Overview & Scrutiny

Inner North East London Joint Health Overview and Scrutiny Committee

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Wednesday, 19th April, 2017,

6.30 pm
London Borough Tower Hamlets - MP701, 7th floor, Mulberry Place, 5 Clove Crescent, East India Dock, E14 2BG

Tim Shields
Chief Executive, London Borough of Hackney
Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Members: **Cllr Ben Hayhurst, Cllr Ann Munn and Cllr Clare Potter**
Co-Optees

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

This page is intentionally left blank

TOWER HAMLETS

INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Wednesday, 19 April 2017 at 6.30 p.m.

MP701, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG.

This meeting is open to the public to attend.

	Representing
Chair:	
Councillor Clare Harrisson	INEL JHOSC Representative for Tower Hamlets Council
Vice-Chair:	
Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Members:	
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councilman Wendy Mead	INEL JHOSC Representative for City of London
Councillor Sabina Akhtar	INEL JHOSC Representative for Tower Hamlets Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Clare Potter	INEL JHOSC Representative for Hackney Council

The quorum for this body is the presence of a member from each of three of the four participating authorities.

Contact for further enquiries:
Daniel Kerr, Strategy, Policy and Performance Officer,
Tel: 0207 364 6310
E-mail: daniel.kerr@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

Scan this code for electronic agenda:

PARTICIPATING LOCAL AUTHORITIES

PAGE NUMBER

MAP OF LOCATION

PAGE NUMBER

1. PUBLIC PARTICIPATION

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. DECLARATIONS OF INTEREST

Any Member of the Committee or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

4. MINUTES (Pages 5 - 20)

To agree the minutes of the meeting held on 13th December 2016.

5. NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN; GOVERNANCE (Pages 21 - 28)

6. NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN; FINANCE (Pages 29 - 50)

7. NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN; DIGITAL ENABLEMENT (IT) (Pages 51 - 72)

Date of the next Meeting:
The next meeting of the Committee will be held on the 26th June 2016 in C1, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG.

This page is intentionally left blank

Inner North East London

Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Membership 2016-17

The Committee comprises 3 members each from Hackney, Newham and Tower Hamlets and 1 member from the City of London.

Borough	**Members**
Hackney	Cllr Ann Munn (L)
	Cllr Ben Hayhurst (L)
	Cllr Clare Potter (L)
Newham	Cllr Susan Masters (L)
	Cllr Anthony McAlmont (L)
	Cllr James Beckles (L)
Tower Hamlets	Cllr Clare Harrisson (L)
	Cllr Sabina Akhtar (L)
	Cllr Muhammad Ansar Mustaquim (I)
City	Common Councilman Wendy Mead OBE (I)

L=Labour; I- Independent

Only named substitutes are allowed to substitute for a Member should there be a vote. One named substitute has been notified:

City of London: Revd. Dr Martin Dudley

The London Borough of Waltham Forest is a Member of the Outer North East London JHOSC but their Scrutiny Chair(s) are also invited to attend INEL meetings, as observers, when there are items of mutual interest.

The officer contacts are:

Hackney: Jarlath O'Connell jarlath.oconnell@hackney.gov.uk
Tower Hamlets: Daniel Kerr Daniel.kerr@towerhamlets.gov.uk
Newham: Michael Carr Michael.carr@newham.gov.uk
City: Neal Hounsell Neal.hounsell@cityoflondon.gov.uk

This page is intentionally left blank

Travel to Tower Hamlets Town Hall Offices

By Bus

The site has excellent bus links which connect it to East and Central London and beyond.

The 277 bus route begins and ends at the site, and the 15 begins and ends a 3 minute walk away at Blackwall Station. There are a number of other bus stops close by.

Most local bus services are listed overleaf and shown on the map, with the closest bus stops clearly marked on the enlarged map below.

By DLR and Tube

East India and Blackwall DLR Stations are in the immediate vicinity of the Town Hall site, with many other DLR stations within a short walk.

The closest Tube stations are Canning Town or Canary Wharf (both Jubilee Line).

For further information visit www.tfl.gov.uk/journeyplanner

By Foot

An approximate 20 minute walk from the site is shown by the blue circle (on the map overleaf). Many DLR and both Tube stations are within this zone.

There is pedestrian access to the site from all directions, allowing good access to the surrounding area.

For more information on walking in Tower Hamlets see www.towerhamlets.gov.uk/walking

For walking directions see www.walkit.com

HEALTHY BOROUGH PROGRAMME

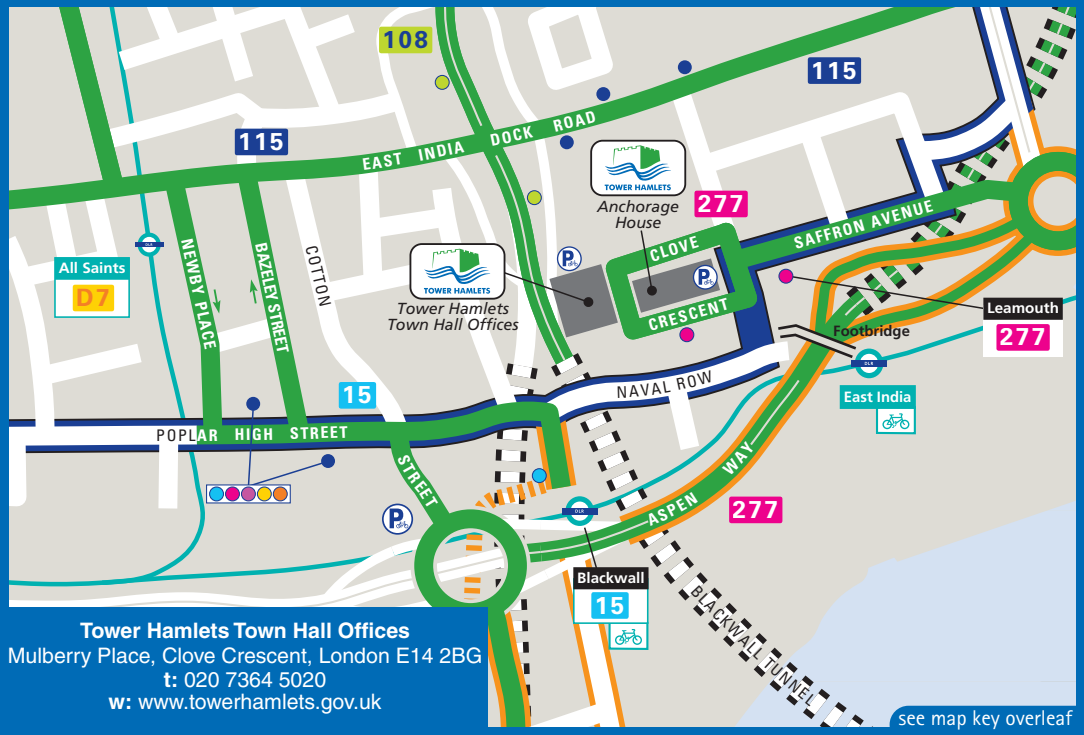
tower hamlets becoming a healthy borough

change 4 life

This map has been funded as part of the Tower Hamlets Council Travel Plan which aims to boost the number of staff and visitors travelling to the site by sustainable modes of transport.

Tower Hamlets is one of 9 areas designated as a 'Healthy Town' and has been awarded Government funding to tackle the environmental causes of overweight and obesity. Active Travel (cycling and walking) plays a major role in the programme.

www.towerhamletshealthyborough.co.uk



Tower Hamlets Town Hall Offices
Mulberry Place, Clove Crescent, London E14 2BG
t: 020 7364 5020
w: www.towerhamlets.gov.uk

By Bike

The site is well served by cycle routes, including Cycle Superhighway route 3 opening in 2010.

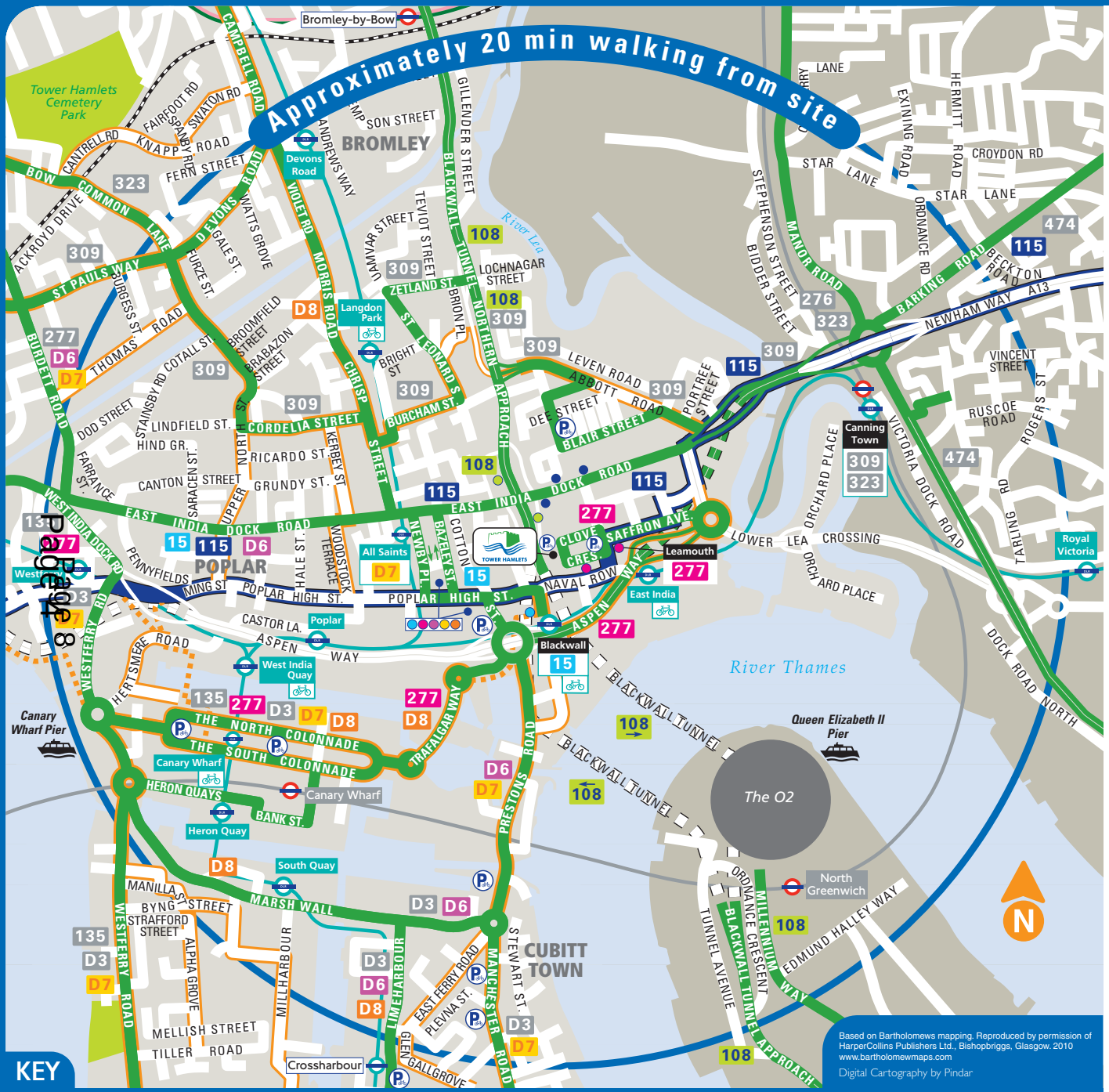
Cycle parking facilities for visitors are provided at ground level – see map (left).

Extensive cycling facilities are also available for staff who wish to cycle to work; email cycling@towerhamlets.gov.uk for details.

Further information on planning your journey by bike can be found at www.tflgov.uk/cyclejourneyplanner or visit www.towerhamlets.gov.uk/cycling for more information.

Map ▸▸▸

Design, digital cartography and print by Pindar www.pindar.com 03.10



Bus Frequencies

15 Blackwall - Paddington Basin — Daily

Blackwall DLR - All Saints DLR - Limehouse DLR - Aldgate - Fleet Street - Charing Cross - Oxford Circus - Paddington - Paddington Basin

Monday - Friday daytime 6-10 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 6-10 minutes

Operated by East London

108 Lewisham - Stratford — 24 Hour

Lewisham DLR - North Greenwich - Blackwall Tunnel - Bromley-by-Bow - Stratford DLR

Monday - Friday daytime 8-10 minutes. Saturday daytime 10-14 minutes. Evenings and Sundays 20 minutes.

Operated by London General

115 East Ham - Aldgate — Daily

East Ham - Upton Park - Plaistow - Canning Town DLR - All Saints DLR - Limehouse DLR - Aldgate

Monday - Friday daytime 5-9 minutes. Saturday daytime 8-12 minutes. Evenings and Sundays 10-12 minutes.

Operated by East London

277 Leamouth - Highbury — 24 Hour

Leamouth - Canary Wharf DLR - Westferry DLR - Mile End - Hackney Central - Highbury & Islington

Monday - Friday daytime 5-8 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 9-12 minutes.

Operated by East London

D6 Hackney - Crossharbour — Daily

Hackney Central - Cambridge Heath - Bethnal Green - Mile End - All Saints DLR - Crossharbour DLR - Crossharbour ASDA

Monday - Friday daytime 6-10 minutes. Saturday daytime 7-11 minutes. Evenings and Sundays 15 minutes.

Operated by First

D7 All Saints - Mile End — Daily

All Saints DLR - Island Gardens DLR - Canary Wharf DLR - Westferry DLR - Mile End

Monday - Friday daytime 8-12 minutes. Saturday daytime 7-10 minutes. Evenings and Sundays 15 minutes.

Operated by First

D8 Crossharbour - Stratford — Daily

Crossharbour - Canary Wharf DLR - All Saints DLR - Bow Church DLR - Stratford DLR

Monday - Friday daytime 9-13 minutes. Saturday daytime 11-12 minutes. Evenings and Sundays 20 minutes.

Operated by First

For further information call 020 7222 1234 or visit www.tfl.gov.uk

Inner North East London Joint Health Overview and Scrutiny Committee 19th April 2017 **Minutes of the previous meeting**	Item No **3**

OUTLINE

Attached please find the draft minutes of the meeting held on 13th December 2016.

ACTION

The Committee is requested to agree the minutes as a correct record.

This page is intentionally left blank

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

HELD AT 6.30 P.M. ON TUESDAY, 13 DECEMBER 2016

MP702, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON E14 2BG.

Members Present:

Councillor Clare Harrisson (Chair)	INEL JHOSC Representative for Tower Hamlets Council
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councilman Wendy Mead	INEL JHOSC Representative for City of London
Councillor Sabina Akhtar	INEL JHOSC Representative for Tower Hamlets Council
Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Clare Potter	INEL JHOSC Representative for Hackney Council

Other Councillors Present:

Councillor Anna Mbachu	Waltham Forest
Councillor Richard Sweden	Waltham Forest

Others Present:

Stephanie Clark	Healthwatch Tower Hamlets
Dr Coral Jones	Keep Our NHS Public
Mary Burnett	N E London Save our NHS
Terry Day	N E London Save our NHS
Archna Mathur,	Director of Performance and Quality NHS Tower Hamlets CCG,

Selina Douglas	Deputy Chief Officer Newham CCG
Henry Black	Chief Finance Officer NHS Tower Hamlets CCG
Nicola Gardner	Programme Director, North-East London Sustainability and Transformation Plan (STP)
July Lowe	Director of Provider Collaboration North-East London STP
Ian Tomkins	Director of Communications and Engagement North-East London STP

Officers Present:

Daniel Kerr	– Strategy, Policy & Performance Officer
Antonella Burgio	– Democratic Services

WELCOME AND INTRODUCTIONS

The Chair opened the meeting. She introduced herself and welcomed Members and guests to the meeting. She then asked all those participating to introduce themselves and state their role at the meeting.

