Hackney

NHS
City and Hackney
Clinical Commissioning Group

Meeting-in-common of the City & Hackney Clinical Commissioning Group and London Borough of Hackney Integrated Commissioning Boards

Meeting on Wednesday 21 March, 10am – 12 noon

Committee Room 102, Hackney Town Hall,
Mare Street, London E8 1EA

1 Hackney Integrated Commissioning Board Agenda (Pages 1 - 274)

Contact Matt Hopkinson, Integrated Commissioning Governance Manager – matthewhopkinson@nhs.net; 020 3816 3292

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City Integrated Commissioning Board

Meetings in-common of the City and Hackney Clinical Commissioning Group and the City of London Corporation

Hackney Integrated Commissioning Board

Meetings in-common of the City and Hackney Clinical Commissioning Group and the London Borough of Hackney

Joint Meeting on Wednesday 21 March 2018 10am-12 noon
Room 102, Hackney Town Hall, Mare Street, London

Item no.	Item	Lead and action for boards	Documentation	Page No.	Time
1.	Apologies/Introductions	-	-	-	10.00
2.	Declarations of Interest	*For noting*	2. ICB Register of Interests	1-8	
3.	Questions from the Public	Chair	Verbal	-	
4.	Minutes of the Previous Meeting	Chair *For approval* *For noting*	 4.1 Minutes of Joint ICBs meeting in common, 28 February 2018 (public session) 4.3 ICBs Action Log	 9-17 18	
5.	Transformation of Outpatients Services	Simon Cribbens *For approval*	5. Transformation of Outpatients Services	19-36	10.10
6.	London Borough of Hackney Advice and Debt Review	Sonia Khan *For noting*	6. London Borough of Hackney Advice and Debt Review	37-56	10.25
7.	Care Workstream Assurance Review: • CYPM Point 2	 Angela Scattergood / Amy Wilkinson	 7.1 CYPM Point 2	57-140 (63-94)	10.35

	• Planned Care point 3 • Unplanned Care point 3 • Prevention Point 3 • Care Workstream Asks 2018/19	Simon Cribbens / Siobhan Harper Tracey Fletcher / Nina Griffith Anne Canning / Jayne Taylor Workstream SROs *For approval*	7.2 Planned Care Point 3 7.3 Unplanned Care Point 3 7.4 Prevention Point 3 7.5 Care Workstream Asks 2018/19	(95-102) (103-110) (111-122) (123-140)	
8.	Proposal for Award of a single Outcomes-Based contract for clinical Locally Enhanced Services	David Maher / Lee Walker *For discussion and endorsement*	8 Proposal for Award of a single Outcomes-Based contract for clinical Locally Enhanced Services	141-158	11.05
9.	Enabler Funding Proposals • IT Enabler support for VCS – including scoping for Social Prescribing software • Engagement Enabler Funding	Jackie Brett Jon Williams *For noting and approval*	9.1 IT Enabler support for VCS – including scoping for Social Prescribing software 9.2 Engagement Enabler Funding	159-168 169-176	11.15
10.	Proposal to merge Cedar Lodge with Thames House	Daniel Burningham / Rhiannon England *For discussion and endorsement*	10 Proposal to merge Cedar Lodge with Thames House	177-192	11.25
11.	Mental Health Investment • Recurrent • Non-Recurrent	Daniel Burningham / Rhiannon England *For discussion and endorsement*	11.1 Recurrent Investment 11.2 Non-Recurrent Investment	193-212 213-232	11.35

12.	Integrated Commissioning Governance Review Specification	Devora Wolfson / Matt Hopkinson *For approval*	12 Integrated Commissioning Governance Review Specification	233-244	11.45
13.	Integrated Finance Report - Month 10	Philippa Lowe / Ian Williams / Mark Jarvis *For noting*	13 Integrated Finance Report - Month 10	245-258	11.55
14.	AOB & Reflections	Chair *For discussion*	-	-	12.00
	Attached for Information - • Integrated Commissioning Escalated Risk Register (Paper 15, page 259-267) • Integrated Commissioning Boards Forward Plan (Paper 16, page 268-270)				

