

STRENGTHS

- Good coverage of GP and pharmacy services throughout the borough
- Mix of experienced and new GPs
- Offers a range of enhanced services
- Good QOF outcomes, but high levels of exception reporting.

IMPLICATIONS FOR CSP/CHOICE

- Strengthen commissioning of GPs for quality, support access
- Tender for additional dentistry including oral health promotion focus
- Introduce services to provide more comprehensive urgent response

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

9. Strategic cost/Benefit analysis

"How we justify the investment"

The Primary Care Strategy pump priming investment to deliver the transformational strategy is £46.7m (risk adjusted) across three years. In common with all PCTs, until our annual operating plan is approved by the Department of Health, we cannot confirm the spend for 2012/13. However, we are currently optimistic that our plans will be approved by the end of March 2012.

Investment will be across the nine strategic domains of:

1. Integration
2. Clinical services
3. Information Technology

} = Integrated Care Network

4. Public Health
5. Premises
6. Productivity
7. Workforce, leadership and team development
8. Commissioning
9. Communications

As well as strengthening general practice performance monitoring and analysis and programme management costs.

PRIMARY CARE PUMP PRIMING 2012/13 – 2014/15 (£M)

	2012/13	2013/14	2014/15	Total £m
Total spend	12.0	17.5	17.3	46.7

The gross savings will be a multiple of the investment in the strategy and represents less than 1.5% of acute expenditure. The savings will be confirmed as part of the work that is being undertaken as part of the Integrated Care financial analysis.

APPENDIX A - FACTS AND FIGURES

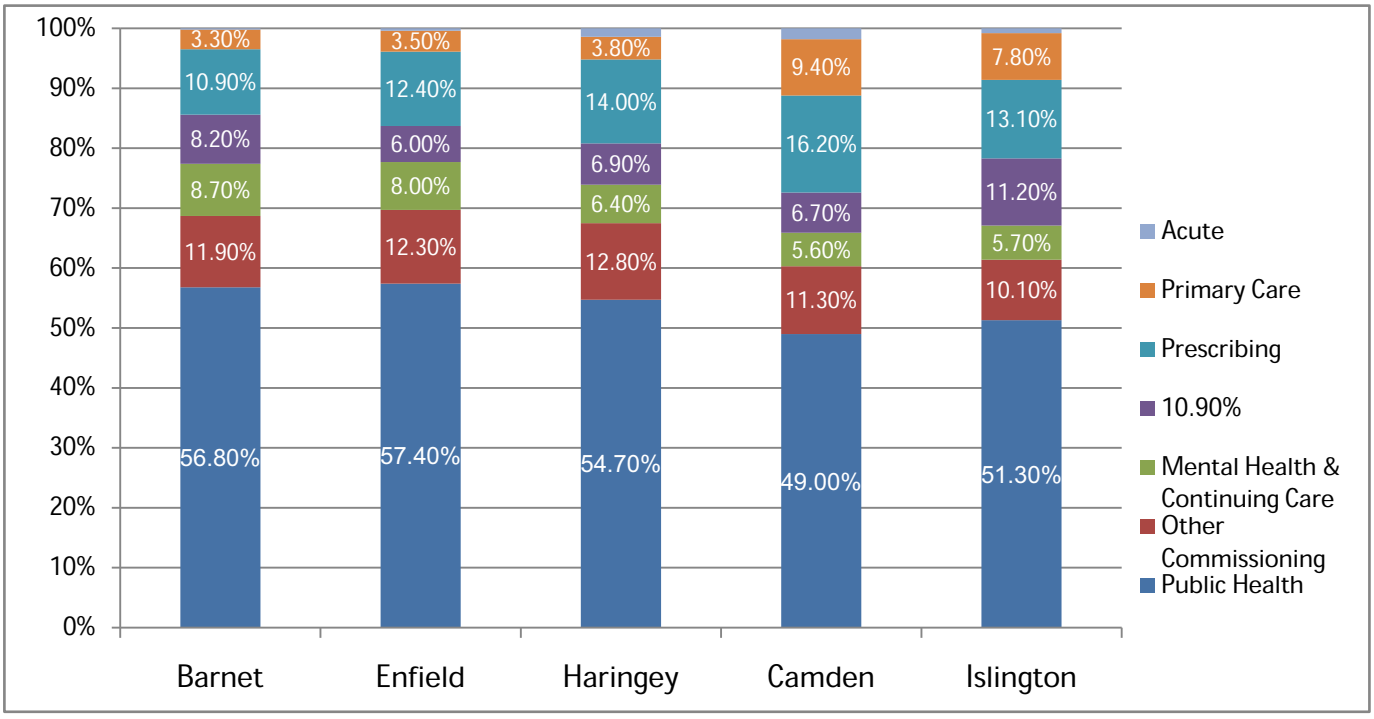
FIG 1 - GENERAL PRACTICES (WITH LISTS) BY TYPE OF CONTRACT

	Barnet	Camden	Enfield	Haringey	Islington	Total
GMS	42	20	28	23	35	**148**
PMS	26	16	31	30	2	**105**
APMS	0	3	1	1	0	**5**
Totals	68	39	60	54	37	**258**

FIG 2 - GP PRESCRIBING COSTS PER WEIGHTED AVERAGE LIST SIZE (RANK ORDER)

2010/11	Camden	Haringey	London Average	North Central London Average	Enfield	Barnet	Islington
Cost per Astro PU	£21.94	£22.06	**£23.40**	**£24.15**	£25.33	£25.47	£25.93

FIG 3- NORTH CENTRAL LONDON EXPENDITURE – VARIATION IN 2011/12 FORECAST EXIT RATE SPEND BY CATEGORY - % OF SPEND (EXCLUDING CONTINGENCY AND OTHER CORPORATE)



There is a significant variation in acute spend as a percentage of total spend across NHS North Central London PCTs, ranging from 49% to 57.4%. Across London the average PCT spend is 47.6%.
Note: Public Health spend includes the running costs associated with the Public Health function

FACTS AND FIGURES

FIG 4 - FUNDING AND POPULATION NUMBERS

How much money will North Central London/PCTs spend in 2011/12?	£000s					
	Barnet	**Camden**	**Enfield**	**Haringey**	**Islington**	**NCL**
Total spending by PCT 2011/12 as at Month 6 projected to full year	£579,500	£518,499	£482,704	£469,554	£481,540	£2,531,797
How much is that per head "crude population"?						
"Crude Population" numbers @ 1st July 2011	351,286	247,303	277,429	244,489	191,810	1,312,317
£s per head "Crude Population"	£1,650	£2,097	£1,740	£1,921	£2,511	£1,929
How much is that per head "registered patients"?						
"Registered patient" numbers @ 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per head "Registered Patients"	£1,551	£2,066	£1,614	£1,725	£2,219	£1,792
How much is that per "unified weighted population"?						
"Unified Weighted Population" numbers 2011/12	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per head "Unified Weighted Population"	£1,770	£2,023	£1,669	£1,703	£2,040	£1,828
% difference between "Registered patients" and "Unified Weighted Population"	*-12.4%*	*2.1%*	*-3.3%*	*1.3%*	*8.8%*	*-2.0%*

a) Department of Health funding can be viewed on a per capita basis in various ways. The weighted capitation formula produces a PCT 'Unified Weighted Population'. This is a hypothetical population that DH uses as a target to guide most of the PCT's allocation. It is based on a weighted combination of 19 socio-economic factors that are seen as convenient proxies for health needs.
b) The apparent massive funding differential using "Crude" or "Registered" populations is significantly reduced to the range of £1,669 per capita in Enfield to £2,040 in Islington. Using UWP means that the Barnet population theoretically reduces whilst Camden, Enfield, Haringey and Islington theoretically increase.
c) The difference between Registered Patients and UWP also highlights a funding challenge in Barnet.

FIG 5 - EXPENDITURE PER CAPITA (UNIFIED WEIGHTED POPULATION) ON PROVIDERS AND PRESCRIBING

Commissioned Services spend per capita UWP	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Acute	£1,014	£887	£979	£938	£955	£958
% of total projected spend on Providers and Prescribing	57.3%	51.3%	58.0%	55.9%	51.7%	55.0%
Mental Health	£119	£225	£147	£176	£222	£173
% of total projected spend on Providers and Prescribing	6.7%	13.0%	8.7%	10.5%	12.0%	10.0%
Community	£150	£122	£103	£116	£212	£139
% of total projected spend on Providers and Prescribing	8.5%	7.0%	6.1%	6.9%	11.5%	8.0%
Other	£115	£191	£107	£131	£166	£139
% of total projected spend on Providers and Prescribing	6.5%	11.0%	6.3%	7.8%	9.0%	8.0%
Total Commissioned Services per capita	**£1,399**	**£1,424**	**£1,336**	**£1,361**	**£1,556**	**£1,410**
% of total projected spend on Providers and Prescribing	**79.0%**	**82.4%**	**79.2%**	**81.0%**	**84.2%**	**81.0%**

Independent Contractor Services spend per capita UWP	Barnet	Camden	Enfield	Haringey	Islington	North Central London
GP	£136	£137	£132	£119	£118	£129
% of total projected spend on Providers and Prescribing	7.7%	7.9%	7.8%	7.1%	6.4%	7.4%
Dentists, optometrists and pharmacists	£77	£66	£83	£86	£66	£76
% of total projected spend on Providers and Prescribing	4.3%	3.8%	4.9%	5.1%	3.6%	4.4%
Total Independent Contractor Services per capita	**£212**	**£203**	**£215**	**£205**	**£184**	**£205**
% of total projected spend on Providers and Prescribing	**12.0%**	**11.7%**	**12.7%**	**12.2%**	**10.0%**	**11.8%**

	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Prescribing spend per capita UWP	**£160**	**£101**	**£137**	**£114**	**£107**	**£126**
% of total projected spend on "Providers and Prescribing"	9.1%	5.8%	8.1%	6.8%	5.8%	7.2%
£s per capita UWP spent on "Providers and Prescribing"	**£1,771**	**£1,728**	**£1,688**	**£1,680**	**£1,847**	**£1,740**
% of total projected spend on "Providers and Prescribing"	100%	100%	100%	100%	100%	100%