PROCEDURAL MATTERS

The Chair informed all present that a procedural issue had arisen because due notice of the meeting had not been given across all of the participating boroughs; legal advice on this matter had therefore been sought. Having received this advice, the Chair informed the Committee she intended that the meeting should be held because of the time sensitive nature of the issues to be discussed. Members considered the rationale presented and all supported the proposal that the meeting should proceed.

PUBLIC PARTICIPATION

Stephanie Clark of Healthwatch Tower Hamlets made a submission concerning agenda item 5, 'Update on the North-East London Sustainability and Transformation Plan (STP), highlighting concerns around whether the requirement to consult could be met within NHS England's deadlines for the sustainability and transformation plan STP.

Dr Coral Jones representing Keep Our NHS Public, made a submission in relation to agenda item 4, 'Overview of NHS 111 Integrated Urgent Care Procurement', highlighting issues revealed in a study undertaken by Cambridge University in 2011 which related to the value of the 111 service in reducing emergency visits to Accident and Emergency departments. Dr Jones, noting that the timeframe for procurement of this service in the Inner

North East London NHS area remained at 1 April 2016, asked what steps would be taken by STP to avoid the issues revealed by the local study and over-reliance on A and E services as a result of 111 calls.

The Chair thanked the contributors for their submissions and advised that the matters raised would be considered as part of the discussion of the respective agenda items.

1. APOLOGIES FOR ABSENCE

No apologies for absence were received.

2. DECLARATIONS OF INTEREST

No declarations of disclosable pecuniary interests were made.

3. MINUTES

The minutes of the meetings held on 7 November 2016 and 17th of November 2016 were presented.

RESOLVED:

1. that the unrestricted minutes of the meeting held on 7 November 2016 be approved as a correct record of proceedings.

2. that the minutes of the meeting held on 17 November 2016 be approved subject to the following amendments:
    - that the apologies of Councillor Mustaquim be noted
    - that the question from Councillor Masters which was omitted regarding the capacity for elective surgery and how this was quantified be added to the minutes; and the NHS response to this question be pursued and appended to the minutes.
    - that the amendments be incorporated into the finalised document.

4. NHS 111 SERVICE

Archna Mathur, Director of Performance and Quality NHS Tower Hamlets CCG, Selina Douglas Deputy Chief Officer Newham CCG and Henry Black Chief Finance Officer NHS Tower Hamlets CCG attended to discuss the report which provided an overview of NHS 111 Integrated Urgent Care (IUC) procurement. Ms Mathur provided an overview of the intended procurement for NHS 111; which was to be rolled out in February 2018. Service specification and vision for the wider IUC services were presently under consideration.

The Committee was informed that the 111 service:

- concept was born out of work carried out in 2014 and aimed to ease pressures in the system. The PowerPoint presentation circulated in the agenda set out how the services will mirror the sustainability and transformation plan (STP).
- was intended to address access to health care issues in the context of significant population growth, significant challenges faced by Accident and Emergency (A&E) Departments and Ambulance services, difficulty in accessing emergency services quickly and patient confusion about when best call 999, GP or other healthcare services.
- was intended to deliver more accessible seven-day primary care and fulfil national priorities.
- would comprise: 111 helpline, out of hours services, extended primary care, urgent care in hospital and urgent community response.
- vision was to provide better access to the named services by providing a single contact number. Patients would be able to speak to clinicians earlier than present arrangements allowed and receive appropriate triage for the services required by the caller based on early access to advice. An additional benefit would be the economies of scale available through the single service model.
- would be regulated through targets and performance monitoring to ensure that pressure on A&E services was better managed.
- call-takers' role would be to establish the patients' circumstances, verify them and make an appropriate onward referral. Noting that feedback from the survey of the general experience of those using the NHS 111 service was mixed, the Inner North East London model therefore would include call-back targets of 15 minutes and this would be tested in undertaking the procurement for the services.

In summary the NHS 111 IUC Service would form the first port for telephone emergency access and involve assessment for appropriate onward referral to clinical or other services. This Service would create a central point of delivery were clinicians, doctors and other professionals were available to give advice.

The Committee considered the report and Dr Jones' submission and this was followed by questions and comments from Members. Ms Mathur representing the CCG responded to Members' questions. These are summarised below and attributed to Members of the Committee at their request:

Questions, Comments and observations:

Publicity and Communications

Ms Mathur responded to Councillor Masters' questions regarding:

- how the service would be publicised to hard-to-reach groups and non-English speakers. She informed the Committee that this matter had also been raised elsewhere and this question will be referred back to the project group.

- how the service would respond to speakers of other languages. She informed the Committee that a language line will provide immediate translation via a three-way conversation between translator professional and caller.

Ms Mathur responded to Councillor Harrisson's question regarding why the Somali community was not using the 111 Service as indicated in the consultation with community groups. She informed the Committee that it had not been well advertised but the effects of the decision to implement locally and nationally at the same time had been recognised.

Councillor Akthar queried whether patients were not using the 111 Service because they didn't know that it was possible to call this number for emergency matters. Ms Mathur acknowledged that effective communication was very important. It was necessary to enable 111 callers to understand that an out-of-hours call to 111 or to 999 would deliver the same service on assessment.

Councillor Akthar noted that should this service be accessed during normal hours, this would be a waste of money.

Ms Mathur responded to Councillor Potter's question regarding what sites had there been community engagement in the City and Hackney. She informed the Committee that this information was not available at the meeting but a response would be provided to Members.

Action by: Ms Mathur, Director of Performance and Quality NHS Tower Hamlets CCG

Potential Risks of the Service

Ms Mathur responded to Councillor Munn's question regarding how (since the provision was intended for out of hours urgent and emergency circumstances) it could be ensured that callers would not use the 111 IUC services to obtain earlier appointments with their own GP. She informed the Committee that a callers' first point of referral would always be the GP surgery. However the 111 IUC service would be applied in circumstances where a caller was unable to access their own GP surgery and the matter was urgent. The purpose of the service was not to create demand but to manage patients' direct self-referrals to hospital A & E. It was intended that care services will deal with relevant onward referrals.

Ms Mathur responded to Councillor Munn's question regarding how demand would be managed and clients prevented from circumventing the system for a GP appointment. She acknowledged that this was a possibility and would be managed by conveying appropriate messages to callers that regular GP services should be accessed in the first instance.

Councillor Munn noted that Hackney health service already operated a call handling arrangement for out-of-hours services. Ms Mathur agreed to investigate what was provided and respond to the Committee.

Action by: Ms Mathur, Director of Performance and Quality NHS Tower Hamlets CCG

Ms Mathur responded to Councillor McAlmont's query regarding whether over-75s and under-twos would be safe under the new service, since these vulnerable groups exited the current arrangements. She informed the Committee that these groups would continue to be safe as they would be immediately spoken to by a GP.

Councillor Hayhurst noted that the proposals would be a step down from the services already provided since in Hackney out of hours calls are responded to by GPs and Hackney A&E services were excellent. In his view:

- The proposal was a step down.
- He was surprised, given the current provision enjoyed, that Hackney services would support the proposals for IUC services.

Ms Mathur responded to Councillor Munn's query whether healthcare professionals would be the first point of contact for all callers. She informed the Committee that there would be a number of trained call handlers to act as first point of call. This is why there will be other clinicians present also to take calls. During the assessment there will be referral to a wider clinical team.

Financial Matters
Ms Mathur responded to Councillor Munn' question regarding how would savings be ensured. She informed the Committee that the new service would reduce costs by reducing inappropriate A and E use and by ensuring that as many 111 callers as possible have answers to their issues earlier in that process thereby saving trips to and the resources of hospital A & E.

Transitional Matters
Councillor Munn enquired how much contact had there been with GPs in relation to establishing confidence about booking GP appointments through the 111 service.

Ms Mathur responded to Councillor Potter's query concerning from where GPs for this service would be sourced. Ms Mathur noted the retention and recruitment issue, informed the Committee these would be sourced through consolidation of existing GP service. It was noted that there were some concerns about numbers realistically; however the STP intended to address these. Also because other clinicians would be involved (e.g. pharmacists to respond to calls about medications) there was scope to answer calls appropriately and such skills could give better suitability.

Councillor Munn noted that the proposals assume that the choices service operates. She also commented that in her view it would be appropriate to

look at what already exists and how this could be integrated into the new provision. Ms Mathur responded that the CCG was in negotiations with City and Hackney to this end.

Ms Mathur responded to Councillors Munn and Councillor Mustaquim's enquiry about:

- timescales
- whether implementation would be phased in or 'big bang' approach.
- how this implementation would be delivered without interrupting quality of services.

She informed the Committee that the new service would begin in February 2018. All new services will be implemented at that time on the basis that the Provider has had learning and has made provision for the transfer to the new arrangements. A test will be added to the staff procurement procedure in this regard.

Purpose/objectives of the new service

Ms Mathur responded to Councilman Mead's question whether the proposed service just a rebranding of NHS direct service. She informed the Committee that the new service would give more flexibility and enable calls to be referred back to GPs.

Ms Mathur responded to Councillor McAlmont's query on whether there will be sufficient resources to ensure that respondents would be able to speak to an appropriate professional for their issue (he contrasted the current circumstances of numbers waiting to speak to a GP). She informed the Committee that the service would be appropriately resourced. The minimum number of professionals present would be; one GP, one paramedic and one nurse. If it were possible to resource calls through a wider hub, then they could be better referred to the appropriate local hub to ensure that confidence remains high. Therefore the service would be resourced from across seven CCGs of N E London to ensure that the workforce was sufficient to make the proposed system resilient.

Ms Mathur responded to Councillor Munn's question concerning whether it was intended that there would be one or multiple providers to deliver one service across the inner in north-east London area. She informed the Committee that the procurement was for one provider for 111 calls across the seven CCG's of the inner North-East London area.

Ms Mathur responded to Councillor Hayhurst regarding whether present GP out of hours telephone numbers would be replaced by the new service. She informed the Committee that the new 111 Service would replace all current contact numbers for out-of-hours primary care. It was intended that the new provision would build more resilience into each local system and future proof the provision. However, where clients needed a face-to-face service this will still be delivered locally. Councillor Hayhurst noted that the present arrangements in Hackney had been rated very good and was concerned that the proposed change would result in a deterioration of the good provision

currently enjoyed by Hackney residents and would be detrimental for Hackney residents.

Performance
Ms Mathur responded to Councillor Harrisson's question regarding whether feedback was already embedded in the system. She informed the Committee that a feedback system was already in use and already embedded.

Ms Mathur responded to Councillor McAlmont's query on whether the call-back targets were achievable. She informed the Committee that the targets were met and standards for responses were built into the metrics. The average call-back time was eight minutes. Additionally, since services would have greater resources, there was confidence that call-backs would be timely. Referring to the submission from Ms Clark, Ms Mathur advised also that the new service would provide greater capacity to meet needs.

Concluding Comments
Ms Mathur advised:

- That the current consultation was almost complete and there were points to take back from the JHOSC engagement but the proposals will consider the area's wishes.
- That the time that remained until the closure of the consultation in February 2017 would enable the INEL JHOSC. Members to take matters of interest and contention back to be discussed by their own local authority.

The Chair confirmed that there would be matters that each local authority representative wished to take back and to discuss with their own area health scrutiny bodies

The Chair thanked the CCG representatives for their presentation and report.

RESOLVED

1. That the report presented and discussion on the overview of NHS 111 integrated urgent care procurement be noted
2. That that issues raised at the meeting relating to specific local authority matters be referred back to the originating local authority by be relevant INELJHOSC Member.
3. That any further local comments be referred back to the CCG by the consultation closing date of 28 February 2017

5. UPDATE ON NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

Nicola Gardner Programme Director, North-East London Sustainability and Transformation Plan, (STP), July Low, Director of Provider Collaboration North-East London STP and Ian Tomkins, Director of Communications and

Engagement North-East London STP introduced the report and presentation which provided an update on the development of an STP in the North-East London NHS area. This set out how the NHS five-year forward view would be delivered and health and care services will transform and become sustainable and be built around the needs of local people.

Mary Burnett (a former social worker) and Terry Day (Formerly a Non-Executive Member of Whipps Cross Hospital; Board) representing North-East London Save Our NHS made the following representations:

- STP representatives were asked to justify the approach that had been taken in delivering the STP, in the context of the statement made by Stephanie Clark regarding the requirement for formal consultation when considering a substantial variation in service provision (such as that proposed in the NELSTP) and
- asked JHOSC to consider if this this requirement can be met within the timeframe notified by NHS England (namely that the STP was to be signed by December 23rd 2016).
- Ms Day although not arguing against the integration of community care put forward that the overall financial deficit will counteract the intended benefits of the plan and, coupled with the expected population increase, it was not credible that the STP could deliver its intended benefits.
- Ms Burnett noted:
    - That the NHS plans are not quantified and NHS providers are being forced into the transformation program in order to gain access to funds.
    - The proposal for a whole system change in the period proposed was not achievable.
- Ms Day put forward:
    - That it was necessary to test the provision before bed-base is reduced. This testing was not taking place and therefore creates risk in the inherent service delivery.
    - There is no plan to meet the service requirements.

The Committee noted these submissions and the Chair then invited the Programme Director, North-East London STP to make her presentation.

The Programme Director noted the challenges to delivering the STP described by Ms Burnett and Ms Day. She made her presentation informing the Committee that:

- The STP Project Team was presently translating the ideas of the STP into the procurement.
- There would be no sign-off of the plan on 23 December 2016 because feedback was presently awaited.
- Paragraph 6 of the report outlined the plan to deliver a single sustainability and transformation plan across the seven North-East London Clinical Commissioning Groups (CCGs).

- There were eight work-streams including services, property, workforce, and new roles to address short-term and medium-term shortages and IT/ media.
- NHS England was presently beginning to work up proposals and these would require further work over the coming months.
    - Plans were to be worked up by clinicians, local authorities and stakeholders.
    - NHS England was, eager to receive input into the proposals from local authorities and agencies.
- Mr Tomkins acknowledged that notice of the STP had not been communicated in an ideal way. However it was necessary:
    - to continue to progress the project and
    - to enable people to understand the aims and content of the STP and the difference it will make to services.
- Attitudinal and behavioural change was required and therefore NHS England was looking to engage with groups (especially to hard-to-reach groups) to communicate to this change.
- In order to achieve communication they needed to connect the networks and to publish more information on the website.

The Programme Director further informed the Committee that:

- She was eager to make plans available to the public therefore these had been published in advance of the NHS recommended dates.
- Where significant changes to services were required, she was determined that these changes would be informed by consultation.
- The STP was not a constituted body but has a governance board to ensure that there is participation in the programme.
- Financial challenges would need to be met and the financial gap closed by the following:
    - By noting the savings being worked towards,
    - Collaborative back-office roles,
    - Focus on community and out-of-hospital care.
- Transformation of STP is a condition of access to funding.

The Committee considered the report and public submissions and this was followed by questions and comments from Members. These are summarised below and attributed to Members of the Committee at their request:

Questions, Comments and observations:

Revised sign-off deadline

Ms Gardner responded to Councillor Harrisson, who noted that historically the NHS undertook its annual planning in a cycle ending 31 March, and asked

- for clarification of what was to be signed off on 23 December 2016 and
- its value.

Ms Gardner informed the Committee that NHS England had instructed that the date to be brought forward by three months to give a period of stability. The deadline applied to contracts between the CCG's and hospitals; each

organisation had its own operating plan which must also be signed off. It was noted that this signature related to plans for future years.

Scope of the Procurement
Mr Black responded to Councillor Munn's enquiry regarding what contracts will be put through TST in the coming year and Councillor Sweeney's enquiry as to what order the contracts would be placed. He advised the Committee that the initial phase would involve the following areas:

- outpatient redesign,
- diagnostics/unnecessary testing,
- improving access to GP specialist advice.

Other plans would continue to be developed but would not be signed off on 23 December 2016. He noted that, on the deadline date, even the above areas notified might not be signed off in their final form.

