5 year plan 2014/15-2018/19: summary

Introduction

1. Haringey Clinical Commissioning Group (CCG) is a clinically-led membership organisation consisting of all 49 member GP practices in the London Borough of Haringey. The CCG came into being on 1 April 2013 and is the responsible body for making sure the people of Haringey can access safe, well co-ordinated, high quality health services. We are committed to serving our local people – our vision is to enable the people of Haringey to live long and healthy lives.

2. All our practices share our vision and values about how we will operate and how we will achieve our ambitions and the plans that we set out. We will encourage and support people to make healthy choices and when people need support with their health problems, we want to make sure they get to see the right professional, in the right place, without having to wait. Local GPs will use their skills and experience to buy high quality, safe and accessible services and use the feedback patients give them to make sure the healthcare we buy will result in better services.

3. Our plans set out how we will meet the national objectives for the NHS and local needs and priorities identified in the Haringey Joint Strategic needs Assessment and Health and Wellbeing Strategy. The broad areas of health and care where the government and Haringey CCG expect to see improvements are:
   - Preventing people from dying prematurely
   - Enhancing quality of life for people with long term conditions
   - Helping people recover from episodes of ill health or following injury
   - Ensuring people have a positive experience of care
   - Treating and caring for people in a safe environment and protecting them from avoidable harm

4. NHS England anticipates CCGs will need to implement transformational service models to improve access for all our local people and all healthcare conditions, drive up quality and value and embrace innovation in order to achieve the outcomes that really matter to people.

Background

5. Haringey CCG has summarised its plans for the next five years on a single page (‘plan on a page’, appendix 1). Our draft 5 year plan sets out at a high level what we want to achieve for the people of Haringey to improve their mental and physical health and wellbeing. The plan identifies how we are going to deliver those achievements, who will be involved, what they will have to do, and some of the features of how health and care services will be different as a result of our collective work. These documents were submitted to NHS England on 4 April 2014 following many conversations with our stakeholders and partners, along with a 2-year operating plan for 2014/15 – 2015/16.
6. Haringey CCG is also working in partnership with the 5 CCGs in North Central London - Barnet, Enfield, Haringey, Camden and Islington - to develop a five year plan for this local ‘Strategic Planning Group’. There is more information on the Strategic Planning Group’s 5 year plan at the end of this summary.

7. The draft 5 year plan had to be submitted to NHS England in a format which is not ‘reader friendly’. Haringey CCG has prepared this summary to help staff and stakeholders better understand the plan and be able to engage with its further development. This summary is also available on the CCG website with information about how people can provide comments and feedback.

8. The structure of this summary follows the structure of the ‘plan on a page’ and incorporates the relevant sections of the draft 5 year plan. All service and pathway reconfigurations are designed to meet the needs of the people of Haringey regardless of age and health condition, unless otherwise stated. For example, admission avoidance initiatives are designed to meet the needs of children and adults alike.

**Strategic vision (mission)**

9. We want our starting point to be people. What can we do to make life better for people in Haringey when it comes to their mental and physical health and wellbeing? If we think about people’s needs first, everything else should fall into place. We want to make sure that:

i. People **feel confident to manage their condition** and continue to live their normal life. More people are living with a long term condition like diabetes or breathing problems and if their health deteriorates, we want people to know where to get high quality healthcare, treatment and support which is safe, effective and provides a positive patient experience, to get them back on track. Where we know that services are working well we will build on and spread good practice.

ii. People are **supported to live independently** for as long as possible as more people are living longer.

iii. **Young people get the best start in life** and are equipped to make healthy decisions which will positively impact their lives as adults.

iv. People have a **choice** about how, where and when they access information and support from health and social services, no matter where they live, their age, or their background.

v. **Convenient and easily accessible services** are available near where people live. For example, enabling people to receive benefits and welfare advice when they visit their GP practice. Services should appear seamless so people cannot notice differences between providers or when one takes over from another.

vi. **Community based, out of hospital services are accessible** to everyone who lives in Haringey as most people would prefer to be treated in or near their homes.

vii. People know they can access much better care and outcomes for certain rarer conditions such as uncommon cancers, burn care and cardiac surgery in **specialist hospitals** even if it means travelling a bit further.
10. We need to do more with less money and still make sure that everyone in Haringey always experiences safe, effective and high quality care. We want to equip people to feel able to make informed choices about their own health and care, and that of the people they care for.