FIG 6 - DENTISTS, OPTOMETRISTS AND PHARMACISTS (£000S)

How do we spend the dentists, optometrists and pharmacists funding?	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Dentists	£13,160	£10,010	£13,514	£15,546	£9,018	£61,248
Number of Contractors	70	42	44	51	23	230
£s per contract	£188,000	£238,333	£307,136	£304,824	£392,087	£266,296
£s per capita UWP	£40	£39	£47	£56	£38	£44
Optometrists	£3,345	£2,183	£2,550	£2,368	£1,531	£11,977
Number of Contractors	88	77	72	33	53	323
£s per contract	£38,011	£28,351	£35,417	£71,758	£28,887	£37,080
£s per capita UWP	£10	£9	£9	£9	£6	£9
Pharmacists	£8,574	£4,751	£7,816	£5,755	£5,065	£31,961
Number of Contractors	71	65	61	56	46	299
£s per contract	£120,761	£73,092	£128,131	£102,768	£110,109	£106,893
£s per capita UWP	£26	£19	£27	£21	£21	£23
Total Dentists, optometrists and pharmacists	**£25,079**	**£16,944**	**£23,880**	**£23,669**	**£15,614**	**£105,186**
% of total projected spend on Providers and Prescribing	**4.3%**	**3.8%**	**4.9%**	**5.1%**	**3.6%**	**4.4%**
£s per capita UWP	**£77**	**£66**	**£83**	**£86**	**£66**	**£76**

FIG 7 GENERAL PRACTICE (£000S)

How do we spend the general practice funding?	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Total GMS	£20,863	£15,273	£12,916	£10,952	£26,526	£86,530
Number of practices	42	20	28	23	35	148
£s per practice	£496,734	£763,650	£461,286	£476,174	£757,886	£584,662
Registered patients at 1st July 2011	217,695	120,664	117,557	104,334	207,468	767,718
£s per registered patient	£96	£127	£110	£105	£128	£113
Estimated Unified Weighted Patient population (using % difference)	190,701	123,198	113,678	105,690	225,725	758,992
Estimated £s per capita UWP	£109	£124	£114	£104	£118	£114
Total PMS	£23,013	£18,043	£24,090	£21,786	£1,103	£88,035
Number of practices	26	16	31	30	2	105
£s per practice	£885,115	£1,127,688	£777,097	£726,200	£551,500	£838,429
Registered patients at 1st July 2011	156,020	118,717	173,862	167,902	9,532	626,033
£s per registered patient	£148	£152	£139	£130	£116	£141
Estimated Unified Weighted Patient population (using % difference)	136,674	121,210	168,125	170,085	10,371	606,464
Estimated £s per capita UWP	£168	£149	£143	£128	£106	£145
Total General Practice Budgets	£44,399	£35,019	£38,251	£32,738	£27,864	£178,271
Number of practices	68	39	60	54	37	258
£s per practice	£652,926	£897,923	£637,517	£606,259	£753,081	£690,973
Registered patients at 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per registered patient	£119	£140	£128	£120	£128	£126
Unified Weighted Patient Population	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per capita UWP	£136	£137	£132	£119	£118	£129

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North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, ENFIELD, HARINGEY, ISLINGTON, CAMDEN **WARDS:** ALL
REPORT TITLE: **Further Development of the NHS North Central London Strategy and QIPP plan 2013/14 – 2014/15/Month 9 Finance Update**	
REPORT OF: Liz Wise Director of QIPP NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 13/02/12**

SUMMARY:
To receive and overview of;

- Progress with the QIPP plan; and
- NHS North Central London's financial position in Month 9, along with a borough specific review

CONTACT OFFICER
Elizabeth Stimson
Senior Communications and Engagement Officer
NHS North Central London

RECOMMENDATIONS:
To note the contents of this report

Liz Wise
Director of QIPP
NHS North Central London

Ann Johnson
Director of Finance
NHS North Central London

DATE: 13/02/12

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NHS
North Central London

Further Development of the NHS North Central London Commissioning Strategy and QIPP Plan 2012/13 – 2014/15
Report to the Joint Overview and Scrutiny Committee

27 February 2012

1. Summary

The draft Cluster Commissioning Strategy and QIPP Plan (2012/13 – 2014/15) was submitted to NHS London on 2 December as planned. Feedback on the draft acknowledges the comprehensiveness of our Case for Change and indicates support for our vision, strategic goals and the four Strategic Programmes (Prevention, Primary Care, Integrated Care and Clinical Effectiveness) that we have developed to address the key challenges outlined in the Case for Change. NHS London's primary concern with our plan mirrors our own and relates to the need for further QIPP in order to improve the financial position of the Cluster overall, and in particular, to address the projected financial deficits in Barnet, Enfield and Haringey. An action plan has been developed and agreed with NHS London to support the completion of the Plan by the end of February 2012 the main thrust of which focuses on:

- Assuring and increasing the value of the Plan
- Preparing for implementation of 2012/13
- Understanding the impact of the changes on commissioners and providers

During December and early January work has focused on identifying additional stretch potential from existing schemes and scoping potential additional opportunities. Alongside this a further review of planning assumptions and the likely 2011/12 exit rate, based on our month 08 position, has been undertaken in order to update the predicted run rate for 2012/13 and financial challenge for future years. This has identified a financial gap before QIPP for 2012/13 of £105m and £151m by 2014/15. The value of assured schemes currently remains at £45m with potential additional opportunities of £31m identified leaving a remaining gap for 2012/13 of £29m.

The intention over the next few weeks is to increase the value of the plan to 24% above what is required in line with good practice for such programmes (to allow for delay or under deliver of initiatives) whilst in parallel increasing the proportion of the initiatives that are assured as outlined in the table below;

	2/12/11	30/1/12	27/2/12	31/3/12
Total value of initiatives	£75.3m	£110m	£120m	£130m

*Assured initiatives value to requirement	£45m	£60m	£85m	£105m

*Assurance reflects an aligned PMO/SRO/Project Lead/Finance/Borough view in terms of deliverability quantum and timing.

In overall terms this approach is intended to secure for 2012/13;

- A balanced position for the Cluster
- All PCTs achieving run rate (i.e. recurrent) balance during 2012/13
- Generation of sufficient funds to enable investment to improve health outcomes in all PCTs in 2012/13
- Use of non recurrent income and available capital to pump prime change and transition.

In parallel with this work on increasing value and initiative assurance, work is underway to review and improve the overall system leadership management, governance and delivery of the QIPP Programme in order to optimise implementation/execution in 2012/13. The intention is to begin mobilisation of priority initiatives in mid February prior to formal implementation from the beginning of April.

Initial presentations on the Plan have taken place with all Clinical Commissioning Groups and further are planned for February Board meetings. Engagement with providers on the Plan continues, on both a collective and bilateral basis, and 2012/13 initiatives will form a key element of contract negotiation discussions.

The Cluster has also submitted the first draft of the Operating Plan for 2012/13 to NHS London. The Operating Plan is due for completion by 9 March 2012. There is significant overlap between the work to complete the Strategic and Operating Plans. Teams are working together to ensure that work is appropriately coordinated and integrated

2. Next Steps:

Work to complete the Commissioning Strategy and QIPP Plan will continue in line with the action plan with regular reporting of progress to Senior Leadership Team prior to presentation of the complete Plan to the Joint Boards seminar in February.

North Central London

NHS North Central London Month 9 Finance Update
Report to the Joint Overview and Scrutiny Committee

Overview:
This finance report is divided into the following sections:

1 Executive summary
2 Barnet PCT overview
3 Enfield PCT overview
4 Haringey PCT overview
5 Camden PCT overview
6 Islington PCT overview
7 Overview of year to date, in-month and forecast variances by cost
8 Cash and capital
9 Conclusion: further action

EXECUTIVE SUMMARY

1.1 Month 9 has continued the trend of improvement seen in previous months, within individual PCTs as well as at cluster level. We are now forecasting a favourable £11.0m full year variance against the cluster control total, compared to a forecast deficit against control total of £2.1m at month 8. This is an improvement of £13.1m since month 8 and is due to the following key improvements:

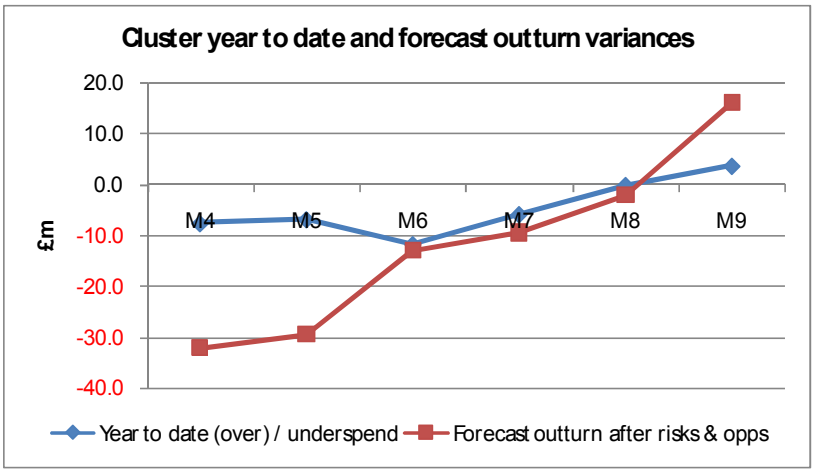
- NHS London has confirmed that unspent 2% non recurrent monies will be returned to the cluster to be utilised to ensure the delivery of the Barnet and Enfield control totals. This means that repayable inter PCT support will not be required and represents an improvement of £12m in the base case.
- The PCTs have continued their sharp focus upon controls and turnaround across all five PCTs.
- The Camden position is a substantial surplus in excess of its control total and the Camden underspends will not now be required to provide repayable cluster support.
- Dental underspends have increased compared to those reported previously, as it is now unlikely that the underspend will be recovered.
- Funds have been released in a number of PCTs where care closer to home activity is below the level planned
- Risks and opportunities have been reviewed in detail to ensure that they reflect a realistic position for the last quarter of the year.