Latent consequences
Ms Lowe responded to Councillor Sweeney's question whether STP representatives could guarantee that latent financial facts would not be created that might later come to light and force a particular service on an irreversible path. She advised the Committee that that most of the arrangements related to intra-NHS services. The STP was a five-year programme and the plan required many more consultations to be undertaken. The advantage of implementing an early deadline was that savings will be identified and agreed on 23 December and foster a period of stability during which the budget will be known before its implementation on 1 April. No such facility presently operated.

Data
Councillor Ben Hayhurst noted that no numerical information was presented in the report and argued that the process was therefore based on an assumption. He asked what the decrease figure was. Mr Black responded that:

- The total amount would increase but not necessarily in line with the demographic.
- At present it was not possible to give definitive numbers because contracts were under offer.
- The value of the transformation for Barts NHS Trust was £14 million on a £6 million patch.
- The value for the Hommerton NHS Trust was not known.
- Details of the value of year one of the STP would be provided to members in writing.

Ms Douglas informed the Committee that local CCGs possessed this data as the offers had originated with them.

Action by: Mr Black, Chief Finance Officer NHS Tower Hamlets CCG / Joseph Lacey-Holland, Strategy Policy and Performance LBTH

Responding to Councillor Hayhurst's enquiry regarding what were the differences between offers and counter offers Mr Black advised that some CCG's had their own savings plans and made their calculations after the local facility plan. He agreed to provide figures to Members after the meeting.

Action by: Mr Black, Chief Finance Officer NHS Tower Hamlets CCG

Consultation
Councillor McAlmont, referencing the submission from Ms Clark, enquired what the plans for consultation were. Mr Tompkins responded that, at present, the plan was in draft. Once the proposed changes to the services were known, formal consultation would be undertaken.

Mr Tompkins responded to Councillor Harrisson's enquiry concerning what was the threshold for determining significant changes. He advised that STP representatives were not able to answer at present but a response would be provided later. Ms Lowe noted that there was no suggestion that STP in its entirety was subject to statutory consultation but only specific proportions of the plan. At present there were no proposals to undertake any changes which met the threshold to trigger formal consultation.

Action by: Mr Tompkins, Director of Communications and Engagement North-East London STP

Ms Lowe responded to Councillor Masters' comment that consultation should take place at the point where plans were being formed and that in this case however plans were already defined considerably. She advised that the statement was a legal definition of consultation but was not used for the entire STP.

Mr Tompkins responded to Councillor Munn enquired what would engage people on the STP. He advised its about the encompassing process and pulling strands together as the area was very large and covers many diverse services. Ms Gardner advised also that had already been consultation with local health trusts about what the engagement should look like. Councillor Munn further enquired what organisations had been engaged with and Mr Tomkins advised that STP would meet with Redbridge who have been procured for engagement.

Legal/Governance
Ms Gardner responded to Councilman Mead, who noted that on 31 January 2017 local authorities would be asked to sign a memorandum of understanding and enquired how they would be able to do so in the absence of information on costs. She advised that the memorandum of understanding concerned an agreement to work together to develop the STP, in terms of establishing governance arrangements. It was noted that these arrangements were not binding.

Service Resourcing

Councillor McAlmont expressed concern that, under the STP, it would be necessary to deliver efficiencies year-on-year while the population continued to grow. This arrangement implied there would be a cut in resources for services. Through ongoing the years, CCG will return to seek efficiencies which will ultimately result in cuts to frontline services. Therefore it was necessary for TST to have ballpark figures of what savings must be delivered in the current year. He noted that INELJHOSC had been given no information about what cuts were being mandated.

Councillor Hayhurst put forward that if a substantial variation threshold had been crossed, value of the figure suggested would be £540M, equivalent in financial terms, to the closure of the Hommerton Hospital for two years.

Ms Lowe responding to Councillor Munn's enquiry on whether there was information on the consolidation of pathology services, informed Members that pathology was part of the provider productivity work stream and there were issues at Hommerton due to the review in hand. As the STP footprint was too large, there were questions around pathology at Royal London and Queens working collaboratively together which rendered it unlikely that the service would to go to a single pathology provision. Councillor Harrison enquired whether it was necessary to wait for the work to be completed. Ms Lowe advised that the work at Homerton was being reviewed but will continue since it was not reliant on work at other hubs..

Councillor Munn also enquired whether money would be taken from services to plug gaps elsewhere.

Councillor Mbachu, asked that the data requested by Members should be provided as soon as possible by email.

Action by: Mr I Tompkins, Director of Communications and Engagement North-East London STP

Councillor Harrisson requested that the following information be provided:

- In-year devolved financial information on savings
    - against priorities,
    - against CCG,
- how things will be allocated,
- where savings will come from,
- figures year-on-year against timescales, and
- governance.
- how the STP would be segmented to enable INELJHOSC to consider any proposals brought forward in a timely manner.

She advised that INELJHOSC would give engagement but needed appropriate levels of detail so that they can engage with STP effectively.
Mr Black informed Members advised that STP was not a statutory body and was therefore not able to compel any parties to do anything against their wishes. Additionally there was no plan to reassign money.

Action by: Mr I Tompkins, Director of Communications and Engagement North-East London STP

Councillor Mbachu, asked the Committee to examine/investigate whether the STP contained within it, significant variations that that would trigger statutory consultations. In particular she asked for the Committee to consider and determine whether services and proposals were being artificially ungrouped so as not to trigger the statutory consultation threshold. The Chair agreed that the CCG would be requested to specify the elements of the STP.

Action by: INEL JHOSC Members

The Chair:

- summarised the discussion and noted the Committee's intended activities in forthcoming meetings and
- thanked NHS England (STP) representatives attending for their presentation and report.

RESOLVED

1. That the report and discussion on the North East London NHS STP be noted
2. That the data requested by Members during the discussion be provided post- meeting.

The meeting ended at 8.50 p.m.

Chair, Councillor Clare Harrisson
Inner North East London Joint Health Overview & Scrutiny Committee

Inner North East London (INEL) **Joint Health Overview and Scrutiny Committee** 19th April 2017 **North East London Sustainability and Transformation Plan; Governance**	Item No **4**

OUTLINE

Over the course of 2016, health and care organisations across 7 boroughs in North East London (NEL) have been working to develop a draft Sustainability and Transformation Plan (STP). The STP sets out how the NHS Five Year Forward View will be delivered across the NEL footprint and how local health and care services will need to transform in order to ensure their financial sustainability and improve their clinical effectiveness.

INEL JHOSC has requested that NHS partners provide an overview of how the draft NEL STP will be developed through consultation, engagement and scrutiny processes so that the plans are given appropriate oversight and accountability.

This report and its accompanying summary include items covering:

- Governance for the NEL STP

ACTION

- The Committee is requested to give consideration to the report and discussion and provide comments.

This page is intentionally left blank

East London Health and Care Partnership – Update on governance arrangements

Report to the Inner North East London Joint Health Overview and Scrutiny Committee 19 April 2017

1. Background

The launch of the Sustainability and Transformation Plans (STP) process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level. To achieve this, 20 organisations in East London have been working together to develop the East London Health and Care Partnership (ELHCP which previously known as NEL) STP.

The original governance arrangements for the ELHCP STP programme were designed to oversee and direct the development of the draft ELHCP STP document that was submitted to NHS England on 30 June 2016.

Following this submission, the STP moved into the next phase which was planning in detail to develop the next iteration of the ELHCP STP (which was submitted to NHS England in October 2016) and the mobilisation and implementation of the delivery programmes.

A governance task and finish group (including health organisations, local authorities and Healthwatch) was set up to review and update the governance arrangements to reflect this change in focus and to ensure that the governance arrangements remained effective with appropriate membership. Through this group the STP developed a shadow governance structure, and initial terms of reference for the key governance forums.

This governance structure recognised and respected the statutory organisations, while providing the necessary assurance and oversight for system level delivery. In addition to reinforcing some of the existing governance forums (i.e. re-focusing the membership of the ELHCP STP Board), several new bodies were added to strengthen the level of assurance and engagement, most notably:

- ELHCP Community Group – A council of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance
- ELHCP Mayors and Leaders Advisory Group - To provide a forum for political engagement and advice to the ELHCP STP
- ELHCP Assurance Group – An independent group of audit chairs to provide assurance and scrutiny
- ELHCP Finance Strategy Group -To provide oversight and assurance of the consolidated East London (EL) financial strategy and plans to ensure financial sustainability of the EL system.

The ELHCP STP has been operating the governance arrangements in shadow form and will continue to do so until end of March 2017. This shadow working has been conducive to testing, reviewing and updating the governance arrangements.

2. Engagement with Local Authorities

The ELHCP engaged widely with stakeholders to shape its governance arrangements. Engagement with local authorities has been paramount and has been achieved through various forums.

Rob Whiteman, ELHCP Chair attended a joint meeting of all the Chief Executive Officers of Local Authorities to discuss the ELHCP STP including its governance arrangements. This meeting took place on 19 December 2016 and was hosted by Martin Esom, Chief Executive Officer, London Borough of Waltham Forest.

The East London NHS and Local Authority Communications and Engagement event took place on 26 January 2017. Rob Whiteman discussed the ELHCP STP and its governance arrangements with political leaders on 20 February 2017.

The ELHCP discussed the governance arrangements in relation to setting up of the ELHCP Social Care and Public Health Group with the Adult Directors of Social Services, Directors of Children Services and Directors of Public Health on 7 March 2017. The setting up and operation of the ELHCP Mayors and Leaders Advisory Group was discussed with the political leaders on 8 March 2017. In both instances, ELHCP is waiting for the stakeholders concerned to come back with their proposals on how they would like these groups to operate.

Further engagement with local authorities took place at the Communications and Engagement leads STP update meeting on 9 March 2017.

3. Development of the ELHC Partnership Agreement (originally called Memorandum of Understanding (MoU))

The ELHCP developed a draft Partnership Agreement for the governance arrangements of the STP between the health and social care partners. The governance arrangements are shown in **Appendix 1**.

The Partnership Agreement was not legally binding, but was intended to ensure a common understanding and commitment between the partner organisations on the ELHCP STP governance arrangements, specifically:

- The scope and objectives of the ELHCP STP governance arrangements
- The principles and processes that would underpin the ELHCP STP governance arrangements
- The governance framework / structure that would support the development and implementation of the ELHCP STP

This draft Partnership Agreement was discussed at the Partnership Board meeting in October 2016 and updated versions of the Agreement were taken to the November 2016 and January 2017 Partnership Board meetings where further discussion and debate took place.

The Partnership Agreement was circulated to Local Authorities, Trust Boards and CCG Governing Bodies in December 2016 with a request for comments and feedback to be sent by end January 2017.

4. Next steps

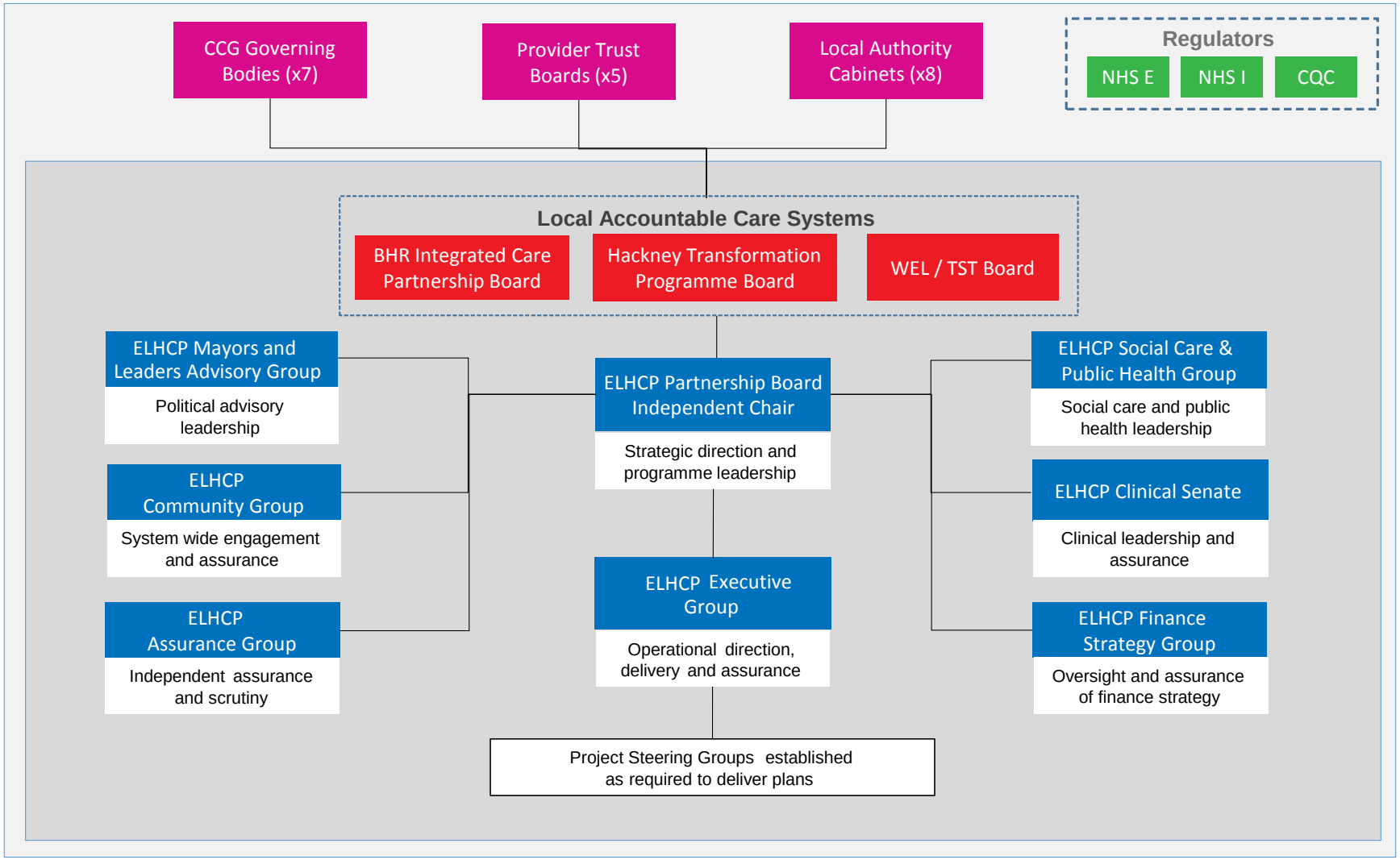
After extensive engagement, the Partnership Agreement has been revised in view of the comments received from stakeholders and the organisations involved in the STP process.

An updated version of the Partnership agreement has been sent to the 29 March 2017 ELHC Partnership Board for review. This will be discussed at the Partnership Board and following approval at the Board meeting, the governance arrangements outlined in the Partnership Agreement will be in place in ELHCP.

This page is intentionally left blank

East London Health & Care Partnership

Governance structure



This page is intentionally left blank

Inner North East London (INEL) **Joint Health Overview and Scrutiny Committee** 19th April 2017 **North East London Sustainability and Transformation Plan; Finance**	Item No **5**

OUTLINE

Over the course of 2016, health and care organisations across 7 boroughs in North East London (NEL) have been working to develop a draft Sustainability and Transformation Plan (STP). The STP sets out how the NHS Five Year Forward View will be delivered across the NEL footprint and how local health and care services will need to transform in order to ensure their financial sustainability and improve their clinical effectiveness.

INEL JHOSC has requested that NHS partners provide an overview of how the draft NEL STP will be developed through consultation, engagement and scrutiny processes so that the plans are given appropriate oversight and accountability.

This report and its accompanying summary include items covering:

- Finance considerations of the NEL STP

ACTION

- The Committee is requested to give consideration to the report and discussion and provide comments.

This page is intentionally left blank

Finance Report to the Inner North East London Joint Health and Overview Scrutiny Committee

April 19th 2017

Index

1. Introduction.

The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

The NHS Five Year Forward View was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care. It has been developed by the partner organisations that deliver and oversee health and care services including Care Quality Commission, Public Health England and NHS Improvement (previously Monitor and National Trust Development Authority).

Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

We want people in East London (EL) to live happy and healthy lives. To achieve this, we must make changes to how local people live, access care, and how care is delivered. During 2016, 20 organisations across EL have worked together to develop a sustainability and transformation plan (STP). This builds on our positive experiences of collaboration in EL but also protects and promotes autonomy for all of the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. We all recognise that we must work together to address these challenges; this will give us the best opportunity to make our health economy sustainable by 2021 and beyond.

We have adopted a joint vision:

1. To measurably improve health and wellbeing outcomes for the people of EL and ensure sustainable health and social care services, built around the needs of local people.

2. To develop new models of care to achieve better outcomes for all, focused on prevention and out of hospital care.

3. To work in partnership to commission, contract and deliver services efficiently and safely.

EL is an area with significant health and wellbeing challenges. Our population is set to grow by 18% in the next fifteen years, and five out of our eight boroughs are in the lowest quintile for deprivation in the UK. Health inequalities are high, with many residents challenged by poor physical and mental health driven by factors such as smoking and childhood obesity. People frequently move around

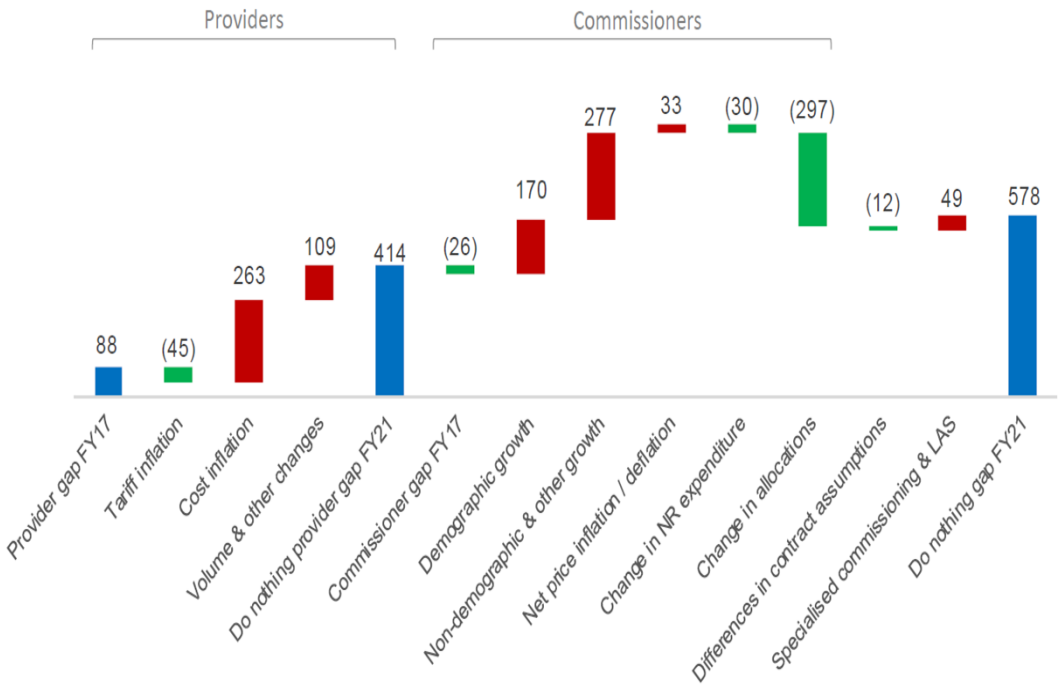
the patch and are highly dependent on secondary care. This makes our challenges unique and places significant pressure on local services.

2. Summary of the Financial Challenge

2.1 Do Nothing Scenario

The forecast EL provider deficit in FY16/17 is c£88m which will rise by £319m to £414m in FY20/21. EL CCGs are projecting a £26m surplus (including carried over surpluses from prior years) but CCG allocations uplifts of £297m are not sufficient to offset cost pressures over the planning period. Differences in contract assumptions net out to around £12m by FY21 overall and specialised commissioning and LAS add a £49m pressure, resulting in a total financial challenge of £578m in the 'do nothing' scenario to reach a break even position.

Achieving a 1% surplus target for commissioners increases the gap by another c£30m to around £610m.



2.2 Do Something Scenario

Our total financial challenge in a 'do nothing' scenario would be £578m by 2021. Achieving ambitious 'business as usual' cost improvements as we have done in the past would still leave us with a funding gap of £336m by 2021. Through the STP, we have identified a range of opportunities and interventions to help reduce the gap significantly.

This will be aided by Sustainability and Transformation Funding (STF) funding, specialised commissioning savings and potential support for excess Public Finance Initiative (PFI) costs. Significant work has started to evaluate the savings opportunities.

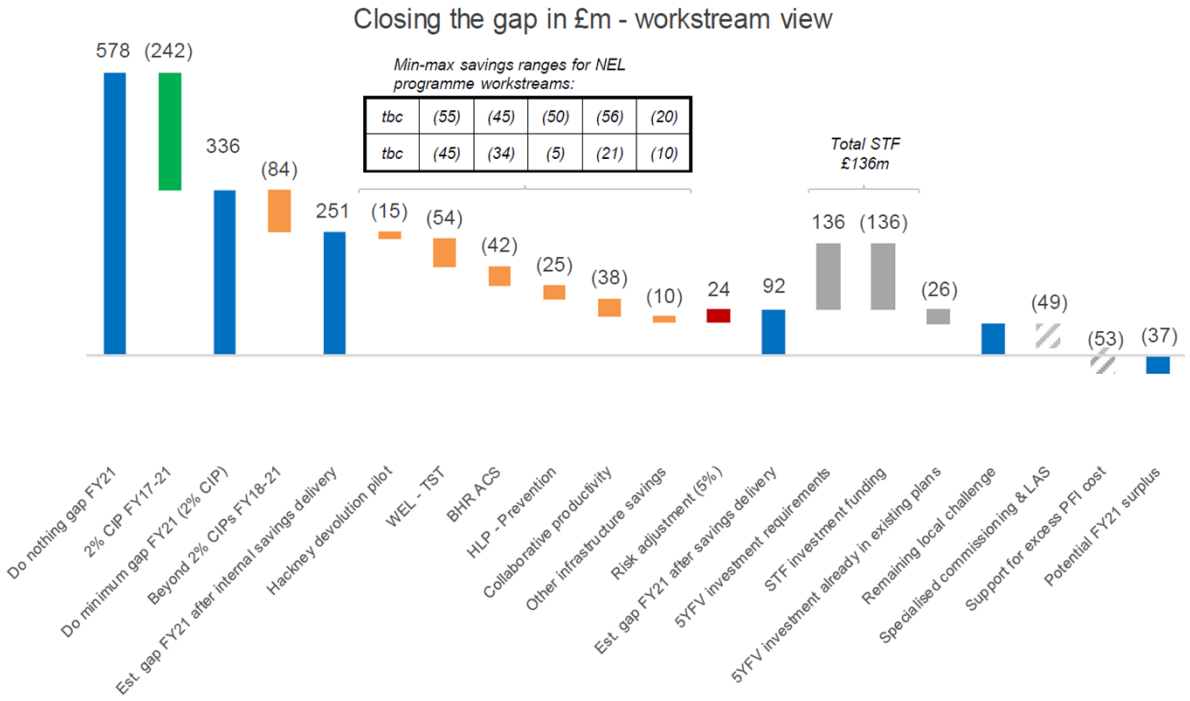
We have developed our governance structures to support the next stages of planning and implementation. Our robust governance structure allows individual organisations to share responsibility while balancing the need for autonomy, accountability and public and patient involvement.

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

Over the course of the last year, ELHCP STP has developed several work streams through which it has identified potential solutions to closing the financial gap.

3. STP Solutions

The ELHCP STP Work streams have been working closely with STP partners to develop solutions to close the gap. Some of those solutions are listed below.



3.1 2% CIP & Beyond 2% CIPs - £326m

Providers are normally expected to deliver business as usual savings of approximately 2%. This is in sync with the expected provider efficiencies within the current tariff guidance and assumptions made by other London STP's. Some providers have put forward CIP schemes over 2%.

3.2 WEL TST - £54m

Transforming Services Together sets out to improve and modernise healthcare services across three London boroughs – Newham, Tower Hamlets and Waltham Forest – addressing inequalities, helping patients take control of their own health and tackling the problems faced by health services across the area.

This area of east London has a growing and ageing population, with 270,000 more residents – the equivalent of a new borough or a city the size of Southampton – expected to arrive in the next 15 years.

TST seeks to avoid a projected deficit across the three boroughs in just over a decade. If no changes are made, 550 more hospital beds would be required, which is unaffordable and not the best way to provide services for local people.

Key TST schemes include but are not limited to:

- Expand integrated care to those at medium risk of hospital admission.
- Put in place a more integrated urgent care model.
- Improve end of life care, improving access, capacity and co-ordination in primary care.
- Establishing surgical hubs including interventional Radiology.
- Establishing acute care Hubs on each site.
- Increase proportion of natural births.
- Transform patient pathway and outpatients.
- Reduce unnecessary testing.
- Deliver shared care records across organisations.
- Explore the opportunity that physician associates may bring.
- Developing a strategy for future of mile end Hospital and Whips cross hospital.

3.3 BHR ACS - £42m

Accountable Care Organisations (ACO) are a new way of structuring health and social care services, which were referenced by NHS England chief executive Simon Stevens in his Five Year Forward View (5YFV).

The partners working together on the business case for an ACO in Barking and Dagenham, Redbridge and Havering are:

- The three local clinical commissioning groups (CCGs)

- Three local authorities – London boroughs of Havering, Redbridge and Barking and Dagenham.

- The acute hospital provider Barking, Havering and Redbridge University Hospitals NHS Trust

- The community and mental health provider NELFT NHS Foundation Trust. They are working together with UCL Partners, an academic and health partnership providing operational support and clinical leadership.

The primary aim is to improve the experience and quality of care for patients and service users by ensuring it is joined up and seamless, and leads to better health and wellbeing for our residents. However, it is clear that there is a major challenge in the coming years for health and social care to be financially sustainable. A key test for an accountable care organisation will be that it is more efficient, helping us tackle some of the financial challenges facing the NHS and local government and protecting the interest of patients and service users.

Key BHR ACO schemes include but are not limited to:

- Gastroenterology Virtual pathway
- MSK Service Re-design
- POLCE
- Dermatology service redesign
- KGH UCC
- Right Care
- Community Health Service re-design
- Acute provider productivity.

3.4 Healthy London Partnership (HLP) Prevention - £25m

HLP was born in March 2015 when London's NHS (32 Clinical Commissioning Groups (CCGs) and London Region of NHS England) agreed to come together using the recommendations set out in Better Health for London as a blueprint to meet the challenges set out in the Five Year Forward View.

A key strength of HLP is its partnership approach, including Public Health England, NHS England, London's 32 CCGs, London Councils and the Greater London Assembly, as well as members of the public and patient groups. We have come together to address the unique health challenges London faces and deliver this transformation.

Our aspiration is based on the belief that a truly great global city is a healthy city. The aim is to take London from seventh in the global healthy city rankings, to the number one spot. We want to make London a place that helps its residents to make healthier choices, improves the health of its most vulnerable, provides consistently excellent care for people when they need it most and enables its health service to prosper and flourish to the benefit of all its citizens.

3.5 Collaborative productivity - £38m

ELHCP STP expects to make significant productivity savings within its providers. Key areas expected to deliver these savings are:

- Bank and Agency spend
- Back office
- Procurement
- Theatre Productivity

3.6 Hackney Devolution - £15m

Hackney devolution is a shared vision of delivering an integrated, effective and financially sustainable system that covers the whole range of wellbeing-from public health initiatives for school children, timely and appropriate access to GP's and community pharmacists and top quality hospital treatment as well as supporting people to remain independent in their community for as long as possible.

Some of the expected benefits are**:**

- Giving parents easier access to immunisation for very young children by providing more community based services.
- Tackling Obesity through better co-ordinated services and greater local powers to create a healthy environment.
- Quicker progress towards parity of mental health and physical healthcare services.
- Providing tailored, more integrated support for people at the end of their life.

4. Conclusion

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

1. **The right services in the right place: Matching demand with appropriate capacity in EL to meet the fundamental challenge of our rapidly growing, changing and diverse population we are committed to:**

- Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care.

- Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary, community and mental health care at its heart.

- Establishing effective ambulatory care on each hospital site and mental health community based crisis care, to ensure our beds are only for those who really need admission, so we don't need to build another hospital.

- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care.

- Addressing demand for acute and mental health inpatient services: streamlining outpatient pathways, introducing new technology, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice, improving psychosis pathways, and encouraging provider collaboration

- Ensuring our estates and workforce are aligned to support our population.

2. **Encourage self-care, offer care close to home and make sure secondary care is high quality We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy:**

    - Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support in localities and hubs from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges.

    - Investing in mental health, community, Learning Disability, & substance misuse services to improve quality and tackle health inequalities. Ensuring parity of esteem and good mental wellbeing, embedding this throughout all of our services.

- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, maximising new technologies and pathway redesign.

3. **Secure the future of our health and social care providers, many of whom face challenging financial circumstances. They are committed to working together to achieve sustainability and changes to our EL service model will help to ensure fewer people either attend or are admitted to hospitals unnecessarily (and that those admitted can be treated and discharged more efficiently):**

    - We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (for example procurement, clinical services, back office and bank/agency staff).

    - The providers are now evaluating options for formal collaboration to help support their shared ambitions.

    - ACS development (CH/BHR devo business cases Oct 31 2016) in development with LA and efficiencies being established.

4. **Improve specialised care, by working together we will continue to deliver and commission world class specialist services. Our fundamental challenge is demand, and associated costs, are growing beyond proposed funding allocations. We recognise that this must be addressed by:**

    - Working collaboratively with NHS E and other STP footprints, as patients regularly move outside of EL for specialised services.

    - Working across the whole patient pathway for our priority areas from prevention, diagnosis, treatment and follow up care – aiming to improve outcomes whilst delivering improved value for money.

5. **Create a system wide decision making model that enables placed based care and clearly involves key partner agencies**

    We are committed to establishing robust leadership arrangements, based on agreed principles that provide clarity and direction to the EL health and wellbeing system, and can drive through our plans.

This will be achieved through genuine partnership between the health system and Local Authorities to create a system which responds to our population's health and wellbeing needs.

6. **Using our infrastructure better**

We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single EL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.

Appendix 1

Summary of Key TST Areas

Efficiency - progress

We recognise the efficiency targets are challenging as is managing the flow of people attending A&Es. However WEL CCGs have achieved the required efficiency savings in the last three years and are on track to deliver the 2015/16 target. New schemes in the TST programme (and others) will continue to ensure we achieve our targets. For instance:

Waltham Forest Integrated Care

Population based approach to systematic risk stratification involving community based intervention(s) for adults according to level of need e.g. planned case management; unplanned care rapid response and psychiatric liaison; GP national & local enhanced schemes; care coordination and self-management.

This has achieved an 18% reduction in unplanned hospital admissions in 2015/16 and £2million health savings which have been reinvested in other service.

Tower Hamlets urgent care

This scheme introduced streaming of people attending A&E and a tariff restructure to encourage urgent care centre (UCC) usage. This resulted in A&E attendances being reduced by c14, 000 and savings of c£3million.

East London Foundation Trust community rapid response

Aims to prevent avoidable emergency admissions and readmissions to hospital using short term intensive packages of clinical and social care and a presence in A&E/UCC. The Service works closely with all care homes in Newham through regular visits.

51% of referrals have prevented an admission to A&E.

Reducing unnecessary testing

Local discussions with clinicians (over 100 attended an event in October) agreed that c25% of pathology tests are unnecessary and 20% of primary care initiated MRI requests could be avoided (as per clinical guidance).

In the first two months, enabling and encouraging GPs not to request Gamma GT tests (which have no clinical value in the vast majority of cases) has saved around £54,000. The test is still available but guidance has been developed and circulated to GPs.