11. Our vision and aims are underpinned by six corporate values, showing our commitment to being engaging, efficient, innovative, open, inclusive, and focused on quality.

**What we are currently doing and areas to build on (backstory/narrative)**

**Haringey’s population and their health needs**

12. Haringey is the fifth most ethnically diverse borough in the country. Nearly half of our residents come from black and minority ethnic (BME) communities, mainly concentrated in the east of the borough. Some of the health needs experienced by the BME communities are strongly linked to higher rates of deprivation and poverty, as well as other factors such as the impact of discrimination or differential access to services.

13. Haringey has a relatively young population which will remain the pattern over the next ten years, although the elderly population in the west of the borough will increase. There is a high birth rate, greater ethnic diversity among pregnant women, a higher proportion of older mothers and teenage pregnancy has increased. Infant mortality rates in Haringey are higher than the average for England and London, although the gap has closed in recent years.

14. Men in the east of the borough die up to 9 years younger than men in the west. For men and women, deprivation and lifestyle factors (such as smoking, physical inactivity, obesity, poor nutrition, and alcohol) account for much of this major health inequality. Early deaths due to cardiovascular disease and cancers (in particular lung, bowel and breast cancer) are high and the prevalence of long-term conditions is increasing due to lifestyle behaviours that are impacting adversely on the health of a large proportion of the population.

15. Find out more about Haringey’s population by looking at the Joint Strategic Needs Assessment on Haringey Council’s website.

**What we are currently doing**

16. Haringey CCG’s work is closely aligned with the London Borough of Haringey’s Joint Health and Wellbeing Strategy. This strategy has three main outcomes to improve health and reduce health inequalities in the Haringey population:
   - Every child has the best start in life
   - A reduced gap in life expectancy
   - Improved mental health and wellbeing

17. The CCG is already commissioning services to meet the local health needs and has identified six priority areas which have been a focus of our work for the past year:
   - Prevention
   - Integrated Care
   - Urgent Care
• Planned Care/Care Closer to Home
• Mental Health and Learning Disabilities
• Children and Young People

18. Where there is evidence that things are working well, the CCG will build on these initiatives and roll out good practice.

Areas to build on

19. We need to change how we commission services in order to improve efficiency and sustainability and increase the scale and pace of change to meet the needs of more people more locally. A good example of how this is beginning to happen is in the ambitious 20-year regeneration programme for Tottenham which is already underway. The CCG is working alongside stakeholders to ensure the development of a modern model of health services is available for people who live in Tottenham.

20. The cost of providing the current service models is set to rise and will not be sustainable based on the forecast demand and funding levels. CCG commissioners have been working with providers of health services to control and manage the financial challenge. Changes in service delivery, as described in more detail in this document and the draft 5 year plan, are currently being discussed with providers in order to deliver efficiencies to close the financial gap.

20. A number of initiatives have been introduced to improve quality, productivity, innovation and prevention (also known as QIPP). For example, over the past two to three years, patient pathways have been revised with more treatment and support provided locally for a range of long term and other conditions, such as diabetes, heart failure, chronic obstructive pulmonary disease (COPD), gastroenterology, cataracts, and children’s allergies and breathing difficulties. The CCG has also implemented a range of telephone helplines to support GPs in early identification and diagnosis of conditions and introduced weekly multi-disciplinary teleconferences to discuss the care for older people with frailty. The CCG has also launched a ‘choose well’ app to give people more information and help them find the most appropriate local service to meet their needs.