Integrated Commissioning
2017/2018 Register of Interests

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Jon	Williams	29/03/2017	Transformation Board Member - Healthwatch Hackney Attendee - Hackney Integrated Commisioning Board	Healthwatch Hackney	Director Hackney Council Core and Signposting Grant - CHCCG NHS One Hackney & City Patient Support Contract - CHCCG NHS Community Voice Contract - CHCCG Patient User Experience Group Contract - CHCCG Devolution Communications and Engagment Contract Hosted by Hackney CVS at the Adiaha Antigha Centre, 24-30 Dalston Lane	Pecuniary Interest
Simon	Cribbens	27/03/2017	Transformation Board Member - CoLC	City of London Corporation	Acting Assistant Director - Commissioning & Partnerships, Community & Children's Services	Pecuniary Interest
				Porvidence Row	Trustee	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Penny	Bevan	25/03/2017	Transformation Board Member - DPH, LBH & CoLC	London Borough of Hackney	Director of Public Health	Pecuniary Interest
				City of London Corporation	Director of Public Health	Pecuniary Interest
				Association of Directors of Public Health	Member	Non-Pecuniary Interest
				British Medical Association	Member	Non-Pecuniary Interest
				Faculty of Public Health	Member	Non-Pecuniary Interest
				National Trust	Member	Non-Pecuniary Interest
Jake	Ferguson	31/03/2017	Transformation Board Member - Hackney CVS	Hackney Community & Voluntary Services	Chief Executive	Pecuniary Interest
Clare	Highton	23/12/2016	Transformation Board Member - CHCCG CoLC/CCG ICB Chair LBH ICB Member - CHCCG	City & Hackney CCG	Chair	Pecuniary Interest
				Body and Soul	Daughter in Law works for this HIV charity.	Indirect interest
				CHUHSE	Sorsby and Lower Clapton Group Practice's are members	Pecuniary Interest
				GP Confederation	Sorsby and Lower Clapton Group Practice's are members and shareholders	Pecuniary Interest
				Local residents	Myself and extended family are Hackney residents and registered at Hackney practices, 2 grandchildren attend a local school.	Non-Pecuniary Interest
				Lower Clapton Group Practice (CCG Member Practice)	Partner at a GMS and an APMS practices which provide a full range of services including all GP Confederation and the CCG's Clinical Commissioning and Engagement contracts, and in addition child health, drug, minor surgery and anticoagulation clinics. We host CAB, Family Action, physiotherapy, counselling, diabetes and other clinics. The buildings are leased from PropCo, and also house community health services. The practices are members of CHUHSE and the GP Confederation. Lower Clapton is a teaching, research and training practice, and I am a GP trainer. I am a member of the BMA and Unite. One partner is a member of the LMC.	Pecuniary Interest
				Sorsby Group Practice (CCG Member Practice)	Partner at a GMS and an APMS practices which provide a full range of services including all GP Confederation and the CCG's Clinical Commissioning and Engagement contracts, and in addition child health, drug, minor surgery and anticoagulation clinics. We host CAB, Family Action, physiotherapy, counselling, diabetes and other clinics. The buildings are leased from PropCo, and also house community health services. The practices are members of CHUHSE and the GP Confederation. Lower Clapton is a teaching, research and training practice, and I am a GP trainer. I am a member of the BMA and Unite. One partner is a member of the LMC.	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				Tavistock and Portman NHS Trust	Husband is Medical Director of Tavistock and Portman NHS FT which is commissioned for some mental health services for C&H CCG.	Non-Pecuniary Interest
				N/A	Daughter is a trainee Psychiatrist, not within the City and Hackney area.	Non-Pecuniary Interest
Philippa	Lowe	22/12/2016	Transformation Board Member - CHCCG CoLC ICB Attendee - CHCCG LBH ICB Attendee - CHCCG	City & Hackney CCG	Joint Chief Finance Officer	Non-Pecuniary Interest