Anomalies in the budget spent on AST tests (£1000/year in Newham compared with £400,000 in Tower Hamlets) suggests that sharing good practice would result in significant savings.

These small changes suggest our target efficiency of £5 million a year is achievable.

Efficiency - Summary

In summary, the increasing demand driven by the existing population and increases in population and the need of that population, cannot be reasonably afforded if provided in the existing model of care and given the expected levels of resource allocation.

In order to continue with the current model of care and cope with this situation, demand would have to be curtailed requiring the rationing of key healthcare services or additional funding would have to be sought from central government. Neither of these options is reasonable or feasible and therefore efficiencies in the delivery of healthcare need to be found.

The acute providers will continue to look for internal cost improvement plans to improve their efficiency in delivering standard items of care, and thereby improve their financial viability.

Commissioners will look to more transformational measures to change the method by which some aspects of care are delivered to move towards more efficient methods.

The Transforming Services Together programme provides an opportunity to significantly improve care provided to our population and will provide a sizeable but not exhaustive proportion of the necessary transformational efficiency measures.

Workforce - Modelling

The current primary care workforce model was developed in June 2016 and addresses the issues highlighted in the TST Strategic Investment Case Part 3 (High Impact Changes Page 41). If we do not change our model of care:

- In Newham, Waltham Forest and Tower Hamlets we would require an additional 195 GPs (over current levels) within 10 years if we do not change the way we work and introduce new roles
- Whilst we have examples of good practice, around 40% of those responding to the GP National Patient Survey report they cannot see a GP of their choice and over 30% find it difficult to get through on the phone
- Up to half of practices in some areas are shut at lunchtime
- Patient experience of GP out-of-hours services is ranked one of the worst in England
- Less than a third of the capital's GPs believe they have received sufficient training to diagnose and manage dementia
- We don't have sufficient career development opportunities for GPs and nurses in training
- Some (particularly single-handed) practices are in premises unfit for modern practice
- We do not have sufficient multi-disciplinary teams
- Rising living costs are making living locally almost impossible
- Many outcome indicators (e.g. for cancer survival and support for people with long term conditions) are in the bottom 20% nationally.

Whilst this paper focuses on the model of care and activity in **GP surgeries** it should be noted that TST and other local schemes describe a range of other activities that are intended to support the GP surgery and wider primary care workforce including:

- the development of multi-disciplinary teams
- the development of proactive care which will identify people at risk and diagnose patients more quickly - reducing the burden of disease on both patients and the NHS

- support for helping people to lead healthier lifestyles, support to put patients in control of their own care and to self-care

- shared care records and interconnectivity between primary care and between primary and secondary care - reducing time spent in gaining health histories, reducing the need for repeat tests, enabling people to be treated more quickly and providing more opportunities to access the primary care system

- more opportunities for innovative ways of conducting appointments e.g. online, by telephone or by video - reducing the need for face-to-face services

- the development of federations of practices and hubs which will increase back office efficiency and be able to offer more services in one place

- cross-system recruitment and retention schemes into new and existing careers, to make east London a destination for a highly skilled workforce

- provision of key worker housing

- financial incentives for staff e.g. support with student loans

- flexible working options

- Improving career development opportunities.

Activity shifts and workforce numbers in GP practices

In order to meet the demand within GP practices and the expected reduction in available GPs we will need to shift activity from GPs to other, more appropriate and more efficient roles.

PRIMARY CARE DEMAND							
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Baseline Activity (incl growth)	4,641,745	4,732,256	4,817,936	4,914,155	5,020,515	5,126,353	5,230,997
Shift to Pharm/Com	0.00%	2.96%	4.00%	5.00%	6.00%	8.00%	9.00%
Shift to Self Care	0.00%	1.85%	2.96%	4.07%	5.60%	6.70%	7.41%
TST Shift to 1ry Care	0	0	9,331	53,174	63,507	74,046	84,793
1ry Care Workforce		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Activty % to GPs	80.0%	79.5%	74.0%	72.0%	64.8%	61.7%	59.4%
Activty % to nurses	20.0%	20.0%	24.0%	24.0%	26.0%	26.0%	26.0%
Activty % to PAs	0.0%	0.0%	0.0%	0.0%	3.2%	4.3%	5.6%
Activty % to Pharm	0.0%	0.5%	2.0%	4.0%	6.0%	8.0%	9.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL Activity		4,732,256	4,827,268	4,967,329	5,084,023	5,200,399	5,315,790

Table 1: Activity Shifts within (and from) GP practices. June 2016-2021

*Pharm/com is activity shifting to pharmacists in the community and other community-based staff.

The model describes a shift of activity to Physician Associates (PAs) and Pharmacy and Community Workers where (in 2021) GP activity is reduced by 20.1%. This reduction is made up by an increase in activity taken on by nursing of 6%, Physician Associates 5.6%, and Pharmacy of 9%.

The model integrates the activity described above with the number of staff required:

- Using a baseline for activity within GP practices as 80% for GPs and 20% for Nurses (including administration and clinical duties).
- using efficiencies based on local statistics and tested locally with clinicians including a 26% reduction in 'Did Not Attend' (DNA) rates (which waste GPs time) over five years – to be tackled by quality improvement initiatives such as text reminders, more proactive care and better management of the issue
- building in an increase in the number of 'longer appointments'
- using data from focus groups that has shown that around 30% of the GP workload can be transferred to other health and social care professionals (e.g. treating coughs and colds)
- Using national data that indicates that around 11% of a GP's time is spent on administrative tasks such as filling in data returns.

The data shows that an additional 81 clinical staff and 23 administrative staff would need to be in place in GP surgeries to meet the activity shifts set out in Table 1. We are already building the supply for physician associates and pharmacists to meet this challenge.

Staff Required - Post TST productivity/efficiency savings							
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**Change from 2015-16**
GP	601	559	532	477	454	445	-156
Nurse	158	206	211	214	207	220	+62
PA	0	0	0	24	33	44	+44
Pharmacist	4	16	33	49	65	73	+69
Locum	0	0	0	0	0	0	0
Admin	133	134	135	137	137	138	+5
Community	25	35	45	55	75	87	+62
Senior Admin	0	4	7	11	14	18	+18
TOTAL	921	954	964	967	986	1025	+104

Table 2: GP Surgery Workforce Modelling June 2016-2021 based on activity shifts in Table 1 and efficiency savings

*Due to different data extractions, 'Community' currently includes healthcare navigators, medical assistants, physician associates etc. but in later years physician associates have their own line.

Healthy London Partnership (HLP) Modelling

We have been working with Healthy London Partnership (HLP) across Waltham Forest, Newham and Tower Hamlets and had two initial workshops in October 2016 to build on the existing workforce modelling.

This process builds on national data and, working with local clinicians, we will model current efficiencies and those being proposed; and then look at how these ways of working can be used to introduce new roles or reassign roles to reduce workforce gaps. Initial efficiencies include the use of telephone appointments and benefits in practices that have multi-disciplinary professionals.

The initial modelling from HLP with a 'do nothing' plan shows a consistent picture with the TST modelling. By 2021 if we do nothing we will have a shortage of 122 GPs. Assumptions made are that 15% of GPs over 55 will retire by 2021, (29% of GPs are aged 55 and over), a population increase in WEL of 76,000 to 2021 (8%) and that we recruit available GPs in line with current London levels.

Analysis shows a gap in the nursing workforce required if we do nothing and this gap is likely to increase as in Waltham Forest 52% of the workforce is over 55 and in Newham 43% of the workforce is over 55.

HLP has highlighted significant differences in baseline numbers of staff across the TST footprint. Tower Hamlets has a lower than the national average of patients per GP and nurse, but Waltham Forest and Newham have higher numbers of patients per GP and nurse.

Training posts and careers

Work is ongoing to map and review training posts and pilot posts to see where training takes place. The data suggests that to deliver a sustainable model we will need to encourage mid-size and smaller practices to provide training as well as large practices to build sufficient capacity and a system to train the workforce of the future.

We are working with colleges to encourage careers in health and build pathways into new roles. We are developing a careers and jobs portal to signpost job seekers to posts and career pathways available in the CCGs.

Workforce - progress

Physician associate at Allum Medical Centre

Allum Medical Centre in Waltham Forest has used a physician associate as part of a range of innovative changes to the way practice staff are working. By sharing the workload the practice can see more patients. The physician associate sees more than 100 patients a week so the patient list size has increased by more than 1,000 without the need to employ more GPs. The practice offers up to 120 same-day appointments each day.

Physician associates programme

The business case was developed in January 2016 to move this project forward and a steering group and a clinical lead appointed. A new curriculum for a physician associate (PA) role in primary care has been developed (other PA roles have been successfully based in secondary care).

- Recruitment is taking place in November 2016 with students starting the two year course in January 2017.

- The CCGs have agreed a matched funded sponsorship arrangement for the first cohort of 24 students for second year fees on successful completion of year 1.

- An engagement event with GPs across TST in September 2016 to discuss the placement and training requirement for physician associates resulted in all 24 placements being filled with an even split across the three boroughs.

- In conjunction with GP practices we are developing posts for successful candidates.

In addition we are looking at developing alternative methods of training to give future cohorts different options to undertake training. Twenty GPs in the TST footprint have signed up as prospective employers to start development of a higher level apprentice standard for physician associates. We will explore different funding streams from Health Education England and providers as this system develops from April 2017 which could allow us to have a flexible employment and training model to sustain the role, and multi- disciplinary teams in primary care across TST.

Pharmacists in GP practices

We have a three year pilot funded by Health Education England (HEE) of 13 pharmacists in Newham GP practices. Further funding has been made available from the GP Five Year Forward View to increase numbers for April 2017. Feedback from practices in the pilot is that this role allows GPs to increase clinical time.

We have two events in November to promote new ways of working and for community pharmacists to shape working practices and roles in GP practices and primary care.

We will be introducing a rotation scheme for pre-registration pharmacists into primary care and GP practices, and an agreed discharge pilot scheme for pharmacy to support patients with respiratory, diabetes and cardiovascular problems. Both schemes are scheduled to start in April 2017 and will see pharmacists working with patients from secondary to primary care.

Practice nurses and support within GP surgeries

We have 26 GP practice nurses in training posts in Newham, Tower Hamlets and Waltham Forest. The Community Education Provider Networks (CEPN) are co-ordinating work to retain nursing staff in the area from this cohort. Recruitment for the January 2017 intake is ongoing through the CEPNs for similar numbers of nursing staff.

There are two other initiatives to build the nursing multi-disciplinary workforce:

- A nursing pilot for rotational nursing posts between acute and primary care will be recruited to – for commencement in January 2017.

- North East London Foundation Trust (NELFT) has just been selected as a pilot site for new nursing associate roles. These posts will start in early 2017 and be based in secondary care (at NELFT), with placements in primary care to be developed.

Workforce - Summary

In order to meet the shortfall of supply of GPs in EL, (high retirement rates and a shortage of available new GPs) and to develop a more efficient, patient-centred service, we will need to develop and increase the numbers of practice nurses, physician associates and pharmacists to provide a full multi-disciplinary team (MDT) workforce model. We are currently on target to deliver physician associate training placements in 2017 and a workforce supply in 2019. We have a pharmacist pilot programme in Newham GP practices and will look to expand this across TST in 2017-18.

This, combined with ensuring that we continue to develop and deliver portfolio careers and flexible employment options for GPs, will allow us to develop our multidisciplinary teams in GP practices.

This page is intentionally left blank

Inner North East London (INEL) **Joint Health Overview and Scrutiny Committee** 19th April 2017 **North East London Sustainability and Transformation Plan; Digital Enablement (IT)**	Item No **6**

OUTLINE

Over the course of 2016, health and care organisations across 7 boroughs in North East London (NEL) have been working to develop a draft Sustainability and Transformation Plan (STP). The STP sets out how the NHS Five Year Forward View will be delivered across the NEL footprint and how local health and care services will need to transform in order to ensure their financial sustainability and improve their clinical effectiveness.

INEL JHOSC has requested that NHS partners provide an overview of how the draft NEL STP will be developed through consultation, engagement and scrutiny processes so that the plans are given appropriate oversight and accountability.

This report and its accompanying summary include items covering:

- How digital technology will support initiatives to help health, social and community care providers meet the needs of local people.
- How digital technology will enable the development of new, sustainable models of care to achieve better outcomes for all; focused on prevention and out of hospital care

ACTION

- The Committee is requested to give consideration to the report and discussion and provide comments.

This page is intentionally left blank

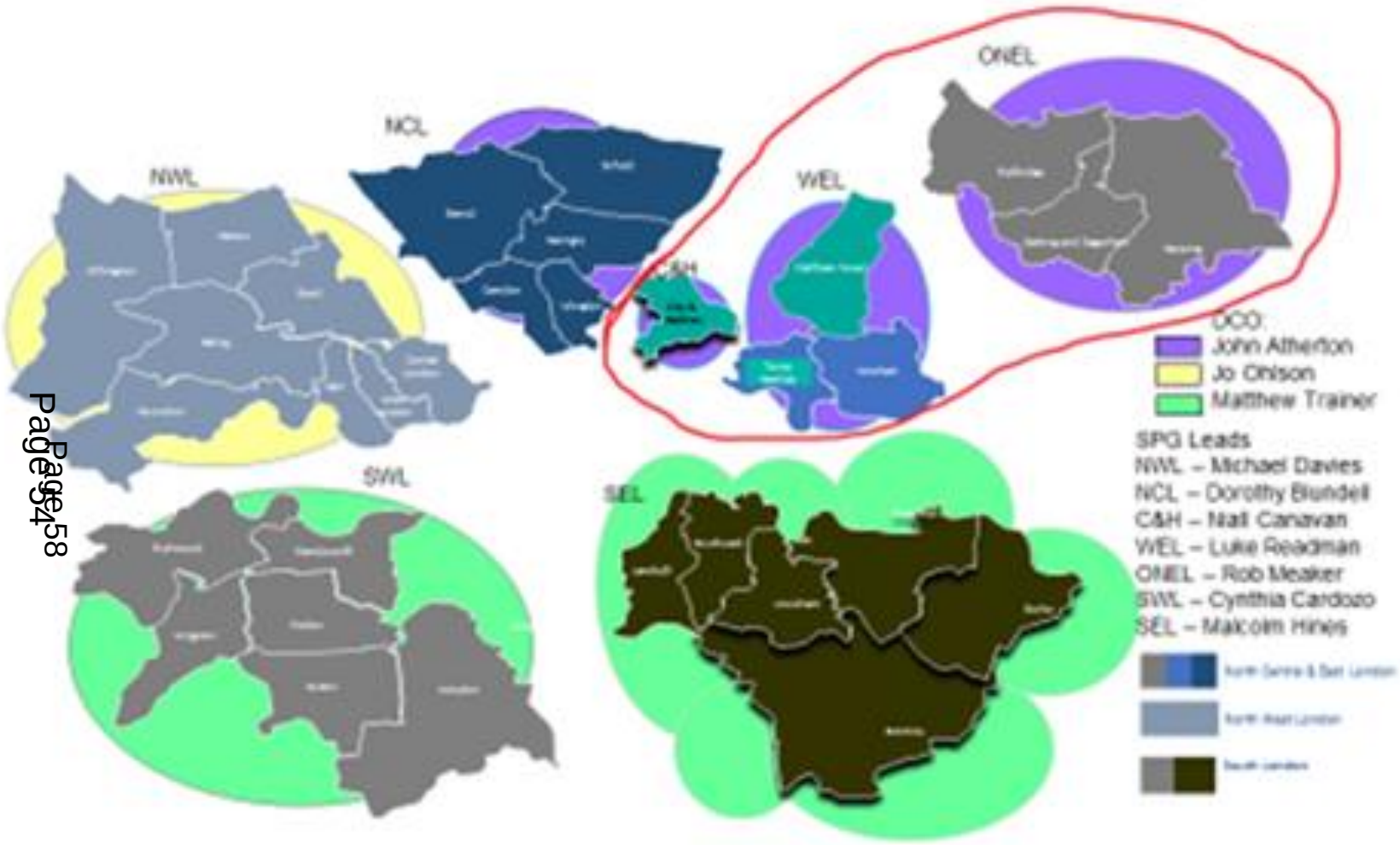
East London Health & Care Partnership

East London Health and Care Partnership STP

Digital Enablement

Report to the Inner North East London Joint Health and Overview Scrutiny Committee – Wednesday 19 April 2017

Digital Footprints – Strategic Planning Groups



Having originally settled on three Local Digital Roadmap (LDR) footprints before the STP footprint was created, we are now in the process of bringing together the three into one LDR. This presentation focussed on the City & Hackney and WEL LDRs

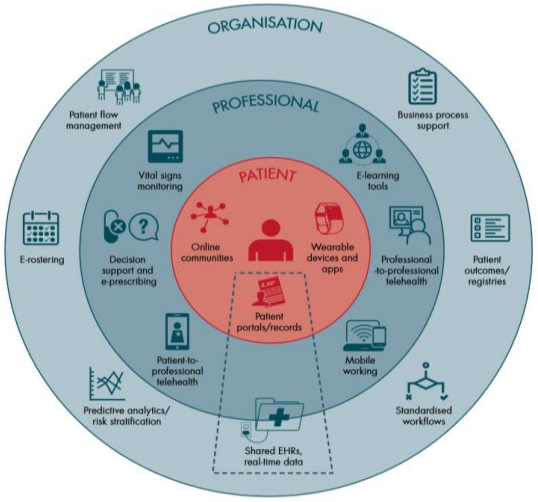
Current situation

The fact that there are three different LDR footprints within the one STP means that, while strategic goals are aligned across the STP footprint, there will be differences in the tactical delivery mechanisms used to meet the strategic objectives. There is clearly more synergy between the C&H LDR footprint and the WEL LDR footprint because both are centred around Health Information Exchange (HIE) as a record sharing mechanism, both are almost entirely EMIS GP based with significant EMIS Community use and both are committed to the same advanced analytics project for Population Health.