21. In April 2012 the CCG embarked on a three year, £10 million programme to improve access to primary care services and give people better care closer to their homes. This includes:

- Supporting GP practices to improve their appointment systems so that more people who need an appointment can get one and won’t feel that their only option is to visit A&E;
- GP practices working together in ‘networks’, providing a range of community services to more patients;
- Better use of information technology such as text messaging to confirm appointments or cancellations; and
- Improving the quality and accessibility of GP practice premises.

Objectives (how are we going to achieve our vision)

Objective 1 – Explore and commission alternative models of care
22. Along with the five CCGs in the North Central London Strategic Planning Group, Haringey CCG is implementing a new way of commissioning called ‘Value-based Commissioning’. The aim is to maximise the quality of care experienced across the whole life course by the Haringey population for every pound spent. We will move away from commissioning units of activity from different service providers and towards commissioning the outcomes that matter to our population groups, resulting in less fragmented care pathways. This will lead to a transformation of services and service providers, and increased joint working between providers.

23. There is a shared commitment across the CCGs in North Central London to drive this new approach and significant investment, and strong support from chief executives and medical directors of provider organisations. Initially the focus for Haringey will be on people with frailty, people with mental health conditions, and people with long term conditions. Once the results of this work in these areas have been established, the approach is likely to be mainstreamed into our commissioning. It is planned to use outcome based contracting for the contracting round in April 2015-16.

24. For example, if someone has diabetes, or complex needs such as mental health needs or learning or physical disability, we want to know that the services we commission are minimising the number of years of life lost to the condition, are maximising people’s quality of life, are actively promoting and supporting self-management in the most appropriate setting, and are working to support the population to behave in healthier ways. Our commissioning approach over the next five years needs to drive services to be organised and working together to meet the outcomes that matter to our patients and the local population.

25. While the approach will need to adapt over time, it is highly unlikely that the CCGs will move away from a focus on commissioning for outcomes. There is a shared and strong recognition of the need to explore models of commissioning that reduce incentives for providers to maximise activity and that orient all providers around the outcomes that matter to patients.

26. Other transformational schemes developed with local providers, stakeholders and service users are being implemented to support our ambition to make sure people are supported in the most appropriate setting, as close to their homes as possible. For example, the Integrated Care Programme supports patients at varying stages during their time of need. Where hospital attendance takes place, a multi-disciplinary team will provide assessment and signpost the patient to the most appropriate service. GP Networks will support the management of patients with long-term conditions more effectively by providing educational and self-management support where appropriate. We will build on this to ensure equity of access and a more effective response to people with more complex needs who can be supported through a multi-disciplinary response in primary care settings. This is a measure which will improve parity of response to people with mental health needs as well as with other conditions.

27. We also want to promote and support self-management and empower people, including those with complex needs, to enhance their own health and wellbeing and behave in healthier ways. For example, people with long-term conditions or poor mental health will be supported to play a more active role in their health and healthcare by providing them with information, practical tools, skills and signposting to relevant support or activities in the wider community.
Objective 2 – a greater range as well as more integration of providers

28. Our goal is to improve integration of health service providers and between council departments, health services and voluntary organisations. This will enable the CCG to meet the National Voices objective: that our population will be able to plan their care with people who work together to understand them, give them control and enable them to achieve the outcomes that are important to them. The vision is of models of care and services that are focused on early identification and proactive, co-ordinated care that prevents crises and enables independence, maximising time spent free from symptoms and avoiding unnecessary hospital admissions.

29. A project is a currently being developed jointly by Haringey CCG and Haringey Council to improve the way local people of all ages access services in a more joined up way that works with their different lifestyles and improves their health and wellbeing. There are already examples of better joined up working, including social workers based in the North Middlesex Hospital A&E department during winter to help residents of Enfield and Haringey get home quicker with the right support.

30. The Better Care Fund (BCF), developed jointly with the Local Authority, will be the mechanism by which commissioners promote and drive service integration to achieve improvements in outcomes and experience for people who use the services. Initially our focus will be on people who are identified as frail and pre-frail, extending to mental health services, children’s services and services for people with long term conditions. The BCF identifies how we plan to use a joint commissioning budget (between the CCG and Local Authority) for reducing admissions to institutions, both hospitals and residential care. It identifies the schemes that will be put in place locally to deliver this transformation which will be characterised by:
   - A focus on supporting primary care to plan and co-ordinate older people’s care
   - The development of multi-agency and multi-professional locality teams that will provide a co-ordinated service close to people’s homes
   - Expansions in ‘rapid response’ and co-ordinated ‘home from hospital’ teams.