1.2 The table below summarises the position at month 9 compared to month 8 and outlines the impact of the non recurrent funds. All PCTs except Islington are now forecast to achieve their control totals. Islington will still achieve a substantial surplus and I am confident that actions underway will improve this position to meet control total during the last quarter of 2011/12.

	Barnet	Enfield	Haringey	Camden	Islington	Total	Movement M8 to M9
Year to date variance	(8,367)	(2,311)	2,045	11,919	379	3,665	3,599
Forecast outturn before risks and opps	(28,014)	(22,362)	(17,532)	35,046	19,043	(13,819)	7,260
Forecast outturn variance before risks & opps	(10,828)	(3,527)	2,746	12,241	390	1,022	7,260
Forecast outturn after risks and opps	**(17,013)**	**(18,736)**	**(18,196)**	**32,765**	**17,370**	**(3,810)**	**13,114**
Forecast outturn variance after risks & opps	173	98	2,083	9,960	(1,283)	11,031	13,114
Movement M8 to M9	**7,877**	**4,617**	**146**	**(1,365)**	**1,839**	**13,114**	
Impact of non recurrent funds	7,250	4,750				12,000	
Real movement M8 to M9	627	(133)	146	(1,365)	1,839	1,114	

1.3 Items where there is a high degree of certainty in the forecast are included within the forecast outturn before risks and opportunities. In addition, there remain a number of risks and opportunities where there is a lower degree of certainty about either the nature of the risks / opportunity or the financial scale of it. These opportunities include those turnaround recovery actions which have been identified but not yet delivered. To get a more robust view of the likely year end position these risks and opportunities are factored into the reported position to give a risk adjusted forecast outturn. Sensitivity analysis is also applied to give a range of risk in the best and worst case scenarios.

1.4 The improvement trajectory has continued at month 9. The material improvement in the forecast outturn is mainly driven by the assumption that £12m of non recurrent funds will be made available to ensure that Barnet and Enfield achieve their control totals. The following graph illustrates the steadily improving position month on month since the cluster recognised the need to take turnaround actions in August.



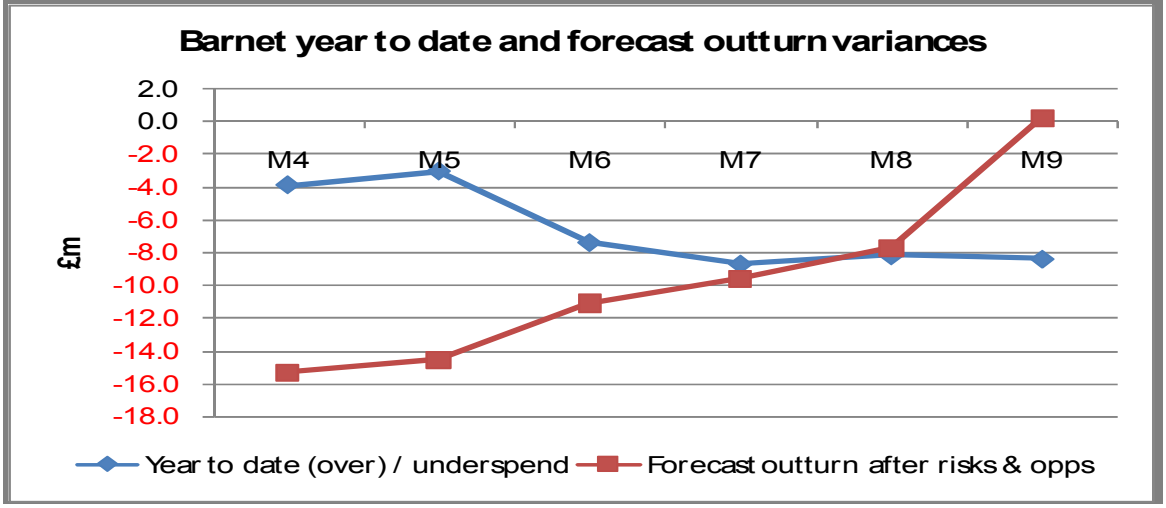
1.5 There remains a level of risk associated with the forecast outturn position. The range remains greater in absolute terms than is ideal at this stage in the year although in percentage terms the range from worst to best is only 2% of the revenue resource limit. £10m of the best case scenario relates to non recurrent accounting adjustments that could be utilised if required. Given the current financial position it is not expected that this will be needed. The other material difference between the likely and best case is a £6m assumption regarding utilisation of contingency in the base case.

	Cluster total		
	Worst	Likely	Best
Planned deficit	(14,840)	(14,840)	(14,840)
Forecast outturn after risks and opps	**(24,483)**	**(3,811)**	**37,842**
Forecast outturn variance after risks & opps	(9,643)	11,029	52,682
Movement M8 to M9	11,053	13,112	20,770

1.6 There has been a further improvement in the year to date position, which is now ahead of plan at cluster level and in Haringey, Camden and Islington PCTs. Barnet and Enfield remain in an adverse position, although the rate of overspend has slowed. Sections 2 to 6 of this report set out the position by individual PCT.

Overview: Barnet

	M9 £000s	Movement M8 to M9
Year to date variance	(8,367)	(149)
Forecast outturn before risks and opps	(28,014)	1,550
Forecast outturn variance before risks & opps	(10,828)	1,550
Forecast outturn after risks and opps	**(17,013)**	**7,877**
Forecast outturn variance after risks & opps	173	7,877
Movement M8 to M9	7,877	



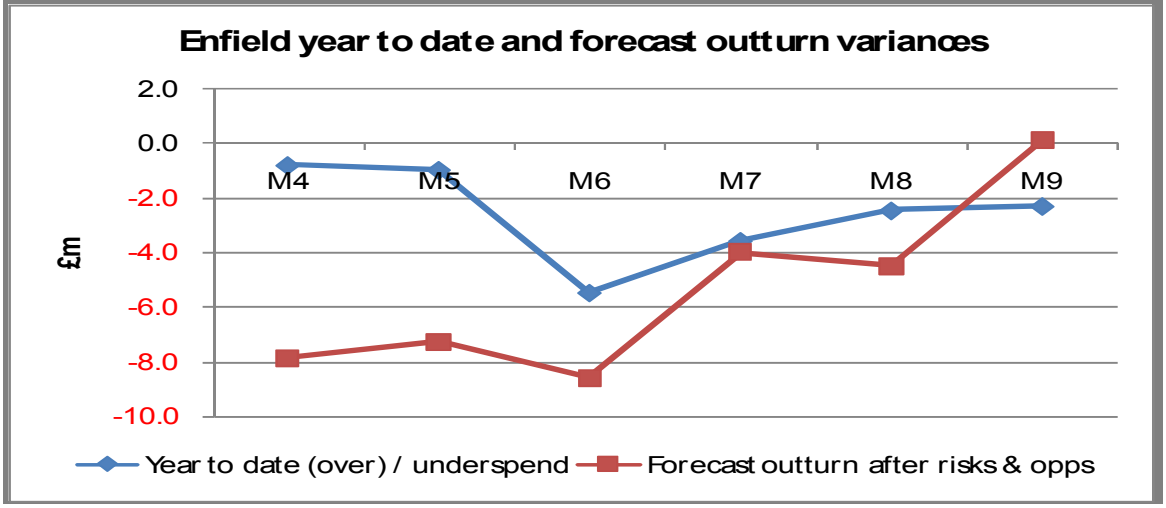
2.1 The Barnet in year position has stabilised over the last four months. This is a potentially positive indication that control over some areas of spend has improved, which is critical for financial recovery. However, acute continues to overspend month on month, albeit at a slightly reduced rate, and there are pressures on both continuing care and high cost mental health placements within the borough, with a substantial increase in the latter in month 9. There was a material movement on community budgets during M9. This is due to the identification of overperformance on GUM with one community provider across several of our PCTs. This appears to be a coding change rather than a real increase in activity and will be challenged for the cluster.

2.2 The main drivers of the acute overspend are day cases, outpatient follow ups and 'other' cost variances. The latter relate mainly to the Royal Free, where the contract contained an aspirational QIPP total that has now been delivered recurrently through price negotiations. Overperformance is seen across all trusts and Barnet has the largest out of sector overspend of all of the 5 PCTs. GP referrals are now reducing, against the trend of the last few years, but this is not yet driving substantial reductions in spend.

2.3 The forecast outturn is now in line with the deficit control total. However, the improvement in month is mainly driven by the return of unutilised non recurrent funds. This does not therefore represent a real improvement in the position and the underlying run rate continues to be negative. CCG members and cluster staff need to continue the focus on the effective management of demand and provider contracts if Barnet is to return to recurrent financial balance next year.

Overview : Enfield

	M9 £000s	Movement M8 to M9
Year to date variance	(2,311)	148
Forecast outturn before risks and opps	(22,362)	1,972
Forecast outturn variance before risks & opps	(3,527)	1,972
Forecast outturn after risks and opps	**(18,736)**	**4,617**
Forecast outturn variance after risks & opps	98	4,617
Movement M8 to M9	4,617	



3.1 The Enfield in year position has improved over the last few months and stayed stable in month 9. As with Barnet, this is a potentially positive indication that control over some areas of spend has improved, which is critical for financial recovery. Acute overspends are lower than at Barnet and have slowed in month 9 but remain a substantial concern. Primary care, learning disabilities and continuing care are also overspending. New systems to control continuing care expenditure have been implemented during the year and are achieving substantial savings without impacting on patient care. Sexual health is overspent in month, again partly driven by the GUM coding issue at one provider.