BHR have a strong track record in the delivery of innovative and forward-thinking technology that supports the NHS future priorities and directly aligns to patient and user outcomes. Their LDR builds on their substantial existing developments and learning from delivering complex technology solutions across BHR.

The London NHS IUC Patient Relationship Manager pilot, which uses the telephone number to retrieve crisis information, care plans (including end of life plans) and Special Patient Notes and enables sharing of this key information with LAS, is expected to be used across the footprint.

There are clearly opportunities to learn from the experiences of each other as all the LDR footprints begin to work more closely over the next few years within the STP footprint.



Patient centred information

From the Nuffield Trust report, 'Delivering the benefits of digital health care'

IT's about supporting transformational change

IT is rightly recognised as a key enabler to the transformation plans that are underway and planned. The work currently underway in WELC has been devised and planned after significant discussion and development work with clinicians and other system leaders to ensure that the information and technology needs of those caring for patients are met. Patient engagement events have also taken place over recent months that have identified transformational change that needs to be underpinned by IT.

The aims of reducing hospital admissions and enabling populations to better care for themselves are underpinned by providing citizens with better access to their own information and to support early intervention through the use of advanced analytics.

It is recognised locally that the ability to view patient information across the various care settings, however it is achieved, leads to improved:

- patient safety – supporting safer and more informed treatment by providing care professionals with timely access to accurate and up to date information
- efficiency – reducing the time, effort and resources required to obtain relevant information regarding patient care, e.g. reducing repeat tests
- effectiveness – supporting the delivery of appropriate care to patients
- patient experience & engagement– reducing the need for patients to recall or repeat their medication information and supporting people with difficulties communicating, and helping patients to be better engaged in their care

Within WELC these transformational aims have been recognised and are supported by many initiatives such as the east London Patient Record (eLPR), Patient On-line, EMIS to EMIS sharing, MIG, SCR, EPS, e-referral, etc., all of which have a significant IT ingredient but more importantly require the business change support that has been supported locally and for which additional funds are being sort via ETTF.

Initiative map

Our approach

There are a wide range of programmes that support our aim of supporting the delivery of care and reduction in use of services through the use of digital technology. These are outlined in our narrative plan for north east London. As the three LDRs come together we will agreed the best level at which each programme should be led and delivered within the health system. This process has begun based on the partnerships and scale required to best implement the specific programmes, using the following rationale for choosing to progress an initiative at a particular level:

1. There is a clear opportunity / benefit in doing it jointly (which is above and beyond what would be achieved through a local programme), to deliver improvement in terms of enhancing the offer, finance, quality, or capacity;
2. Doing something once is more efficient and offers scale and pace;
3. Collective system leadership is required to make the change happen.

We set out these different levels below.

ELHCP STP Level

- Patient access to records is in some ways down to GP and provider level but public awareness and EL level communication plans can be co-ordinated
- As Shared Care Records systems mature they will be joined and provide benefits across the STP and feed into the wider London information exchange

Local Area Level

- Shared care records are currently being achieved at LDR level, although WEL and C&H have connected their primary sharing systems (HIE) and are increasingly working as a single digital footprint
- Population health plans currently exist at LDR level although again WEL and C&H are working on the same programme (Discovery), while BHR is developing its Health Analytics product

CCG / Borough Level

- BHR CCGs act as one collaborative organisation for Digital. GPIT decisions are made at CCG level, although combined where economies are available
- Individual organisations make their own investment decisions for IT systems, bearing in mind the LDRs

London-wide

- Sharing EoL care plans across London (Coordinate my Care)
- Patient consent
- Elements of patient access to their record, such as a common consent model
- Citizen identity
- N3 replacement
- Digital Mental Health

Delivery Plan on a Page

Vision

Digital Technology will:

- *Support initiatives to help health, social and community care providers meet the needs of local people through shared records and access to information, built around the needs of local people*
- *Enable the development of new, sustainable models of care to achieve better outcomes for all; focused on prevention and out of hospital care*

Background and Case for Change

As laid out elsewhere in this document, transformational change is key to providing health and care services in EL over the coming years. The NHS has accepted the challenge of being paper-free at the point of care by 2020. We will accord priority to quickening the pace of appropriate digital technology adoption within our organisation, realigning the demand on our services by reducing the emphasis on traditional face to face care models. We will explore new digital alternatives that will transform our services, with the aim of shifting the balance of care into our communities, enabling new integrated digital outpatient services and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will continue to build on advanced analytics population health management technologies, utilising opportunities for real time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients in a more sustainable way.

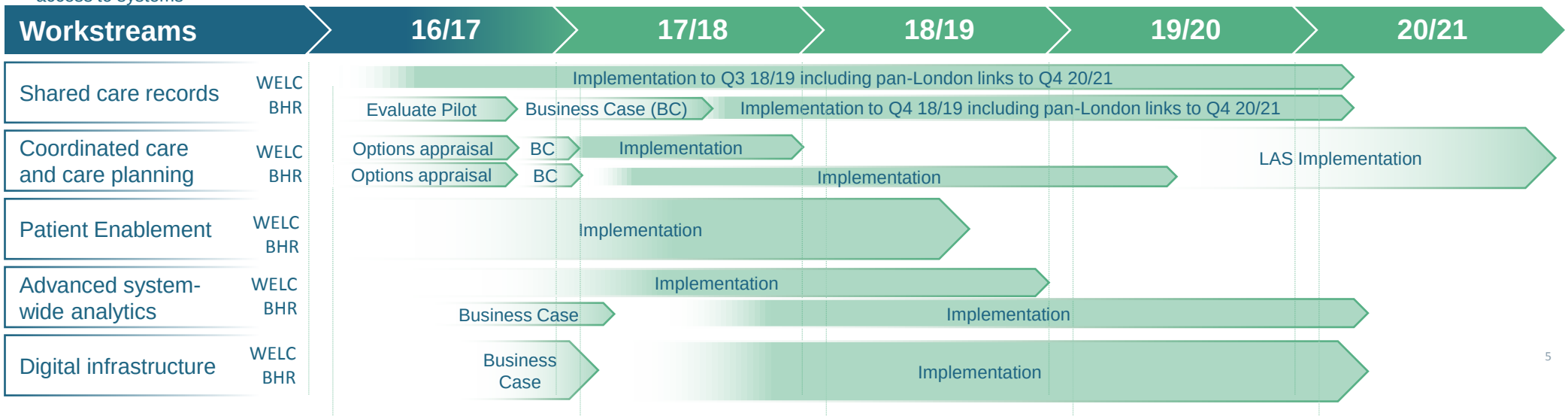
Priorities and Objectives

- **Shared care records** enhancing collaboration - Providers will collaborate with health, social and community care. Systems will therefore need to be interoperable to allow for providers from primary, community, social and secondary care to work together
- **Coordinated care and care planning** to enable more efficient transfers of care, reduce safeguarding risks and support safer and improved management of patients in crisis.
- **Patient Enablement** - Patients require the ability to view their own health records and care plans, book appointments with their GP and, eventually, the wider health and care system, and have greater access to services online.
- **Advanced system-wide health analytics** is needed to provide insight and prompt early interventions to enable informatics driven health management programmes; Population Health. Our health system will need to be proactive at preventing patients from escalating ill health and our interventions will need to be evidence-based. At present, each CCG has separate BI tools which are generally used for analysing corporate performance. This initiative will provide game changing health data analysis
- Ensure that the **digital infrastructure** across the footprint is up to the job of supporting reliable, fast access to systems

Expected Impact

It is recognised locally that the ability for professionals and patients to view and share patient information across the various care settings, leads to improved:

- Patient safety – supporting, safer more informed treatment by providing health and social care professionals with timely access to accurate and up to date information.
- Efficiency – reducing the time, effort, cost and resources required to obtain relevant information regarding patient care, e.g. reducing repeat tests, and transfers of care.
- Effectiveness – supporting appropriate care to patients, elimination of duplicate or unnecessary testing and unnecessary paperwork and handling.
- Patient experience & engagement– reducing the need for patients to recall or repeat their medication information and supporting people with difficulties communicating, and helping patients to be better engaged in their care.



Summary of provider trust capital investment required in 17/18

The table below shows the capital investment identified by each trust as needing funding in 2017/18:

Trust	Capital Cost (£000's)
Barts Health	10086
BHRUT	2770
ELFT	1100
Homerton	1438
NELFT	1017
Grand Total	**16411**

This summary table needs to be verified with each trust.

The table below shows the capital investment identified by each trust as needing funding in 2017/18, broken down into the digital work streams or programmes:

Digital Work stream	Capital Cost (£000's)
Digital infrastructure	15811
Shared record	600
Grand Total	**16411**

This summary table needs to be verified with each trust.

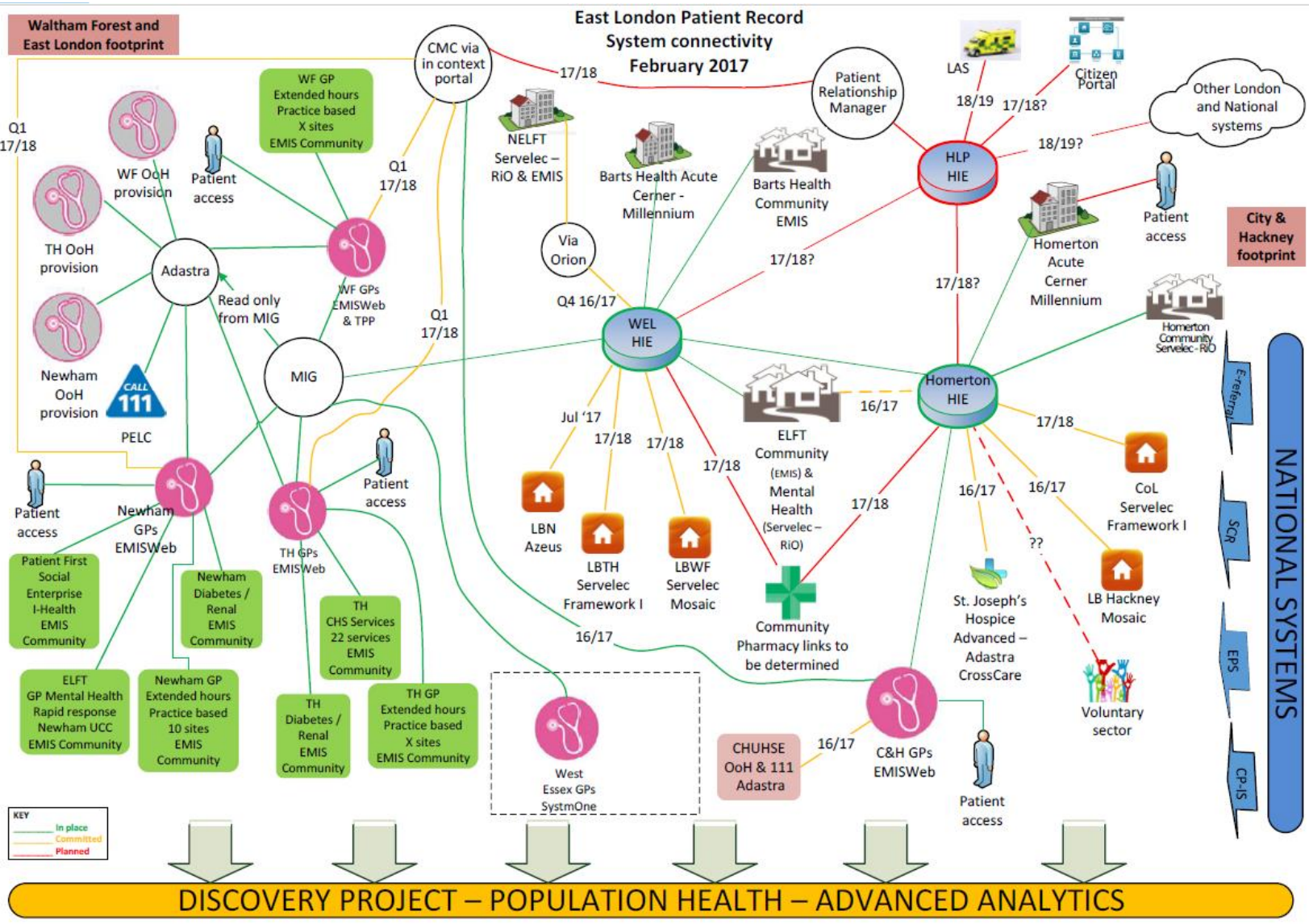
Shared care record

Current situation

The integration between Cerner Millennium and EMIS, for example, has delivered proven integration and secure connectivity which has successfully delivered the following functionality:

- A GP record summary containing 10 pages of patient data is available to Homerton clinicians, including recent advice given, real-time medications, current conditions, allergies and alerts. This is presented by MIG/HIE as a page within Cerner Millennium with tabs for each section of the record.
- Future appointments, radiology results, pathology results and discharge summaries for Homerton patients are viewable by GPs.
- System integration and patient matching between primary and secondary care for practices using EMIS.
- Approval and sign-up to data sharing for all relevant organisations across City & Hackney
- The electronic transition of discharge summaries and other communications through the BT Spine using MESH, a collection of national applications, services and directories, replacing post and fax.

In addition to the work using the east London Patient Record (eLPR), additional sharing capabilities are achieved through the direct sharing between the GP and the Community versions of EMIS, and from other systems such as Adastra via the MIG.



Next steps

As can be seen from the diagram above, a significant amount of work is still planned (amber & red connecting lines) in terms of interoperability of systems via the Homerton and Barts Health HIE platforms. Already connected in 2016/17 is Barts Health's Cerner HIE system. ELFT's RiO EPR, St Joseph's Hospice's Crosscare, CHUHSE's (OoH provider) Adastra, the City of London's CoreLogic and LB Hackney's Mosaic Social Care systems will all follow before the end on 2016/17. This will deliver an increasing richness to the views available to the wider footprint to the benefit of patients. In the second half of 16/17 work will commence on integration with the advanced analytics Discovery Programme and with the HLP Shared Records hub for which a programme of work is currently being drawn up. An Information Sharing Agreement has been put in place across C&H that will facilitate the sharing of third party data via HIE, e.g. GPs seeing LB Hackney data, ELFT seeing GP data, etc. Beyond this, it is expected that most additional connectivity will be achieved through the HLP HIE layer, such as other organisations connecting for care record exchange from 17/18, the use of a cloud-based Patient Relationship Manager to support IUC in 17/18 and LAS in 18/19. A pan-London consent model is vital for this.