31. For people with frailty the model of care will be based around locality teams that can support case management and co-ordination of care. We will commission services that work on a borough-wide basis to support independence. This will include, for example, broadening access to rapid response and an integrated discharge team.

32. People often have problems when they start a new medicine and when they are taking multiple medicines for long term conditions. We plan to better integrate community pharmacists with multidisciplinary teams as they are key to supporting patients to use medicines safely and to their best effect through Medicines Use Reviews and the New Medicines Services.

33. For people with a serious mental illness there have been some real improvements in how we support people to live a full life in the community. We now need to reach more people and grow our offer for recovery. Recovery is about offering opportunities to live a fulfilling life with and without the symptoms of mental illness. By offering hope and control, recovery based approaches can reduce reliance on the need for services. We recognise that mental health is often a lifelong condition and we want to commission pathways that maximise independence, but that also allow quick access back in to services as soon as people need them. Increasingly, at both national and local level, it is understood that improving the mental health and wellbeing of the population requires
a cross-partnership response which seeks to address the causes of poor mental health, increase investment in prevention, offer early help, and engage fully with those affected by mental illness, their families and communities. To support this there needs to be a greater focus on shifting the care from inpatient settings to the provision of integrated services in the community. This offer, to be effective, needs to be co-developed with service users.

34. To support our aspiration to ensure that children have the best start in life we also recognise the need to redesign pathways for peri-natal and CAMHS (Child and Adolescent Mental Health Services) care across all tiers of provision. We will work closely with Local Authority colleagues to implement the Children’s and Families Act.

35. The CCG is committed to working with NHS England to improve primary care. For example, Haringey Council, Haringey CCG and NHS England are working together to modernise health facilities in Tottenham. One of the outcomes will be improvement in the quality of primary care premises which is an essential enabler for the quality of clinical care and better patient experience. The CCG is also working with Community Pharmacists and NHS England to improve access, choice, and support self-care for people with common conditions through the local minor ailments scheme. This enables people exempt from prescription charges free access to medicines for certain common conditions.

36. For people with mental health needs we will also be working closely with acute, criminal justice and emergency services to implement the Mental Health Crisis Concordat to ensure an integrated approach to people experiencing a mental health crisis. This will improve parity with those with physical health needs.

Objective 3 – engaging communities in new and more innovative ways

37. We want to focus on promoting wellbeing and preventing ill health. To do this, we need to work with patients, carers, local people, voluntary and community groups and other agencies and together build healthier communities which have strong networks, friendships and trust.

38. There is a need to make changes in the health service to meet the needs of an ageing population and the increasing number of people living with long term conditions, such as diabetes and asthma. We need partnership with patients and carers to help to create effective service change.

39. We are committed to giving local people the opportunity to help shape the services we commission and contribute to how they are run and monitored (Engagement Strategy). Examples of how we plan to achieve this include:

- Holding meetings throughout the year for the public, stakeholders and our engagement network to give people opportunities to inform the development of the CCG’s plans.
- Creating a pool of Haringey patients and carers to help us review and look at different services and patient pathways
- Working closely with Healthwatch Haringey; sharing intelligence and joining together on specific projects
- Listening to and acting on feedback about experiences of NHS services within Haringey
• Making visits to a number of voluntary and community organisations and groups in Haringey to hear experiences of the different people and communities that they work with
• Identifying particular communities, whether they be ethnic, faith or geographically based, which may have a particularly high prevalence of mental illness and actively targeting services towards them to increase awareness, reduce stigma and promote mental wellbeing.
• Considering the impact of any changes on people with protected characteristics identified by the Equality Act (2010).