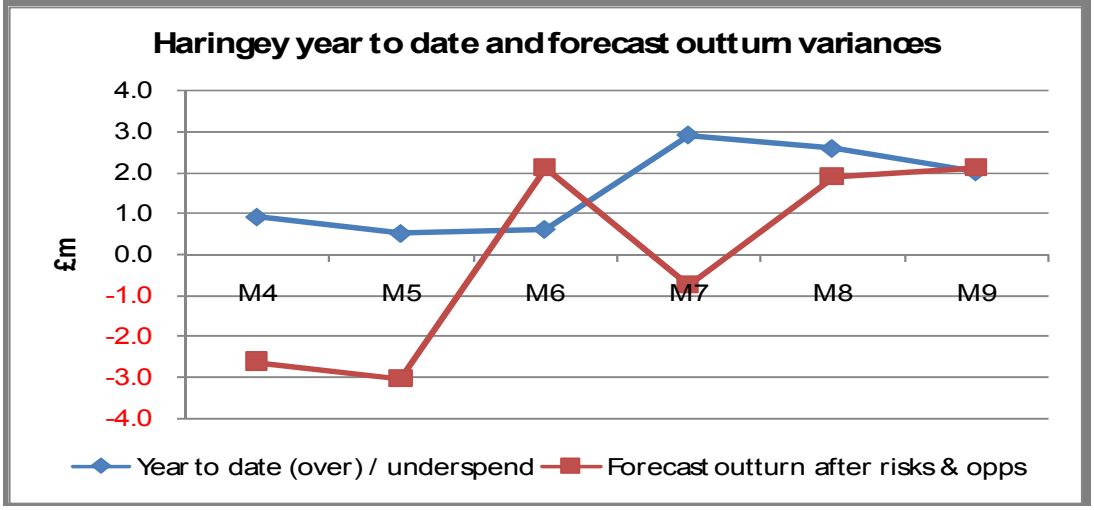
3.2 The main drivers of the acute overspend are day cases, non elective non emergency (maternity) and outpatient procedures. Over-performance is concentrated in in-sector providers, notably Barnet and Chase Farm and UCLH.

3.3 There has been a large adverse movement on non contract activity in month 9, both in Enfield and in other PCTs. Following a change in the resourcing for this area, new controls have found previously unidentified spend which is now included in the year to date and forecast outturn position. A further risk has been added to the risks and opportunities log.

3.4 The forecast outturn is now in line with the deficit control total. However, the improvement in month is mainly driven by the return of unutilised non recurrent funds. This does not therefore represent a real improvement in the position and the underlying run rate continues to be negative. CCG members and cluster staff need to continue the focus on the effective management of demand and provider contracts if Enfield is to return to recurrent financial balance next year.

Overview : Haringey

	M9 £000s	Movement M8 to M9
Year to date variance	2,045	(526)
Forecast outturn before risks and opps	(17,532)	(222)
Forecast outturn variance before risks & opps	2,746	(222)
Forecast outturn after risks and opps	**(18,196)**	**146**
Forecast outturn variance after risks & opps	2,083	146
Movement M8 to M9	146	



4.1 Haringey is ahead of plan for the year to date and forecast to over deliver against control total without requiring any additional support. This is an extremely positive position for a deficit organisation and is testament to the hard work of staff. However, there has been some deterioration in the year to date position in the last two months and this needs to stabilise to ensure that Haringey is in the best position to continue its financial recovery in 2012/13.

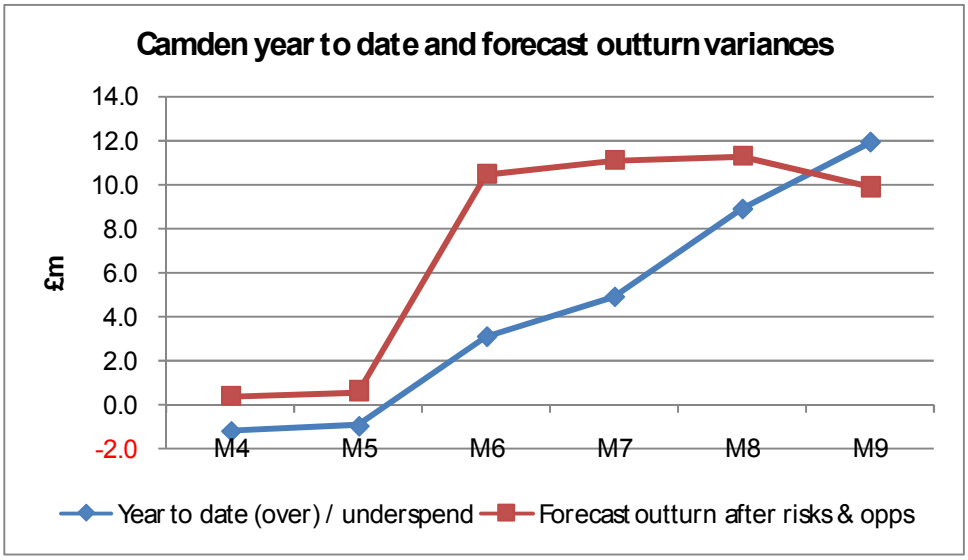
4.2 There have been in month pressures on both prescribing and dental, the latter due to the identification of under-delivery on a local QIPP target which is being further investigated. Mental health also has a large adverse movement in month following the realignment of the year to date and forecast outturn positions to reflect the expected outcome on QIPP.

4.3 The year to date acute overspend is small compared to other PCTs and is concentrated in out of sector trusts, notably Barts and the London. Service areas of over-performance are non elective non emergency (maternity) and day cases.

4.4 The forecast outturn remains at £2m better than the control total. There remain a number of risks within the position that need to be managed but this is a positive result for Haringey. The focus now needs to be the delivery of planned QIPP schemes for the new year and ensuring that the run rate improves moving into 2012/13.

Overview : Camden

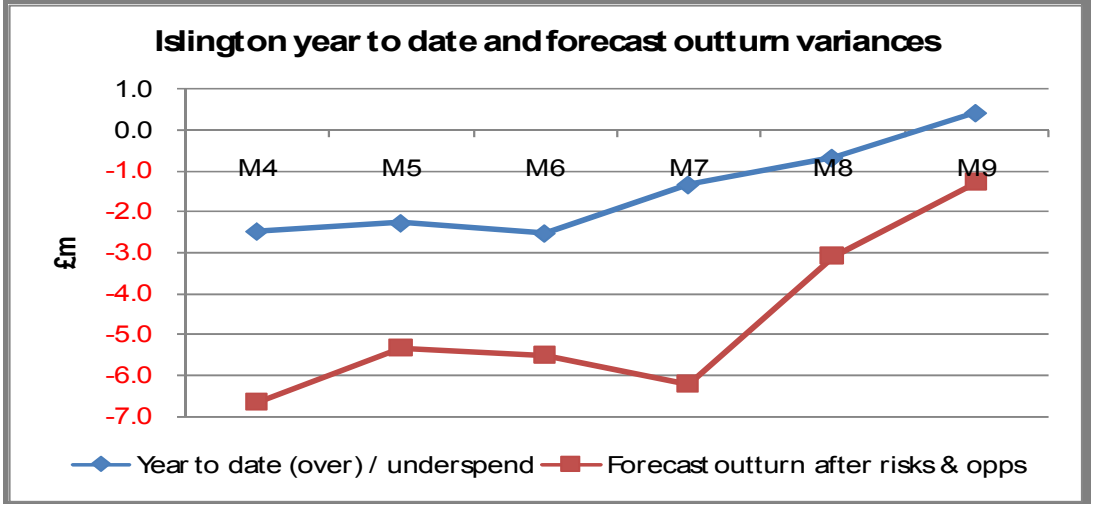
	M9 £000s	Movement M8 to M9
Year to date variance	11,919	3,041
Forecast outturn before risks and opps	35,046	818
Forecast outturn variance before risks & opps	12,241	818
Forecast outturn after risks and opps	**32,765**	**(1,365)**
Forecast outturn variance after risks & opps	9,960	(1,365)
Movement M8 to M9	(1,365)	



5.1 Camden is substantially ahead of plan for the year to date and the forecast surplus is nearly £10m above the control total of £22.8m. This has been helped by a relatively low level of acute over-performance compared to the other PCTs, and large under-spends on continuing care and community budgets as well as public health. A number of reserves had been held against potential utilisation which have not been required and have now been released. In previous months the position was reported as in line with the control total as it was expected that repayable inter PCT support may be required to enable Barnet and Enfield to achieve their control totals. This is not now required and so the forecast outturn position now reflects the full level of under-spend.

Overview: Islington

	M9 £000s	Movement M8 to M9
Year to date variance	379	(1,084)
Forecast outturn before risks and opps	19,043	2,487
Forecast outturn variance before risks & opps	390	2,487
Forecast outturn after risks and opps	**17,370**	**1,839**
Forecast outturn variance after risks & opps	(1,283)	1,839
Movement M8 to M9	1,839	



6.1 The Islington in year position has been improving steadily since month 6 following the recovery actions implemented by the cluster and borough teams. The forecast outturn has also improved, and is in line with the planned surplus before risks and opportunities are factored in. There is a net risk to the Islington position that moves it to a potential shortfall against the control total of £1.3m and these risks will need to be firmly controlled in the remainder of the year if Islington is to achieve its planned surplus. The key driver of the Islington position is the over-spend on acute contracts. Pressures in primary care medical and prescribing are offset by under-spends in dental and public health.

6.2 The year to date acute overspend is driven by UCLH, the Royal Free and Barts and the London. Overspending service areas are non elective non emergency (maternity), day cases and electives.

Overview of year to date and in-month variances by cost

7.1 The table below shows the in month and year to date variances by cost type.

	Month					YTD				
	Budget £k	Actual £k	Variance £k	Variance %	Rating	Budget £k	Actual £k	Variance £k	Variance %	Rating
Revenue Resource Limit	198,301	198,301	0	0.0%	GREEN	1,880,241	1,880,241	0	0.0%	GREEN
Primary care Total	38,871	39,582	(711)	(1.8)%	RED	345,668	343,842	1,826	0.5%	GREEN
Acute Total	112,153	114,629	(2,477)	(2.2)%	RED	1,023,088	1,039,363	(16,276)	(1.6)%	RED
Out of Hospital Total	45,934	46,467	(533)	(1.2)%	RED	431,162	428,584	2,578	0.6%	GREEN
Corporate Total	13,060	12,741	319	2.4%	GREEN	76,013	71,880	4,132	5.4%	GREEN
Borough Directorate	3,207	(494)	3,701	115.4%	GREEN	25,512	19,156	6,356	24.9%	GREEN
CAPITAL CHARGES	694	1,440	(747)	(107.6)%	RED	13,517	14,120	(603)	(4.5)%	RED
ESTATES INCOME	(4,184)	(3,792)	(392)	(9.4)%	RED	(30,415)	(30,258)	(157)	(0.5)%	AMBER
QIPP shortfall / budget variance	3,800	0	3,800	100.0%	GREEN	(141)	0	(141)	(100.0)%	RED
Contingency	995	357	639	64.2%	GREEN	8,963	3,013	5,950	66.4%	GREEN
Reserves	(13,920)	(13,920)	0	0.0%	GREEN	(656)	(656)	0	0.0%	GREEN
Gross Operating Costs	200,609	197,010	3,599	1.8%	GREEN	1,892,710	1,889,044	3,666	0.2%	GREEN
Net surplus / (deficit) before risks and opportunities	(2,308)	1,291	3,599	155.9%	GREEN	(12,469)	(8,803)	3,666	29.4%	GREEN
(Risks) / opportunities	0	0	0	0.0%	GREEN	0	0	0	0.0%	GREEN
Net Surplus / (Deficit) after risks & opportunities	(2,308)	1,291	3,599	155.9%	GREEN	(12,469)	(8,803)	3,666	29.4%	GREEN

7.2 The forecast by cost type for the full year is shown below. The forecast outturn after risks and opportunities has improved by £13.1m compared to month 8. Across all PCTs, some of the opportunities that were flagged at month 8, where in year underspends had not been reflected in the forecast outturn, have now been reflected in the position.