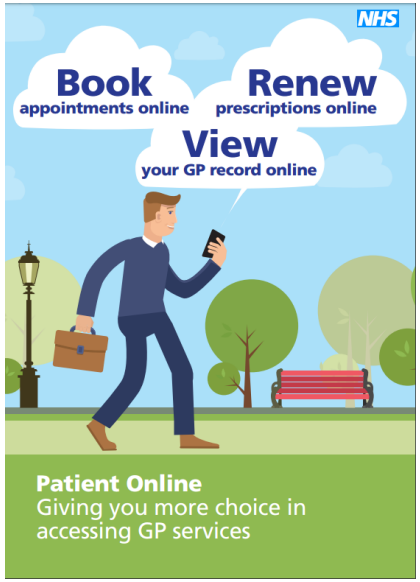
Patient access

Current situation

As a result of the NHSE Patient On Line project, the primary clinical systems (EMIS) in all C&H GP practices are configured to allow patients access to their detailed record, order repeat prescriptions and book appointments with GPs, all online. As with most of the country, take-up of these services is very patchy. Current figure show a poor take-up of the service across the board, with only one practice with more than 30% of their registered patients assigned an account. Some practices, although having small numbers registered are clearly targeting those needing frequent appointments.

As is the case in the rest of the country, a significant issue with the take-up of the service is the number of appointments available for booking on-line. Most practices offer a very small number of appointments because the fear dis-advantaging those unable to access on-line, although two offer over a third. In turn, this discourages those that would make use of the service as, whenever they try to book, there is rarely, if ever an available slot in the timeframe they are seeking.

In addition to this access, all practices send patients SMS text messages as appointment reminders in an attempt to minimise DNA's. Some practices are also able to handle replies.



Next steps

Discussions are underway with EMIS and with the London Digital Programme around developments that will allow patient access to their record from a single source, albeit in multiple forms such as via smartphones, tablets or PCs.

EMIS are looking to develop their existing web application to allow it to pull through data supplied via HIE. This would have the considerable advantage of a simple message being given to the public about how to access all their health records. A potential interim step will be to deploy Cerner's HealtheLife product at the Homerton allowing patient consultant interaction , patient self service, and electronic forms completion e.g. Pre-operative anaesthetic assessment self-assessment. The option of providing patients with access directly to a subset of HIE is also being explored.

The final alternative approach is to await the developments proposed by the LDP. At the time of writing there is no clarity around exactly what would be offered and when it might reach the level of functionality likely to be achievable through the EMIS web site. C&H will co-operate with LDP developments while continuing to work with Cerner & EMIS.

C&H have rolled out the 'Co-ordinate My Care' care planning tool that will allow patients and their carers to actively contribute to, and view the contributions of professionals, to their care plans, initially for End of Life. WEL have just made the same decision

In addition to allowing patients access to records, other digital technology can be used to interact more effectively with patients. For example, the 'eConsult' online triage service is currently being assessed as part of a GP Confederation led approach to Demand Management for GP services.

Primary care transformation

CCG primary care and estates teams are in the process of determining exactly how they will meet the requirements for extended access by the end of 16/17. The interoperability of systems is already in place to facilitate the requirements of this service, although bids will be submitted for additional work as part of the ETTF process

Wi-Fi

Plans are currently being formulated via the IT Enabler Programme Board for a common landing page for when members of the public take advantage of free Wi-Fi provision from any NHS or Social Care provider. This would point people to various services including the identity and citizen portal being proposed by HLP

Wearables

An investigative piece of work is underway to explore the collection and use of data from patient owned wearable devices which can then be shared via eLPR and analysed in Discovery

Encouraging take-up

The intention is to pilot a range of demand management activities to encourage patient engagement through the adoption of digital technologies such as 'eConsult', Patient Access and health apps. The hope is that it will be possible to demonstrate significant savings to the practices in terms of time and money, and an increase in patient satisfaction with the practice. Case studies would then be created that would encompass 'lessons learned' reports so as to encourage more practices to make serious efforts to shift patients to digital channels.

Advanced analytics Discovery Project – growing a learning health system

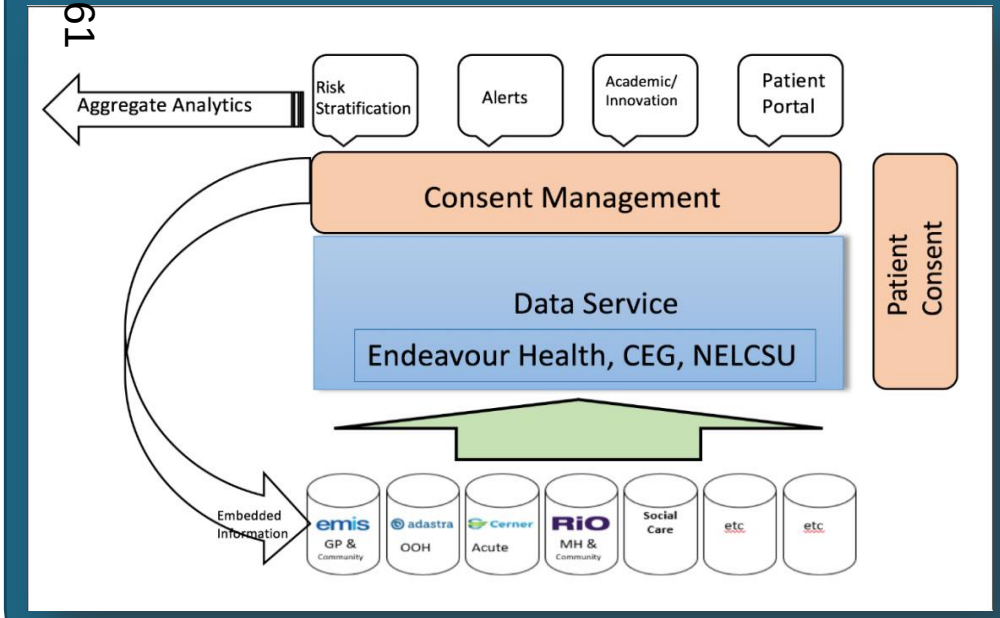
Current situation

No comparable information system exists in the footprint at present. The CCG has a Business Intelligence tool which is used to a greater or lessor extent to achieve a small subset of what the Discovery Project is expected to achieve.

Next steps

The Discovery Project has received formal approval and financial sign-off, with the WELC CCGs contributing revenue over four years. This commitment has released charitable resources from the Endeavour Foundation. Data feeds have been established from Homerton, Barts Health and over 40 Practices. A Community of Interest Company is being created that will hold the application and the data from all sources. Key to the initial work is agreement on quite who will hold the data in the time before the CIC is created.

The diagram below shows a high level view of the Discovery project architecture:



A Learning Health System…

"…will improve the health of individuals and populations. The learning health system will accomplish this by generating information and knowledge from data captured and updated over time – as an ongoing and natural by-product of contributions by individuals, care delivery systems, public health programs, and clinical research – and sharing and disseminating what is learned in timely and actionable forms that directly enable individuals, clinicians, and public health entities to separately and collaboratively make informed health decisions… The proximal goal of the learning health system is to efficiently and equitably serve the learning needs of all participants, as well as the overall public good."

Extract from http://www.learninghealth.org/

Aims of the project

The Population Health Discovery project aims:

a) To predict, anticipate or inform individual health needs from algorithms running in real time (or as near as possible) and to deliver the insight gained directly into the patient's record across the whole of their pathway, whether in primary or secondary care or elsewhere, thus creating the opportunity to improve or prevent adverse outcomes.

b) To expand the existing primary care informatics driven population health programme in east London, led by the Clinical Effectiveness Group at Queen Mary's, to all health and care sectors.

c) To enable the real time reporting on programmes by providers and commissioners supporting clinical improvement and new payment mechanisms. This would involve reporting on either a pseudonymised or identifiable cut of the clinical data, as appropriate.

d) To use data by third parties (commissioners, public health, and academics) to support research, development and planning, whether on consented identifiable data, or the pseudonymised dataset. East London would thus become a research enabled community.

Infrastructure

Current situation

Underpinning all of the digital technology work and the current drive to make systems interoperable, is the IT infrastructure that is vital to allow the various systems to communicate and to allow staff to access them. Infrastructure in almost all organisations is currently at reasonably good levels, which no major expenditure envisaged beyond normal equipment replacement programmes.

Next steps

CCGs have put forward bids to the Estates & Technology Transformation Fund (ETTF) to further improve the effectiveness of GPs, including Demand Management tools for Primary Care, and for each practice, staff to support significant take-up of Patients Online and channel shifting technology and solutions.

For mobile working and infrastructure, further analysis will be required to determine how this could be linked in with the GP demand management service so that the primary care interface could be extended to other areas e.g. hospital settings. An option being explored is for Wi-Fi provision across City and Hackney as a whole with a Hackney landing page for service users to access apps, etc. Similar options are being explored in WEL.

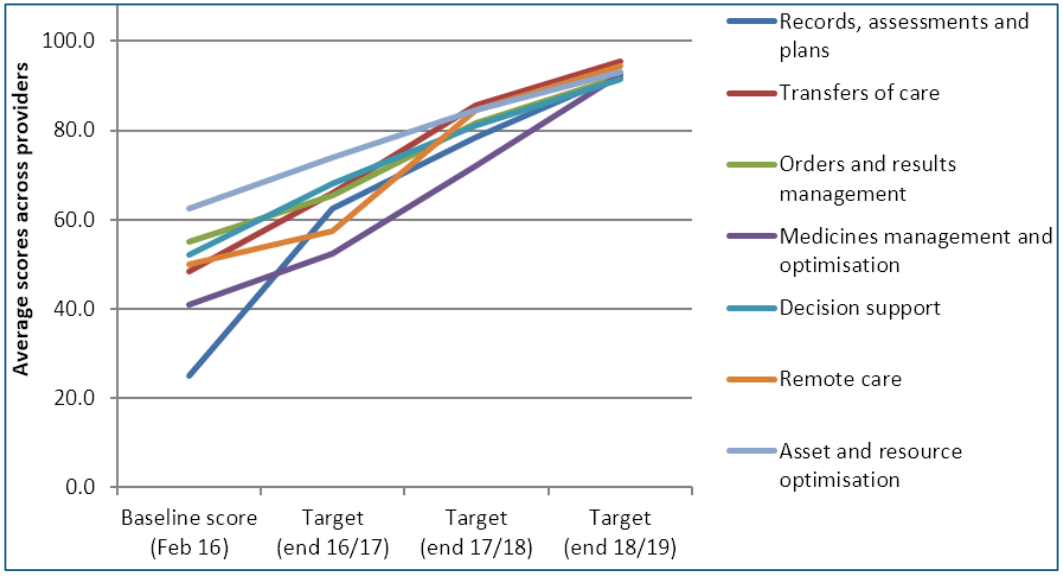
Discussion are underway at London level for a single approach with regard to the replacement of N3 that will see a far more joined up approach with Social Care colleagues.

Bids are currently being prepared to secure capital funding from NHSE for investment across the STP providers

Digital Maturity Assessment

As secondary care providers, Homerton, Barts Health, NELFT, BHRUT and ELFT were required by NHSE to complete a self-assessment in January 2016. The DMA provides a wide ranging assessment of the state of play in each organisation allowing for comparison between providers and against national averages. The providers across the STP footprint all have different strengths and weaknesses compared with each other and each has areas in which they exceed the national average and areas where they are below. Each provider has been asked to predict where they will be for each of the seven sections particularly focussed on 'Paperless by 2020' measures, over the next three years. The graph below shows the average situation across the footprint. There is no attempt to weight the scores by size of Trust.

Additionally, Social Care providers and CCGs have been asked to complete similar assessments but results are not yet available.



The C&H footprint shares the HLP Shared Design Principles for Digital Enablement in London

. Citizens should be able to express their information sharing preferences (once) and be confident that these will be remembered by the organisations who provide health and care, (provided that they are prepared to confirm their identity and express these preferences in advance).

- Citizens should be confident that data held by organisations providing care and which is relevant to the immediate care needs of the citizen (e.g. to support an e transaction), is available to be shared (in real time) with clinicians who are involved in the delivery of care anywhere in London.

- Clinicians should expect to be able to locate and access data from multiple sources across London via a single search launched from their normal clinical application and using agreed data content and technology standards.

- Citizens should be able to connect to NHS systems in London through a reliable information exchange using the application of their choice.

Integrated Urgent Care

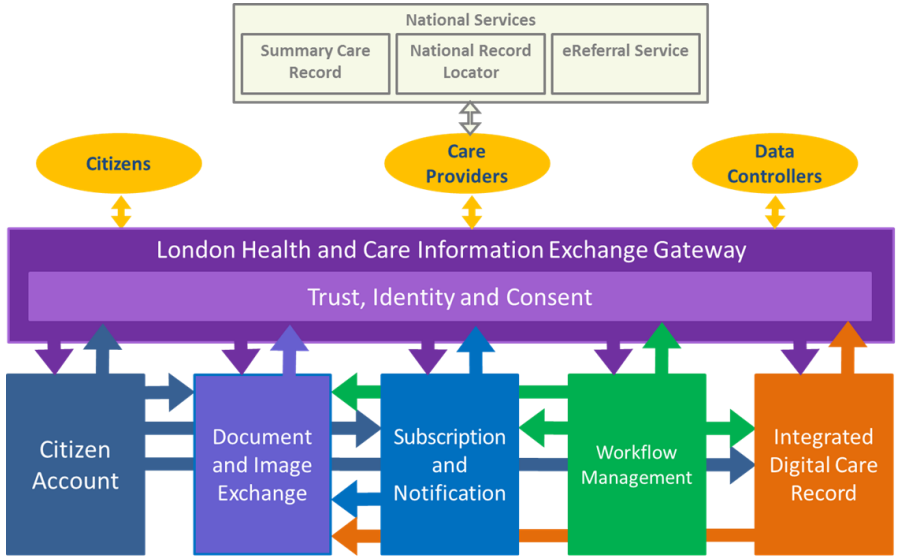
Our approach is to adopt the HLP IUC model for greater joined up working and collective benefits to the system. Further work is needed to understand how the HLP model can integrate locally but it is expected that the local decision to move to using CMC for EoL care plans will aid this integration.

First 'live' HLP product

The advanced analytics Discovery Project uses the Symphonic Data Controller to store, manage and sign data processing agreements since November 2016. This was the first live use of an HLP product, although initially as a stand-alone repository, before being connected into live systems to eventually control access to records.