40. We will continue to focus our efforts on engaging and communicating with a more diverse group of patients and the public, reflective of Haringey’s demographic and health profile. This will involve using different approaches and expanding our use of technology. We will particularly focus on exploring new ways of communicating with our residents so that they are better placed to get information and access to support in a way which suits them.

41. The key themes from the CCG’s engagement work in 2013-14, summarised below (Feedback from our public meetings), have been incorporated into the Plan on a Page:
• More working with the voluntary and community sector
• Better access to GPs and primary care services
• Integration of services across health and social care
• Promoting a holistic approach to health and wellbeing
• Ongoing community engagement to help build strong, local networks
• The importance of a recovery model for mental health and access to a wide range of services and support for people with mental health needs.
• Improved communications with the people of Haringey, in a variety of formats, to help people better understand the health care system (in particular, the urgent care system).

42. Clinicians in Haringey and other key stakeholders like the Health and Wellbeing Board, local authority and Healthwatch Haringey have been involved in the development of the CCG’s plans in a number of ways. This approach to engagement and partnership working will continue.

Objective 4 – a re-defined model for primary care

43. The development of primary care in Haringey is a priority for the CCG and better access to GPs and primary care services is a key theme that has come out of the CCG’s engagement work in 2013-14. The development of primary care services is fundamental to the improvements we want to achieve. For example:
   a. Focusing on supporting primary care to plan and co-ordinate older people’s care and prevent or delay avoidable hospital admission and facilitate early discharge.
   b. Identifying and addressing skills and capacity gaps in responding to people with complex needs in primary care settings and putting in place agreed thresholds for referrals to more specialised services and shared care protocols, for example for people with mental health problems.
   c. Strengthening links with health promotion and prevention services, and developing early intervention services.
   d. By working together in networks of practices we will be able to offer more services locally to more patients. For example, if one GP practice offers a particular service
(such as extended hours, or a preventative service, or on site testing) there will be arrangements in place so that patients from other nearby practices will also be able to go there too. This will hopefully reduce the number of people who need to go to hospital for planned care and help to reduce the demand for urgent and emergency care.

e. Improving access to primary care, in a range of ways and settings, is a really important enabler to ensure that people can more appropriately access high quality urgent and emergency care when they need it most.

44. We have begun working with GP practices so that they develop new ways to provide primary care at greater scale. This means working together with other GP practices, partly so that they can be more viable, and partly to provide more services to patients in that area. This will result in improved access and equity of provision for the whole population, and enable them to benefit from a greater range of services locally.

45. Haringey’s GP practices already work together in four collaboratives. Our strategy is to take this much further, to change the shape of local provision, with networks of practices using a variety of organisational vehicles, rather than a one size fits all approach. For example, for some it may be a loose association, for others a merger, and for others a new legal entity such as a federation. By October 2014/15 we aim for each collaborative to have agreed new ways of practices working together at scale in their area, and each to be in the process of formation. By the start of 2015/16 we aim for each collaborative to have formed new ways of working and to be providing some services together.

46. Evidence shows that many benefits can be seen by changing how practices deliver services, for example the introduction of an 8am-8pm, 7 day model of care and the use of telemedicine. Haringey Council, Haringey CCG and NHS England are working together to improve the quality of primary care and modernise health facilities in Tottenham. Tottenham has a fast growing and diverse population with significant health needs. Practices tend to be smaller, with care delivered from facilities that are not fit for purpose and offering basic services with limited access. The CCG’s aim is that improvement in premises resulting from the Tottenham regeneration programme will have a significant positive impact on patient experience and outcomes.

47. The CCG will be developing primary care information systems. A key enabler for integrating care across primary, secondary and social care, and for practices working together, is the development of clinical information systems which communicate easily with each other.

48. In order to increasingly make joint decisions with NHS England on the commissioning of primary care, Haringey CCG has put forward an expression of interest in co-commissioning primary care services with NHS England, together with the other four CCGs in North Central London.