Month 9 financial position – forecast outturn

	Full Year					M8	
	Budget £k	Forecast £k	Variance £k	Variance %	Rating	Variance £k	Movement £k
Revenue Resource Limit	2,534,321	2,534,321	0	0.0%	GREEN	0	0
Primary care Total	463,471	459,964	3,506	0.8%	GREEN	946	2,561
Acute Total	1,372,279	1,396,216	(23,937)	(1.7)%	RED	(23,281)	(656)
Out of Hospital Total	575,035	574,672	362	0.1%	GREEN	2,065	(1,703)
Corporate Total	102,206	96,657	5,549	5.4%	GREEN	2,827	2,723
Borough Directorate	34,733	31,930	2,803	8.1%	GREEN	4,469	(1,666)
CAPITAL CHARGES	18,023	18,898	(875)	(4.9)%	RED	(17)	(858)
ESTATES INCOME	(39,240)	(39,510)	270	0.7%	GREEN	1,205	(935)
QIPP shortfall / budget variance	1,392	0	1,392	100.0%	GREEN	(6,402)	7,794
Contingency	11,950	0	11,950	100.0%	GREEN	11,950	0
Reserves	9,314	9,314	0	0.0%	GREEN	(0)	0
Gross Operating Costs	2,549,162	2,548,141	1,022	0.0%	AMBER	(6,238)	7,260
Net surplus / (deficit) before risks and opportunities	(14,841)	(13,820)	1,022	6.9%	GREEN	(6,238)	7,260
(Risks) / opportunities	0	10,008	10,008	67.4%	GREEN	4,157	5,851
Net Surplus / (Deficit) after risks & opportunities	(14,841)	(3,812)	11,030	74.3%	GREEN	(2,083)	13,113

7.3 The key movements in the year to date and forecast outturn before risks and opportunities are shown below

Expenditure Group	Monthly Variance £000		Reason for Variance	Actions agreed for Month 10
Primary Care				
Primary Care - Medical	492	628	Improvements due to Deanery Income being fully invoiced, a more prudent approach to the accruals was taken in previous months.	The deanery income is now being invoiced monthly directly from the expenditure statements on the Exeter system, resulting in a zero variance.
Primary Care - Pharmacy		582	This had previously been suppressed due to the data being 2 months in arrears. It is now believed there will be a true underspend at the year end.	
Primary Care - Prescribing	-1,075		There is a change in methodology where we are now accruing to Forecast out-turn from the PPA as opposed to extrapolating from 2 months old data.	
Primary Care - Dental		1,274	Previously the growing underspend has been suppressed due to expectation that underperforming contracts would recover activity in the second half of the year to meet performance targets. The level of recovery is now expected to be lower than previously anticipated	
Acute				
Acute NHS SLA - In Sector	-1,780		Whilst a sizeable increase in the month this is slightly below the normal run rate	There is an acute recovery plan in place to minimise spend in 2011/12 and address the causes of the underlying run rate
Acute NHS SLA - Out of Sector	-498		As per in sector	as per in sector
Acute Demand Reserve	442		This is in line with the monthly run rate.	
Non Contracted Activity	-805	-659	Additional invoices have come through as a result of the Agreement of Balance exercise and a new service manager is now in place and is reviewing the system.	We will thoroughly review the forecasting methodology to ensure it more accurately predicts future costs. The challenges process will be enhanced to ensure that we only pay invoices for appropriate activity
Non acute				
Mental Health	-1,264	-2,332	Four of the 5 Boroughs are showing a material increase in costs with only Islington showing a material decrease. Areas of additional cost include high cost placements and eating disorders. There has been some budget realignment in Haringey and the current QIPP performance is now fully reflected	Budget holders to review additional charges to ensure they are valid. Where appropriate, individual cases to be reviewed to ensure the care package represents best value
Older People	315	462	There are some expected underspends on social care budgets, particularly in Barnet	
Physical Disabilities		436	The month 8 position in Islington was incorrectly reported. The budgets were actually underspending as opposed to overspending as reported.	
Childrens Services		320	The Month 9 Agreement of Balance process confirmed that the individual complex patient placements have reduced in year, notably in Haringey.	
Continuing Care	495	-296	Closer scrutiny of the continuing care budget is providing improved forecasting and year to date information. Accruals levels in some PCTs have increased as the review of invoices against the new system has identified data issues, notably Camden	Continued focus on the implementation of the continuing care recovery plan. Further review of the Camden system to ensure that all data held is accurate
Sexual Health	-391	-286	This is due to the unexpected appearance of material GUM invoices, these are being billed by Community providers at levels significantly above 2010/11 activity. This area is being reviewed to ascertain whether this is the result of an unagreed coding, counting or pricing change	Review the contracts with the community providers and seek to challenge overperformance

7.4 Further key movements in the year to date and forecast outturn before risks and opportunities are shown below.

Expenditure Group	Monthly Variance £000		Reason for Variance	Actions agreed for Month 10
Corporate				
Estates and Facilities Management		1,531	Previous months have shown growing variances due to the assumption that all provider estates would be transferred in October, and hence income and expenditure was not budgeted for. This has been smoothed out in M9.	
Public health	-438	396	All services have been reviewed due to the low level of activity invoiced to date. Services which have not yet been invoiced for have been accrued, resulting in an in year movement. The Barnet and Enfield forecasts have been updated to reflect the areas now identified as underspending	
Human Resources	212	473	Following the transfer of Haringey community services, the budget had not been reduced. The community contract is set at the correct level so the budget has been released	
QIPP		500	Growing Underspends across this sector wide directorate had previously been suppressed due to uncertainty as to future plans. It has now been confirmed that there are no plans to commit this additional budget in the recurrent year.	
Primary Care	1,036		£193k relates to income raised for Haringey not budgeted for. Other drivers at Camden and Islington relate to underspends against CCG and PbC Development funding	
Other				
BOROUGH DIRECTORATE	3,701	-1,666	For Month 9 the borough and cluster finance team undertook another review of all budgets held, amending the requirement in year. The position will be constantly reassessed for the balance of the financial year for both in year and recurrent need.	Assess the recurrent position to underpin the run rate for 2012/13
CAPITAL CHARGES	-747	-858	This is partially due to Goswell road capital charges only having been budgeted for the first six months of the year and partly due to the validation of overspends that were not previously reported	
ESTATES INCOME	-392	-935	Previous months have shown growing variances due to the assumption that all provider estates would be transferred in October, and hence income and expenditure was not budgeted for. This has been smoothed out in M9.	Review all estates income and expenditure budgets to ensure the full 12 months are correctly budgeted.
QIPP shortfall / budget variance	3,800	7,794	For Month 9 the Borough HOF's and the cluster finance team undertook another review of all budgets held. Following from this review a number of budgets were found not to be required in 2011/12, pending assessment of recurrent need some of these budgets. These included some care closer to home budgets where activity is less than budgeted	Assess the recurrent position to underpin the run rate for 2012/13
Contingency	639		Contingency has now been released up to the level assumed in the risk adjusted forecast outturn	
Other Balances	-143	-104		
Total	**3,599**	**7,260**		

Cash and Capital

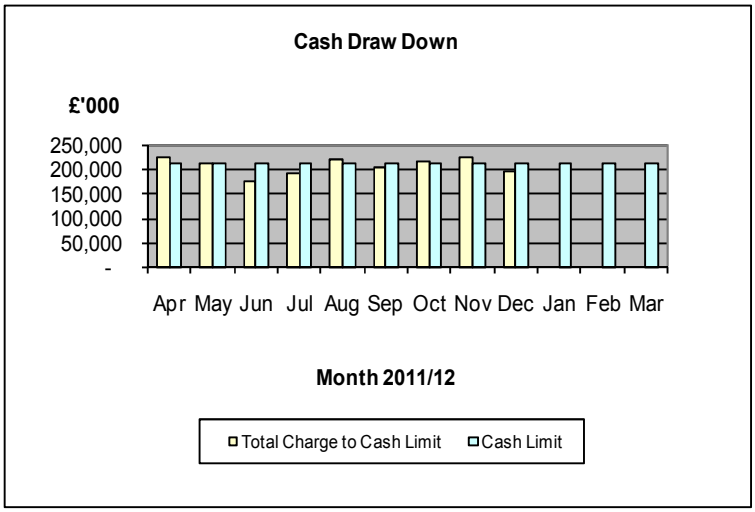
Capital

PCT	Annual Budget £000s	M9 YTD Actual £000s	Forecast Outturn Month 9 £000s	Forecast Variance Over/ (Under) £'000
BARNET	7,632	391	2,209	(5,423)
ENFIELD	1,255	0	180	(1,075)
HARINGEY	800	0	200	(600)
CAMDEN	2,713	0	1,429	(1,284)
ISLINGTON	903	0	88	(815)
NCL TOTALS - CURRENT SCHEMES	13,303	391	4,106	(9,197)

8.1 The confirmed capital resource limit for 2011/12 is £13,433k including £7,033k for existing projects that commenced before 2011/12. £130k is a grant that is expected to transfer to revenue, giving the £13,303k budget shown.