				GreenSquare Group	Board Member, Group Audit Chair and Finance Committee member for GreenSquare Group, a group of housing associations. Greensquare comprises a number of charitable and commercial companies which run with co-terminus Board.	Non-Pecuniary Interest
				NHS Oxford Radcliffe Hospital	Member of this Foundation Trust	Non-Pecuniary Interest
				PIQAS Ltd	Director at PIQAS Ltd, dormant company.	Non-Pecuniary Interest
Ian	Williams	10/05/2017	Transformation Board Member - LBH Attendee - Hackney Integrated Commissioning Board	London Borough of Hackney	Group Director, Finance and Corporate Resources	Pecuniary Interest
				n/a	Homeowner in Hackney	Pecuniary Interest
				Hackney Schools for the Future Ltd	Director	Pecuniary Interest
				NWLA Partnership Board	Joint Chair	Pecuniary Interest
				Chartered Institute of Public Finance and Accountancy	Member	Non-Pecuniary Interest
				Society of London Treasurers	Member	Non-Pecuniary Interest
				London Finance Advisory Committee	Member	Non-Pecuniary Interest
				Schools and Academy Funding Group	London Representative	Non-Pecuniary Interest
				London Pensions Investments Advisory Committee	Chair	Non-Pecuniary Interest
Mark	Jarvis	10/04/2017	Transformation Board Member - CoLC	City of London Corporation	Head of Finance	Pecuniary Interest
Anne	Canning	31/03/2017	Transformation Board Member - LBH LBC/CCG ICB Attendee - LBH	London Borough of Hackney	Group Director - Children, Adults & Community Health	Pecuniary Interest
				Petchey Academy & Hackney/Tower Hamlets College	Governing Body Member	Non-Pecuniary Interest
					Spouse works at Our Lady's Convent School, N16	Indirect interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Honor	Rhodes	05/04/2017	Member - City / Hackney Integrated Commissioning Boards	Tavistock Relationships	Director of Strategic Devleopment	Pecuniary Interest
				City & Hackney Clinical Commissioning Group	Lay Member for Governance	Pecuniary Interest
				The School and Family Works, Social Enterprise	Special Advisor	Pecuniary Interest
				Oxleas NHS Foundation Trust	Spouse is Tri-Borough Consultant Family Therapist	Indirect interest
				Early Intervention Foundation	Trustee	Non-Pecuniary Interest
				n/a	Registered with Barton House NHS Practice, N16	Non-Pecuniary Interest
Gary	Marlowe	06/04/2017	GP Member of the City & Hackney CCG Governing Body	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				De Beauvoir Surgery	GP Partner	Pecuniary Interest
				City & Hackney CCG	Planned Care Lead	Pecuniary Interest
				Hackney GP Confederation	Member	Pecuniary Interest
				British Medical Association	London Regional Chair	Non-Pecuniary Interest
				n/a	Homeowner - Casimir Road, E5	Non-Pecuniary Interest
				City of London Health & Wellbeing Board	Member	Non-Pecuniary Interest
				Local Medical Committee	Member	Non-Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				CHUHSE	Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Haren	Patel	10/04/2017	GP Member of the City & Hackney CCG Governing Body	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				Latimer Health Centre	Senior GP Partner Contract with CCG for carrying out GP services at Acorn Lodge Nursing Home Spouse is a GP Partner Owner (with spouse) of freehold of Latimer Health Centre	Pecuniary Interest
				Newcare Pharmacy, Willesden Green	Joint Director Spouse is Joint Director	Pecuniary Interest
				Klear Consortia	Prescribing Clinical Lead	Pecuniary Interest
				City & Hackney GP Confederation	Member	Pecuniary Interest
				Londonwide Local Medical Committee	Member	Non-Pecuniary Interest
				British Medical Association	Member	Non-Pecuniary Interest
Anntoinette	Bramble	28/04/2017	Deputy Mayor, Hackney Council	Hackney Council	Deputy Mayor	Pecuniary Interest
				Local Government Association	Member of the Children and Young Board	Pecuniary Interest