**Medicines optimisation**

49. Medicines optimisation is about ensuring that the right patients get the right choice of medicine at the right time. By focusing on patients and their experiences, the goal is to help patients to:
- Improve their outcomes
- Take their medicines correctly
• Avoid taking unnecessary medicines
• Reduce wastage of medicines
• Improve medicines safety.

Ultimately medicines optimisation can help encourage patients to take ownership of their treatment.

50. Medicines used today are often sub-optimal and we need a step change in the way that all healthcare professionals support patients to get the best possible outcomes from their medicines. Practices are engaged in a programme of initiatives and educational events to implement best practice, involving patients in optimising their use of medicines and achieving value for money. The current focus is on people with diabetes, cardiovascular and respiratory disease.

51. Our approach to medicines optimisation will require multidisciplinary team working to an extent that has not been seen previously. We plan to increase the skills of health and social care professionals so that they can work together to individualise care, monitor outcomes more carefully, review medicines more frequently and support patients when needed.

**Quality assurance and safeguarding of vulnerable people (Quality and Patient Safety Strategy 2014-16)**

52. Haringey CCG’s vision is to enable the people of Haringey to live long and healthy lives with access to safe, well-co-ordinated and high quality services. Our vision and aims are underpinned by six corporate values, including being focused on quality. This means we are committed to commissioning high quality services and we will build on success and learn from our mistakes. We will promote public sector values and the benefits of clinical excellence in commissioning services. Listening to our patients and learning from their experiences is a core aim.

53. Our focus on quality embraces effectiveness, patient experience, and safety – including safeguarding of vulnerable people. Our challenge as commissioners is to create a culture of continuous quality improvement based on openness, transparency and candour. We have put in place Clinical Quality Review Groups to gain assurance on the quality of services provided. Any quality concerns will be managed through these monthly meetings with the local provider trusts.

54. The CCG has implemented an Insight and Learning programme which we will continue to develop. This programme will oversee our patient experience work and identify areas of good practice to share, as well as alerting us to any trends of poor care or practice. We will use information about patient experience from a wide range of sources to improve the quality of local services and a ‘you said, we did’ web page will be developed.

**Workforce**

55. We will not be able to achieve such an extensive cultural change in how we commission and deliver services in a relatively short time without supporting staff to work differently. We are working with providers and other stakeholders to develop new training and professional education programmes that will train new staff and support existing staff to work more effectively. This will sustain the implementation of the new models of service delivery that we want to commission for people in Haringey.
56. We are also making sure that our commissioning leads, both clinical and non-clinical, have the necessary skills and expertise to plan, lead and coordinate the transformation initiatives within and across organisations and to make sure the benefits are fully realised for the people of Haringey.

North Central London Strategic Planning Group 5 year plan

57. NHS England also asked CCGs to submit a 5 year plan for its local ‘Strategic Planning Group’. For Haringey this group comprises the 5 CCGs of North Central London: Barnet, Enfield, Haringey, Camden and Islington. These CCGs have come together to agree, refine and implement the following strategic intent: To drive improvement in the delivery of high quality, evidence–based and compassionate services, defined and measured by outcomes not process, to the population of north central London (NCL).

58. There are a number of challenges across NCL and the shared intent is to transform services through clinically-led, innovative service re-design in order to deliver the CCGs’ visions. Some of these solutions will need to be delivered locally by individual CCGs and their Health and Wellbeing Boards. However, those described in the Strategic Planning Group 5 year plan will need to be delivered across the wider geography to ensure the sustainability of the health and care system. Specifically, the 5 CCGs are working collaboratively to move to a Value Based Commissioning (VBC) approach. The initial focus is on support for older people with frailty, people with mental health needs and people with diabetes, and will be expanded to cover more areas in the future.

59. In addition, while models and priorities vary, each CCG is adopting a range of approaches to support transformation, including:

- developing integrated care
- working with providers to improve outcomes for patients with long term conditions
- developing primary care, and working closely with NHS England to improve quality and access to primary care
- engaging and involving the local population so that they can work with commissioners to define outcomes that are important to them
- harnessing technological advances to improve communications across the whole health and care system.