8.2 Expenditure to date is very low at £391k as at M9. The current year end forecast against the allocation is £4.1m, an underspend of £9.2m. £3.8m of this relates to Finchley Memorial where the funding will not be needed until 2012/13 and a request has been made to carry the funding, which originated with the Community Hospital Fund, forward. The remaining underspend has been caused by delays in some projects but these are now being actively managed to ensure that we minimise the underutilisation of available resources. New opportunities for capital spend in this financial year have been explored and a paper has been submitted to the Financial Recovery and QIPP Committee for these to be considered and, if appropriate, approved. The total of the new projects is £1,571k. Robust reviews of all schemes are ongoing and any surplus in the 2011/12 capital allocation will be returned through NHS London at the end of January.

Cash



8.3 The cash limit available to the cluster in 2011/12 is £2,571m. The actual cash drawdown in the month was £195m, bringing the cumulative total to £1,870m. The cluster

has drawn down 97% of its annual limit on a pro rata basis and does not anticipate any issues with meeting this target for 2011/12.

Conclusion: Further actions

9.1 The key actions that are still required to ensure that the 2011/12 forecast outturn can be achieved in the most sustainable way are:

- Successful closure of the outstanding acute claims, particularly at UCLH and those other trusts that are not covered by cap and collar arrangements.

- Finalisation of the agreement with Barnet and Chase Farm, and approval for the use of non recurrent funds from NHS London to support that agreement.

- Delivery of those QIPP schemes that will still impact in 2011/12, notably primary care medicines management, continuing care, PoLCE and mental health.

- Ongoing management of budgets and identified risks to minimise overspends.

- Realisation of identified opportunities, notably community contracts, estates disposals and locally identified opportunities.

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Agenda Item 9

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, ENFIELD, HARINGEY, ISLINGTON, CAMDEN **WARDS:** ALL
REPORT TITLE: **NHS North Central London Transition Update Report**	
REPORT OF: Helen Pettersen Director of Transition and Corporate Affairs NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 10/02/12**

SUMMARY:
An overview on the Transition timeline for all NHS and health transitioning organisations (e.g. clusters, CCGs and Public Health).

A focus on the transition arrangements for:

- Public Health England and Local Authorities
- NHS Commissioning Board
- Commissioning Support Service for North Central and North East London

CONTACT OFFICER
Martin Machray
Deputy Director Communications and Governance
NHS North Central London

RECOMMENDATIONS:

1. Note the contents of this report and consider the implications of what this might mean for the overview and scrutiny function in the future,
2. Note the latest development status of the Commissioning Support Service in North East and North Central London, Public Health England (and Local Authorities) and the NHS Commissioning Board.

Helen Pettersen
Director of Transition and Corporate Affairs
NHS North Central London

DATE: 10/02/12

NHS
North Central London

NHS North Central London Transition Update Report
Report to the Joint Overview and Scrutiny Committee

27 February2012

1. Executive Summary

In 2011 members of the Joint Health Overview and Scrutiny Committee indicated their interest in the emerging organisations within the new healthcare system and how NHS North Central London (NHS NCL) is working to ensure the smooth transition of functions from PCTs to these new organisations.

In January, the Committee was updated on the Transition Programme mobilised by NHS NCL and provided with specific information about the delegation of responsibilities to Clinical Commissioning Groups (CCGs) as well as trajectories for delegation to each emerging CCG in North Central London. Members were given the opportunity to reflect on how this could impact on their role in scrutiny.

NHS NCL committed to providing a second transition paper to the Committee in February, focusing on further key elements of transition. This second transition paper gives members an overview of three new 'receiving' organisations within transition: the NHS Commissioning Board (NHS CB), Public Health England (and Local Authorities) and the Commissioning Support Service (CSS) for North Central and North East London.

2. Transition programme milestones

As you will be aware, the Health and Social Care Bill proposes significant changes within the NHS that will focus on improving quality of care, more choice and improved outcomes for patients, as well as long-term financial savings for the NHS, which will be available for reinvestment to improve care.

There has been on-going development of guidance from the Department of Health about this change programme. The guidance released in January and February has refreshed the high level view of national transition activity - attached at Appendix A.

Our current expectation of key transition milestones relating to the three receiving organisations discussed below is as follows:

April 2012

- CSS outline business case developed and organisation set up in shadow form and governance arrangements in place
- Interim CSS leadership and senior teams in place
- NHS CB functions and design agreed and National Directors appointed
- NHS CB recruitment underway
- Public Health England (PHE) established in shadow form and transition plans developed and assessed
- PHE/LA Communications and Engagement Plan produced and Joint Working Groups established

- Local level transition plans for Public Health developed and in place

October 2012

- CSSs have finalised their Full Business Plans
- CSSs and CCGs have service level agreements for provision of commissioning support
- NHS CB fully operational and able to authorise CCGs
- NHS CB operating model operational and accountable for 2013/14 contracting of its directly commissioned services
- NHS CB has made final decision on which Commissioning Support Services to host
- Early draft legacy and handover documents produced for PHE
- Arrangements for Public Health information requirements and governance agreed

April 2013

- CSSs migrate to hosting arrangements with the NHS Commissioning Board
- NHS CB becomes a statutory entity and holds CCGs to account
- PHE becomes a full statutory body

3. NHS Commissioning Board

The NHS CB, operating as a Special Health Authority has identified its proposed operating model. The Board will work in partnership with the Cluster, clinical commissioning group leaders, GPs and the Department of Health to agree the method for establishing, authorising and running CCGs. Focus will also be on creating the infrastructure and organising the resources to allow the NHS CB to operate successfully as an independent body from October 2012.

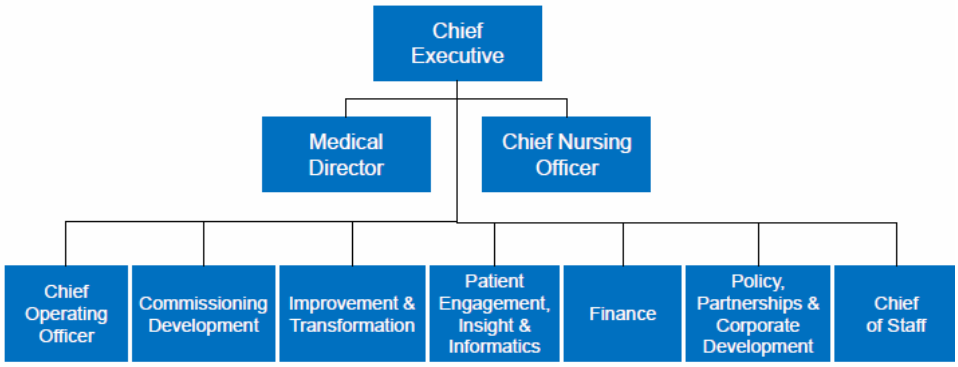
The NHS CB will take on responsibility for a significant number of contracts currently held by the Cluster, Boroughs and Local Authorities. To ensure safe migration of contracts to the NHS CB and to CCGs by April 2013, a programme of 'stocktake' activity has been conducted to assess and novate all NHS funded contracts, including:

- Primary Care
- Pharmacists
- Dental
- Ophthalmic
- Mental Health
- Acute
- Community Services

The NHS CB is also likely to take responsibility for highly specialised commissioning services. The definition of highly specialised services is due to be significantly extended. Work is underway to calculate the increase in activity and cost which will be removed from mainstream contracts and transferred to the NHS CB.

The NHS CB recently released proposals for the design of its new organisation. The organisation has been designed above all to support the NHS CB in its overarching role to improve health outcomes.

The announcement helps us understand more about the future landscape of the NHS, describing how the NHS CB will cut across the national, pan-London, sector and local commissioning level, and how it will interact with other emerging organisations such as CCGs and CSSs.



NB: Directorate names will be reviewed following National Director appointments

Known milestones around NHS CB development have been included earlier in this paper. Detailed planning for the safe transfer of the relevant functions to the NHS CB will take place following further guidance from the Department of Health on staff appointments, and detailed mapping activity of staff in existing NHS NCL functions, using the People Transition Tracker.

The three remaining posts of Chief Nursing Officer, National Director of Finance and National Director of Patient and Public Engagement, Insight and Informatics are expected to be appointed shortly.

Within the NHS NCL Transition Team, the NHS CB destination work stream is being led by the Associate Director for Primary Care. Known high level timeframes of activities in the transition towards assumption of full statutory responsibility in April 2013 have been considered in programme planning.

4. Public Health

The Governments' vision that local authorities will take on a key leadership role for public health locally is driven by the objective of improving their populations' health and wellbeing, co-ordinating local efforts to protect the public's health and ensure health services effectively promote population health. A key method of delivering this objective will be the commissioning of public health services, and working in partnership with CCGs and others to integrate services.

Recently published fact sheets from the Department of Health, as well as the Public Health Outcomes Framework outline the public health services that local

authorities will be responsible for and performance indicators to which they will operate.Public health transition plans will need to be developed by local authorities and consulted on with staff and trade unions.

Proposals are of course subject to the passage of the Health and Social Care Bill, which contains the legislative provisions necessary to confer these new functions on local authorities.

Discussions have taken place with Local Authority Chief Executives toconsider how the Local Authorities want to work in partnership with the Cluster and with each other, and to agree a consistent way forward across all five boroughs.

5.Commissioning Support Service (CSS)

As members were informed at the previous meeting, the three PCT clusters of East London and the City (ELC), Outer North East London (ONEL) and NCL, have been working together to examine opportunities for greater collaboration in order to strengthen the offer to CCGs. This builds on London diagnostic work completed over the summer of 2011.This has culminated in the development of a draft prospectus, outline operating model and an outline transition plan, all of which were submitted to NHS London on 23 December 2011 as part of the Gateway review process. A copy of the prospectus was previously circulated to members.