Target Architecture

The target architecture for the London Health and Care information Exchange comprises a set of regionally provided and 'federated' services that will sit above each local architecture as an overall connectivity layer designed to enable improvements in the patient's journeys across the capital, as illustrated in the diagram below:



Next steps

Homerton and Barts Health have recently connected their HIEs, which is thought to be the first such joining in England. Engagement with the LDP has begun to scope out what is required for the local HIEs to connect to the HIE at the London level; discussions in which Homerton will be a close partner. Work is underway with Cerner to test connections between prototype services at HLP level with the Homerton HIE

Expected Benefits & Metrics

As an enabler, Digital struggles to isolate specific metrics that aren't impacted by other factors outside of its control.
Most of the measures identified here are not currently used or in place and so the exact mechanisms are subject to change

Benefit description (Health & wellbeing, care & quality or financial)	Measurement (metric)	Current performance	Target performance	Target date (default 2020)	Linked work streams
New models of care can be developed, achieving better outcomes for all; focused on prevention and out of hospital care	Other delivery plans supported to deliver new models of care	New models of care not yet in place	All new models of care assessed as being supported	Incremental to 2020	Advanced system-wide analytics, Digital infrastructure
Provide the information needed to enable organisations to work in partnership to commission, contract and deliver services efficiently and safely	Clinically significant information available where requested and agreed by Discovery board	Unknown - Discovery is a newly created service	Information requests met or rejected with good reason	2020 in BHR 2018 in WELC	Advanced system-wide analytics
Improved patient safety – supporting safer and better informed treatment by providing clinicians with timely access to accurate and up to date information	Number of serious incidents found to be as a result of lack of information	Measurement not yet made. Investigating this option	Reduction	Incremental to 2020	Shared care records, Coordinated care and care planning
More efficient care –reducing the time, effort and resources required to obtain relevant information regarding patient care, e.g. avoiding repeat test requests	Amount of repeat testing	Specific measure to be established	Less unnecessary testing	Incremental to 2018/19	Advanced system-wide analytics, Shared care records
Better patient experience– reducing the need for patients to recall or repeat their medication information and supporting people with difficulties communicating	Patient satisfaction rating	Need to develop a specific question that can be used as an indicator	Improved level of satisfaction	Incremental to 2018/19	Shared care records, Patient enablement
Intervention for individual patient prompted by analysis of broad set of data	Reduced incidence of specific life events	Need to consult to establish how this is measured	Reduction	Commencing 20017/18	Advanced system-wide analytics, Shared care records
Patients take more active role in their own wellbeing	Accessing 'patient on-line' functionality	4%	20%-30%	2017/18	Patient enablement

Resources & Delivery Structure

6.1 Resources

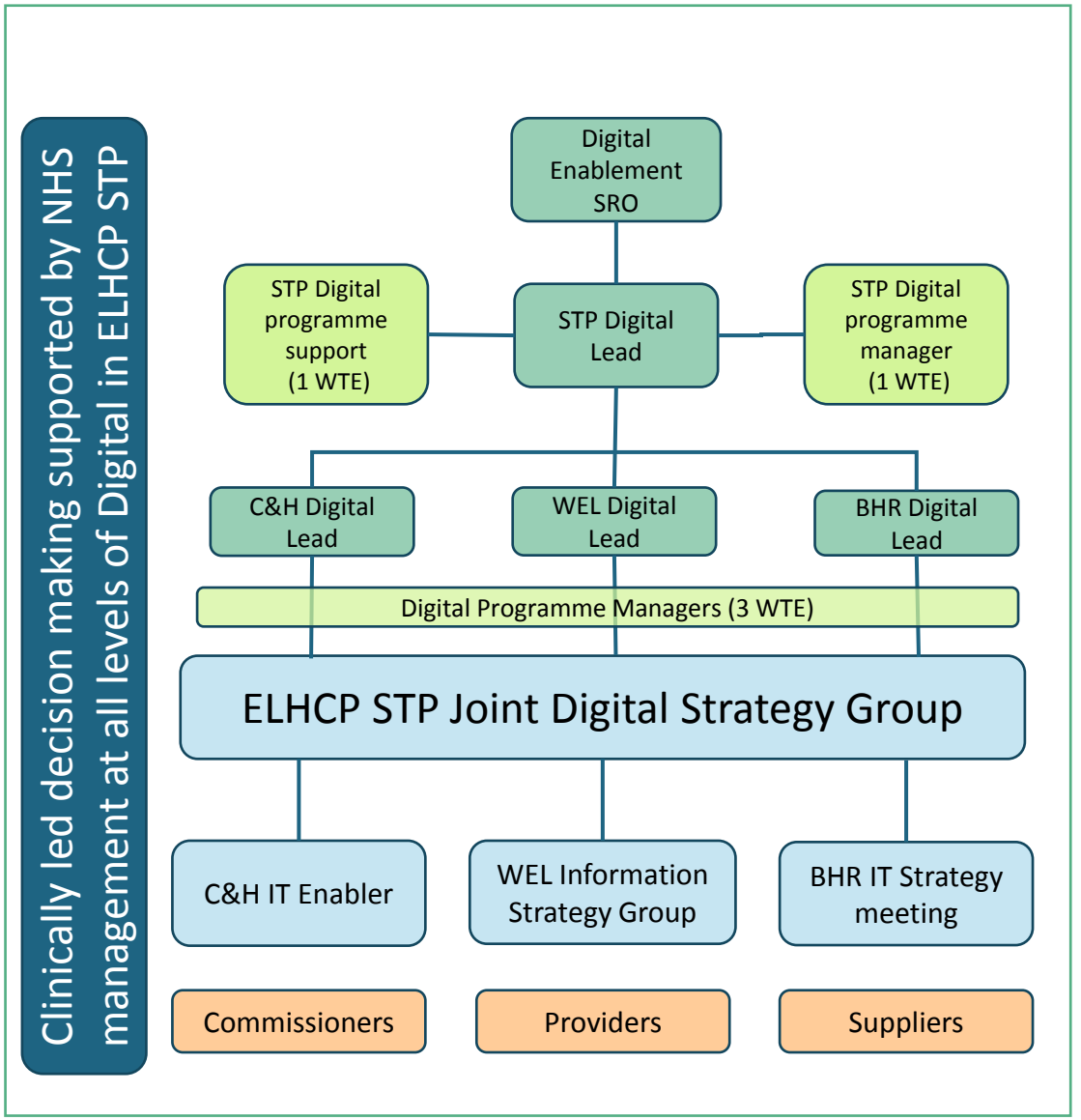
Delivery Plan	SRO	Delivery Lead
Shared care records	*Terry Huff, Accountable Officer, Waltham Forest CCG*	*Anita Ghosh, IT Enabler Programme Manager, Homerton* *Bill Jenks, TST Programme Manager, TH CCG* *Simi Bhandal, Project Manager, BHR CCGs*
Coordinated care and care planning		
Patients' access to their own information		
Advanced system-wide analytics		
Digital infrastructure		

In addition to the SRO and delivery needs named above, Luke Readman, CIO, WEL CCGs is taking the lead for Digital Enablement across ELHCP STP. Rob Meaker (Director of Innovation, BHR CCGs) and Niall Canavan (Director of IT, Homerton), along with Luke Readman in WEL, continue to provide digital leadership across their respective LDR footprints, working ever closer. Two other permanent Programme Managers are in post.

As ever, much of the delivery on the ground is provided through individual IT departments, change facilitators and suppliers which will need augmenting / paying for specific projects.

CCIO support is provided to the overall programme from the CCIOs in individual organisations needing to achieve business change. Clinical leadership is a key strength of the Digital Enablement work stream

6.2 Delivery structure



Risks

Risks			
Work stream	**Description and impact**	**Mitigating action**	**RAG**
All	Finance – much of the Digital programme for the STP is unfunded and is reliant on successful bids to technology funds	Successful bids to Estates Technology Transformation Fund (ETTF) and other upcoming funding streams	**R**
All	Premature consolidation of BHR and WELC LDRs would potentially halt or even reverse progress that has already be made	Take time to consider real benefits verses risk before creating a single LDR	**A**
Digital infrastructure	Poor infrastructure in key areas	Successful technology bids allowing improvement programmes to be launch	**A**
Shared care record, Coordinated care and care planning	Compatibility of systems that haven't yet been connected	All systems use or soon will use recognised interoperability standards. Close supplier engagement underway	**A**
Shared care record, Coordinated care and care planning, Patient enablement	HLP Digital Programme failing to deliver the products they have committed to	Successful ETTF bid and ongoing funding streams secured	**A**
Patient enablement, Digital infrastructure	Progress would inevitably slow if GPIT re-procurement results in a new provider being selected	Careful consideration as to how and when any new service is brought on stream	**A**

This is a list of the highest-rated risks. Additional risks identified at a lower mitigated risk rating

Dependencies, Constraints and Assumptions

This section provides a summary of the key benefits that we expect to achieve through the implementation of this Delivery Plan level:

Dependencies, constraints & assumptions (in order of impact)			
Workstream	**Type: Dependency/ constraint/ assumption**	**Description**	**Actions / next steps**
Shared Care Record, Advanced system-wide analytics	Dependency	New Information Sharing Agreements and fair processing notices need to be in place before significant further steps can be taken	IG groups across ELHCP to collaborate on process and gain approval from all relevant parties
All	Assumption	Sufficient funding will be made available to deliver the transformational digital systems required. Current national (short term) bidding system for IT doesn't allow for good planning	Continuing to make the case for investment in Digital, bidding for monies from funds as they become available
All	Dependency	All suppliers deliver on their commitments	Continue existing good supplier engagement
Patient engagement	Constraint	Concerns from GPs about the effectiveness of patient on-line objectives and patient indifference / lack of awareness	Clinician and public engagement exercises
Patient engagement	Dependency	GP promotion of service to patients and willingness to publish appointment slots on-line	Clinician and public engagement exercises
Advanced system-wide analytics	Dependency	Engagement to determine where to focus initial efforts. Commitment to use information supplied	Continue discussions with clinicians
All	Dependency	Workforce appropriately skilled and engaged to take advantage of new ways of working enabled by Digital Enablement	Engage with Workforce team to ensure full understanding
Coordinated care and care planning	Assumption	Willingness for professionals and patients to use care plans	Fully engage with professionals and patients once clear on delivery mechanism
Digital infrastructure	Dependency	Provision of sufficient facilities for IT in new or refurbished buildings	Fully engage with estates and facilities teams where physical It assets need housing

Dependency map

This dependency map highlights where this delivery plan is linked to another delivery plan within our STP

	Prevention	Access to care close to Home	Accessible quality acute services	Infrastructure	Provider Productivity	Specialised Services	Workforce
Shared care records	View of the entire record can prevent referrals & investigations	A fuller view of the patient record enables out of hospital services	Clinicians often make better decisions with relevant information from all providers	Facilitates MDT working, allowing reconfiguration of services more readily	View of the entire record can prevent referrals & investigations	Supports pathway transformation required for specialised services	Workforce appropriately skilled and engaged
Coordinated care and care planning	Provision of shared care plans facilitates keeping people out of hospital	Provision of shared care plans facilitates keeping people out of hospital	Providers are better able to meet patients' wishes when a care plan is accessible		Patients with EoL care plans are less likely to die in hospital		Workforce appropriately skilled and engaged
Patients' access to their own information	Engaged patients may be more likely to self-medicate	Engaged patients may be more likely to self-medicate or access lower cost services			GPs need to engage with the process of giving patients access	Improve education, prevention and wellbeing	Workforce appropriately skilled and engaged
Advanced system-wide analytics	Engagement to determine where to focus initial efforts.	Management of populations with long term conditions reduces hospital admissions	Management of populations with long term conditions reduces hospital admissions		Providers are able to focus resources on early interventions	Supports pathway transformation & community surveillance and case finding	Workforce appropriately skilled and engaged
Digital infrastructure (what others provide to Digital)				Provision of sufficient facilities for IT. Digital facilitates MDT working	Essential to allowing a paperless NHS by 2020		Workforce appropriately skilled and engaged

As an enabling delivery plan, Digital Enablement has few dependencies on other delivery plans

Contribution to our Framework for Better Care and Wellbeing

This delivery plan sets out how it will deliver improvements against the core areas of prevention, out-of-hospital care and in-hospital care.

Promote prevention, and personal and psychological wellbeing in everything we do

The Patient Engagement work stream supports patients to improve their own wellbeing through providing information to them and enabling them to provide information, e.g. from an activity tracker or mood score app, back to their clinician.
The Advanced System-wide Analytics work stream will provide prompts to clinicians to enable early intervention.

Co-ordinated Care and Care Planning will help patients receive the treatment and social care support they want where and when they want it, initially supporting end of life care. The Shared Care Record will give a sense to the patient that those involved in their care have a complete picture and have the confidence to act upon that information

There is clear evidence that multi-authored end of life care plans have a significant impact on the ability of patients to die in their preferred place. Wider multi-authored care plans enable all those involved in care to provide what is need in the right place and at the right time, involving carers as necessary. A full Shared Care Record can facilitate safe discharge from hospital but also help prevent admission and attendance at A&E because professionals have a full picture and can make more appropriate decisions based on that information

Promote independence and enable access to care close to home

Through the use of all of the Digital Technology described in this Delivery Plan and in the LDRs it is possible to reduce recourse to acute services because professionals and patients alike have a much richer picture of previous care, current conditions, risks and ongoing planned interventions. Such reductions in demand for acute services allows greater access for those that necessarily require them.

Ensure accessible quality acute services for those who need it

Addressing the 10 Big Questions

Q1. Prevent ill health and moderate demand for healthcare

- Greater patient engagement (slide 8 - work stream 3)
- Advanced system-wide analytics uses risk stratification and algorithms to alert clinicians to possible early interventions engagement (slide 9 - work stream 4)

Q2. Engage with patients, communities & NHS staff

- Greater patient engagement though access to their own record and digital interaction with professionals (slide 8 - work stream 3)

Q3. Support, invest in and improve general practice

- Greater patient engagement though access to their own record and digital interaction with professionals (slide 8 - work stream 3) can reduce workload on practice staff

Q4. Implement new care models that address local challenges

- Advanced system-wide analytics can surface bottlenecks in the health and care system and support new models of care with early evidence of effectiveness (slide 9 - work stream 4)

Q5. Achieve & maintain performance against core standards

- Improved e-referral usage can make significant impact on overall system performance. The Local Digital Roadmaps describe how e-referral performance will be improved

Q6. Achieve our 2020 ambitions on key clinical priorities

- Shared care record (slide 6 - work stream 1) and Coordinated care and care planning (slide 7 - work stream 2) generally support professionals delivering care by giving them a more complete picture
- Advanced system-wide analytics will alert for early intervention (slide 9 - work stream 4)

Q7. Improve quality and safety

- Shared care record (slide 6 - work stream 1) and Coordinated care and care planning (slide 7 - work stream 2) support quality improvement by giving professionals a more complete picture
- Advanced system-wide analytics will alert for early intervention (slide 9 - work stream 4)

Q8. Deploy technology to accelerate change

- All work streams in this delivery plan involve the deployment of technology to accelerate change (see slides 6-10)

Q9. Develop the workforce you need to deliver

- Work streams 1,2&4 provide the tools required to support MDTs, for example

Q10. Achieve & maintain financial balance

- The benefits sections of all work streams identify ways in which digital technology can improve efficiency and reduce demand
- In addition to the identified work streams, digital is engaged with Carter review recommendations

Addressing the 9 Must Dos

1. STPs

- This delivery plan outlines our agreed STP initiatives and milestones and the timeline for delivering them. We have also begun to map out the metrics against which we will measure our progress.
- Much more detail is included in the Local Digital Roadmaps

2. Finance

- The Digital Enablement plan will enable the other delivery plans to achieve their financial targets
- We are working collaboratively to develop a flexible / scalable back office service models where this will deliver value for EL;

3. Primary Care

- Digital underpins primary care activity, as expressed in all of the work streams

4. Urgent & Emergency Care

- Access to shared more complete records in EL and across London, plus the ability to write back into records and care plans underpins changes needed in U&EC

5. Referral to treatment times and elective care

- The digital capability is already in place to enable 100% use of e-referrals
- The use of advanced analytics will provide key parts of the information required to streamline elective care pathways

6. Cancer

- The Shared Care Record and the Coordinated Care And Care Planning work streams in particular, support the Recovery Package information requirements

7. Mental health

- The Shared Care Record allows professionals to see what interventions have been tried or are ongoing outside of their own organisation

8. People with learning disabilities

- Shared Care Records reduce the need to ask patients for information about allergies, previous treatments in other care settings, etc.
- Multi-authored care plans that are accessible by patients and their carers support community provision and avoiding admissions

9. Improving quality in organisations

- The information provided by Advanced system-wide analytics can be used to drive up quality across the system
- Access to fuller care record information from beyond own organisations enables professionals to take better decisions, driving up quality and reducing avoidable cost

This page is intentionally left blank