Following positive feedback from NHS London, we have now moved to the next stage of development of the CSS, focusing on:

- Detailed engagement with CCGs to understand their requirements for commissioning support and to agree outline SLAs;
- Developing an outline business plan (this would include identifying local need and mapping the scope and scale of services in conjunction with CCGs);
- Further development of the transition plan;
- Continuing engagement with local authorities to ensure their involvement in the development of the CSS and specifically joint commissioning arrangements;
- Develop detailed Job Descriptions and person specifications, staff consultation document and Organisational Development plan;
- Commercial modelling of income, expenditure and market share analysis;
- Conduct further engagement and consultation events; and
- Prepare for migration to a shadow CSS from April 2012.

A further detailed financial model will be developed as part of this phase of the CSS programme. The financial model which was completed as part of phase one of the programme made the assumption that CCG costs would not exceed £10 per head and that the core CSS offer would be priced at £15 per head with optional extra services above this. This now needs testing on an individual CCG basis.

The key driver of the CSS programme is to ensure that the system is both affordable and effective.

During February the programme team will be detailing the immediate work required. This is expected to focus largely on the migration to shadow form of the new CCG.Staff workshops on developing commissioning support were held on 20 and 21 February look at how we realise the vision of local, responsive and innovative commissioning support services.

6. Recommendations

The Joint Health Overview and Scrutiny Committee is asked to:

1 Note the contents of this report and consider the implications of what this might mean for the overview and scrutiny function in the future,

2 Note the latest development status of the Commissioning Support Service in North East and North Central London, Public Health England (and Local Authorities) and the NHS Commissioning Board.

Useful documentation

In addition to the documents referenced below, please find attached at Appendix B factsheets on the NHS Commissioning Board, Commissioning Support Services and Public Health.

Developing the NHS Commissioning Board' - published in July 2011

http://www.commissioningboard.nhs.uk/commissioningboard/files/2011/10/Developing-the-commissioning-board.pdf

Phase 1 of the 'NHS CB People Transition Policy' (PTP) - also published in July 2011.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129337.pdf

Further current detail on the proposed organisation of the NHS Commissioning Board can be found at:
http://www.dh.gov.uk/health/search/?searchTerms=nhs+commissioning+board

'Healthy Lives, Healthy People: Update and way forward' published July 2011.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128120

'Public Health Transition Planning Support for Primary Care Trusts and Local Authorities', published in January 2012

http://www.dh.gov.uk/health/2012/01/transition-planning/

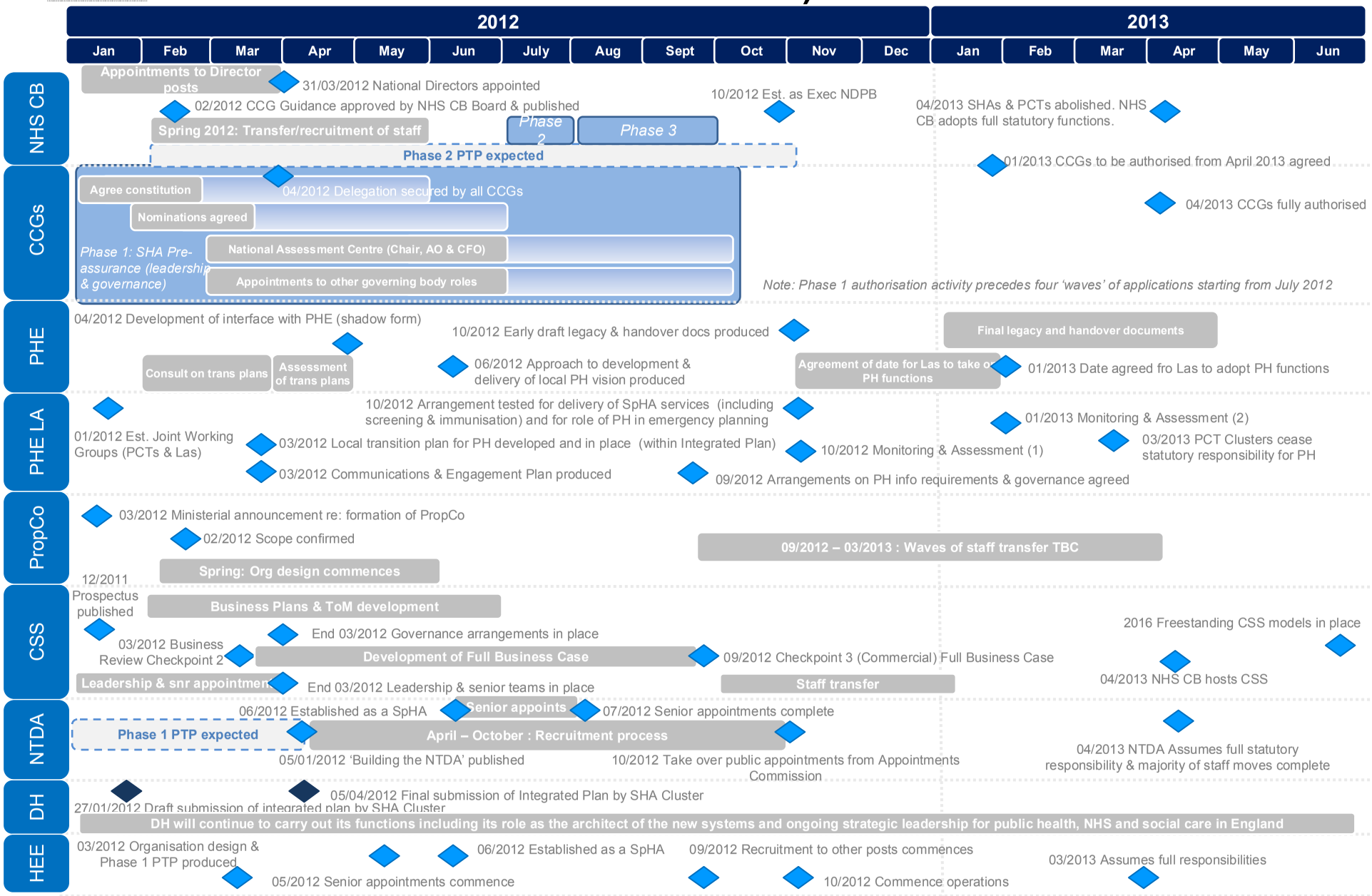
'Local government transition guidance on public health workforce issues'in January 2012

http://www.dh.gov.uk/health/2012/01/public-health-workforce/

Final guidance 'Towards Service Excellence' was published in February 2012:

http://www.hsj.co.uk/Journals/2011/11/09/t/q/p/Towards-Service-Excellence_021111-FINAL.pdf

NHS National Transition Milestones (2 February 2012)



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USEFUL INFORMATION ABOUT
The NHS Commissioning Board

Overview

Subject to the passage of the Health and Social Care Bill, the NHS Commissioning Board (NHS CB) will be established to play a vital role in providing national leadership for improving health outcomes and driving up quality of care. At its simplest, the purpose of the Board will be to work with clinical commissioning groups (CCGs) and the wider system to use the commissioning budget of around £80 billion a year to secure the provision of high-quality health services for patients and communities.

Location

The central headquarters of the NHS CB will be in Leeds and there will also be an office in London.

The Board will work at sub-national and local levels, with a single operating model, through sector and local teams. It is expected there will be 50 local offices and that four sector teams will be co-located with national or local offices.

Numbers of Staff

The establishment of the NHS CB allows a major opportunity to develop a brand new organisation that has the culture, style and leadership to truly improve outcomes for our patients. Achieving that vision will depend on those people who become part of the NHS CB team.

It is expected there will be an overall workforce of around 3,560, with:

- around 2,500 in the 50 local offices
- around 200 in the four sectors
- around 860 at the centre

This represents a potential reduction of almost half from the workforce currently responsible for the functions that are expected to be undertaken by the NHS CB. The Board will be an exemplar of the change it expects to see in CCGs: it will operate in as lean and flexible way as possible.

Organisational Design

- October 2011 - The NHS Commissioning Board Authority (NHS CBA) was established as a Special Health Authority
- October 2012 – Subject to the passage of the Health and Social Care Bill, the NHS Commissioning Board (NHS CB) will be established as an Executive Non-Departmental Body
- 1 April 2013 – Subject to the passage of the Health and Social Care Bill, Strategic Health Authorities and Primary Care Trusts will be abolished and the NHS CB will take on its full responsibilities.

Following a detailed and intensive design process over several months, including engagement with key stakeholders, recommendations for the organisational design and structure of the NHS CB will be considered at the NHS CBA public board meeting on 2 February 2012.

The recommendations are available on the NHS CB website at www.commissioningboard.nhs.uk and set out:

- Details of how the Board would operate through a matrix working approach
- Detailed recommendations on the design of each of the Board's nine directorates, including the sectors and local offices
- Next steps.

The proposed nine directorates of the NHS CB are as follows and we expect national director appointments to be made by the end of March:

- National Medical Director
- Chief Nursing Officer
- Chief Operating Officer
- National Director: Finance
- National Director: Commissioning Development
- National Director: Patient and Public Engagement, Insight and Informatics
- National Director: Improvement and Transformation
- National Director: Policy, Corporate Development and Partnership
- Chief of Staff.

Further transfer or recruitment of staff is expected to start in Spring 2012, dependent upon the passage of the Bill. Job descriptions will be developed in line with a phased recruitment process to the Board. Over the next few months, the NHS CBA will keep affected staff informed and engaged in the development of the Board.

Useful documents

'Developing the NHS Commissioning Board' - published in July 2011

http://www.commissioningboard.nhs.uk/commissioningboard/files/2011/10/Developing-the-commissioning-board.pdf

Phase 1 of the 'NHS CB People Transition Policy' (PTP) - also published in July 2011.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129337.pdf

Phase 2 will be published after Royal Assent. The PTP is essential reading for anyone who believes their future employment will be in the NHS CB. It builds on local HR Frameworks and governs the appointment of staff into the NHS CB and has been developed in partnership with the Trade Unions.

USEFUL INFORMATION ABOUT
Public Health England

Overview

Subject to the passage of the Health and Social Care Bill, the Secretary of State will have new functions in relation to public health. Many of those functions will be exercised by Public Health England (PHE), which is to be established on 1 April 2013 as an Executive Agency of the Department of Health.

PHE's overall mission will be to protect and improve the health and wellbeing of the population, and to reduce inequalities in health and wellbeing outcomes. It will do this in concert with the health and social care system, and with key delivery partners including Directors of Public Health, local government, the NHS and Police and Crime Commissioners, providing expert advice and services and showing national leadership for the public health system.

Location

Further work to finalise the organisation design of PHE - including the number and location of staff and offices - will be conducted by the end of May 2012. This work will be based on the overall functions and organisation structure as set out in the PHE operating model, which includes the following features:

- National office - PHE's senior management team will be based in a national office located in London. The national office will act as the service centre for the organisation, and provide national leadership, strategic direction and support the overall integration and coordination of the public health system.
- National centres of expertise and excellence for public health - PHE will build on and develop current arrangements for national centres which concentrate professional, scientific and analytical expertise to deliver a range of services and functions that support front-line public health activities.
- Hubs - some PHE national office functions will be distributed across geographic hubs, which will be part of the national office and act within a national framework. There will be four hubs that are coterminous with the four sectors of the NHS Commissioning Board and the Department for Communities and Local Government resilience structure: London, the South of England, Midlands and East of England, and North of England.
- Units - PHE will deploy expert and specialist advice capacity at a level that allows it to understand and respond to local needs and support local leaders to tackle the health challenges they face. Units will be developed from the twenty-five current health protection units of the Health Protection Agency.

Numbers of Staff

Approximately 5,000 roles have been identified within the existing organisations and functions that are expected to transfer across into PHE in April 2013. Further work

on finalising transition details will be conducted and published in the first half of 2012.

Organisation Design

It is expected that a PHE Chief Executive designate will be appointed in April 2012 to manage the transition process through 2012/13.

Once the final phases of PHEs design are completed in the summer of 2012, the HR transition processes will begin. Subject to the passage of the Health and Social Care Bill, it is expected that a pre-transfer appointment process will run from July to October 2012. Permanent appointments will only be confirmed after establishment in 2013.

Useful documents

A series of policy updates were published on 20 December 2011 to help partner organisations and staff involved to understand and implement these reforms.

http://healthandcare.dh.gov.uk/public-health-system/

These documents cover:

- The New Public Health System http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131897.pdf
- Public Health in Local Government http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf
- PHE's Operating Model http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131892.pdf

In January 2012, 'Building a Public Health England People Transition Policy' will be published, which will outline the high level process for filling posts, the process for senior appointment and the progress on partnership working. This will be followed in June 2012 by the full 'Public Health England People Transition Policy', which will include terms and conditions.

USEFUL INFORMATION ABOUT
Local Government & Public Health Services

Overview

The Government has set out its vision that certain local authorities will take on a key leadership role for public health locally. They will lead on improving their populations' health and wellbeing, co-ordinate local efforts to protect the public's health and ensure health services effectively promote population health. Building on their central role as democratically accountable bodies which are ideally placed to shape services to meet local needs they will be able to develop holistic solutions to health and wellbeing embracing the full range of local services (e.g. health, housing, leisure, planning, transport, employment and social care). Local authorities' new public health responsibilities will be supported by a ring-fenced budget. Directors of Public Health will lead this work, as the principal adviser on health to the local authority. These proposals are subject to the passage of the Health and Social Care Bill, which contains the legislative provisions necessary to confer these new functions on local authorities.

The provisions include a new duty on county councils, London borough councils and unitary authorities, to take steps to improve the health of their local population. One way those local authorities may fulfil their new health improvement duty will be through commissioning public health services. They will also work with clinical commissioning groups and representatives of the NHS Commissioning Board to integrate services.

Commissioning

In 'Healthy Lives, Healthy People: Update and way forward' we published a provisional list of what should be funded from the public health budget, and who the principal commissioner for each activity should be. We have sought wherever possible to devolve responsibility and resources for public health services to local government. Although in a number of cases where a public health service is deeply intertwined with the delivery of clinical services, or where services are part of the primary care contractual arrangements, the Secretary of State for Health will ask the NHS Commissioning Board to commission services on his or her behalf (for example national screening and immunisation programmes).

The recently published 'Public Health in Local Government' fact sheets confirm the public health services that local authorities will be responsible for. It also identifies areas where further work is required.

Mandatory steps

The Health and Social Care Bill includes a power for the Secretary of State for Health to prescribe that local authorities take certain steps in the exercise of public health functions, including that certain services should be commissioned or provided. The purpose of this power is not to identify some services as more important than others. Rather the issue is that in some service areas (particularly

health protection) greater uniformity of provision is required. In others, the Secretary of State for Health is currently under a legal duty and needs to ensure that the obligation is effectively delivered when the function is delegated to local government (the provision of contraception is an example).

Finally, certain other steps are critical to the effective running of the new public health system at a local level, for example ensuring that the local authority provides public health advice to NHS commissioners.

The planned list of mandatory services is set out in the 'Public Health in Local Government fact sheets'. These fact sheets also cover further information on local authority public health advice to NHS commissioners.

Workforce

Primary care trusts and local authorities will be responsible for developing public health transition plans and consulting with their constituent trade unions and staff on these and the associated workforce plans. To support this, key guidance and support has been developed at national level and published by the Department of Health and the Local Government Association. This outlines the human resources processes and expectations on primary care trusts, councils, NHS and local government trade unions in managing this important change with elements on some remaining key issues being developed. The expected date for any transfer of staff that may occur is 1 April 2013, when subject to Parliament, the relevant parts of the Health and Social Care Bill come into effect and responsibilities transfer.

Organisational Design

Local Authorities will be working to develop their vision and the structure of their new public health function in dialogue with a range of partners and representatives over coming months.

Useful documents

'Healthy Lives, Healthy People: Update and way forward' published July 2011.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128120

A series of policy updates were published on 20 December 2011 to help partner organisations and staff involved to understand and implement these reforms. This includes a suite of factsheets on:

- The New Public Health System
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131897.pdf
- Public Health in Local Government
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf

- PHE's Operating Model
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131892.pdf

In January 2012, 'Public Health Transition Planning Support for Primary Care Trusts and Local Authorities' was published. This is to assist PCT clusters with their requirements to produce public health transition plans as part of their overarching plans for the transition year, as set out in the NHS Operating Framework and planning guidance for 2012/13 recently issued by the Department of Health.

http://www.dh.gov.uk/health/2012/01/transition-planning/

In addition, 'Local government transition guidance on public health workforce issues' has been developed by the Local Government Association, supported by local government union colleagues and NHS Employers and union colleagues. This focuses on public health workforce issues and is primarily for HR specialists in local authorities who will be responsible for managing transfers working with PCTs, and is concerned with the key questions and options where staff are transferring from PCTs to Local Authorities.

http://www.dh.gov.uk/health/2012/01/public-health-workforce/

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USEFUL INFORMATION ABOUT
NHS Commissioning Support Services (CSSs)

Overview

Subject to the passage of the Health and Social Care Bill, there will be new and efficient models of commissioning support to help Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board (NHS CB) in undertaking their commissioning responsibilities and delivering the best possible outcomes for patients.

It is envisaged that the NHS CB will temporarily host commissioning support services (this means that the NHS CB will be the employer of CSS staff) that grow from PCT clusters from April 2013 where those services demonstrate, through the business review, that they will be viable. It is proposed that all these services will move to freestanding models by April 2016 at the latest.

Location

SHA and PCT clusters are working with CCGs to explore the optimum level to operate at and final numbers and locations have yet to be determined. It is likely that some commissioning support services will operate out of a number of locations.

Some of the national 'scale' offers for business intelligence, major clinical procurements, communications, and corporate or business support services, such as finance or HR, are likely to operate at a national and sub-national level with close links and working relationships with local CSS teams and CCGs. It is expected that most of these scale offers are expected to be accessed by CSSs and offered as part of their own service offers. Work is taking place over the next few months to develop and firm up the proposals for how they will operate.

Numbers of Staff

The numbers of commissioning support staff in any service will largely depend on how CCGs decide to operate and the extent to which they carry out activities in house or share or buy in support services, and what operating models NHS CSSs develop.

Early indications suggest there may be around 25 to 35 local CSSs. These numbers will be influenced by a number of factors, including customer support for the services, and a viable and affordable business model.

Organisation Design

PCT Clusters should be working closely with CCGs and other local stakeholders to define the optimum and most efficient operating models and organisational structures as part of the business review.

These will become clearer as CSSs form their outline business plans as part of the assurance business review process and its second 'checkpoint' scheduled in March 2012, and their full business plans during Spring and Summer 2012.

By the end of March 2012, it is expected that each CSS will have developed governance arrangements that allow it to operate at arms length from the PCT Cluster, with clear leadership and senior teams in place, as outlined in the NHS Operating Framework Planning Guidance for 2012/13 (published in December 2011). Consultation exercises are expected to commence thereafter in line with local organisation change policies.

Any transfer that may occur of staff to hosted options is expected to commence later in 2012. For those CSSs transferring to the NHS CB, the NHS CB People Transition Policy will set out the process and timescales. Phase 2 of this framework is expected to be published after the Health and Social Care Bill receives Royal Assent. This will build on local HR Frameworks and governs the appointment of staff into the NHS CB and has been developed in partnership with the Trade Unions.

Useful documents

Draft guidance 'Towards Service Excellence' was published last November that describes the emerging strategy for commissioning support. All Cluster Chief Executives received a copy of this in November.

http://www.hsj.co.uk/Journals/2011/11/09/t/q/p/Towards-Service-Excellence_021111-FINAL.pdf

In December 2011, information on the business review process, timescales and the criteria that emerging CSSs will be assessed against, was sent to all SHA and PCT clusters.

Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London Sector

27 February 2012

Future Work Plan

1. Introduction

1.1 This report outlines the work plan for future meetings of the JHOSC.

16 April (Haringey):

1.2 Items for the next meeting of the Committee are currently as follows:

- Estates Management
- Oral Surgery
- Vascular Surgery – Outcome
- CAMHS Implementation
- BEH MHT quality account
- QIPP Performance

1.3 Items for future meetings are currently as follows:

28 May (Enfield)

- BEH Update
- Acute Commissioning

9 July (Barnet)

- Integrated Care

1.4 Further agenda items for these meetings will be agreed in due course.

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