				HSFL (Ltd)		Non-Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				Urstwick School	Governor	Non-Pecuniary Interest
				City Academy	Governor	Non-Pecuniary Interest
				Hackney Play Bus (Charity)	Board Member	Non-Pecuniary Interest
				Local Government Association	Member	Non-Pecuniary Interest
				Lower Clapton Group Practice	Registered Patient	Non-pecuniary interest
Dhruv	Patel	28/04/2017	Chair - City of London Corporation Integrated Commissioning Sub-Committee	n/a	Landlord	Pecuniary Interest
				Clockwork Pharmacy Group SSAS, Amersham	Trustee; Member	Pecuniary Interest
				Clockwork Underwriting LLP, Lincolnshire	Partner	Pecuniary Interest
				Clockwork Retail Ltd, London	Company Secretary & Shareholder	Pecuniary Interest
				Clockwork Pharmacy Ltd	Company Secretary	Pecuniary Interest
				DP Facility Management Ltd	Director; Shareholder	Pecuniary Interest
				Clockwork Farms Ltd	Director; Shareholder	Pecuniary Interest
				Clockwork Hotels LLP	Partner	Pecuniary Interest
				Capital International Ltd	Employee	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
					Land Interests - 8/9 Ludgate Square 215-217 Victoria Park Road 236-238 Well Street 394-400 Mare Street 1-11 Dispensary Lane	Pecuniary Interest
					Securities - Fundsmith LLP Equity Fund Class Accumulation GBP	Pecuniary Interest
				East London NHS Foundation Trust	Governor	Non-Pecuniary Interest
				City of London Academies Trust	Director	Non-Pecuniary Interest
				The Lord Mayor's 800th Anniversary Awards Trust	Trustee	Non-Pecuniary Interest
				City Hindus Network	Director; Member	Non-Pecuniary Interest
				Aldgate Ward Club	Member	Non-Pecuniary Interest
				City & Guilds College Association	Life-Member	Non-Pecuniary Interest
				The Society of Young Freemen	Member	Non-Pecuniary Interest
				City Livery Club	Member and Treasurer of u40s section	Non-Pecuniary Interest
				The Clothworkers' Company	Liveryman; Member of the Property Committee	Non-Pecuniary Interest
				Diversity (UK)	Member	Non-Pecuniary Interest
				Chartered Association of Buidling Engineers	Member	Non-Pecuniary Interest
				Institution of Engineering and Technology	Member	Non-Pecuniary Interest
				City & Guilds of London Institute	Associate	Non-Pecuniary Interest
				Association of Lloyd's members	Member	Non-Pecuniary Interest
				High Premium Group	Member	Non-Pecuniary Interest
				Avanti Court Primary School	Chairman of Governors	Non-Pecuniary Interest
Joyce	Nash	06/04/2017	Member - City Integrated Commissioning Board	City of London Corporation	Deputy	Pecuniary Interest
				Neaman Practice	Registered Patient	Non-Pecuniary Interest
				Feltmakers Livery Company	Lifemember of Headteachers' Association	Non-Pecuniary Interest
Peter	Kane	12/05/2017	Attendee - City Integrated Commissioning Board	City of London Corporation	Chamberlain	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Jonathan	McShane	15/05/2017	Chair - Hackney Integrated Commissioning Board	London Borough of Hackney	Lead Member for Health, Social Care & Devolution	Pecuniary Interest
				Local Government Association		Pecuniary Interest
				Public Health England		Pecuniary Interest
				The Labour Party		Pecuniary Interest
				LGA General Assembly	Member	Non-Pecuniary Interest
				LGA Community Wellbring Board	Member	Non-Pecuniary Interest
				London Councils Grants Committee	Member	Non-Pecuniary Interest
				London Councils Transport and Environment Committee	Substitute Member	Non-Pecuniary Interest
				Shoreditch Town Hall Trust	Trustee	Non-Pecuniary Interest
				LGA Community Wellbeing Board	Member	Non-Pecuniary Interest
				Unite	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Community Trade union	Member	Non-Pecuniary Interest
				Action on Smoking and Health	Trustee	Non-Pecuniary Interest
				Public Health System Group	Chair	Non-Pecuniary Interest
				NHS Health Checks National Advisory Committee	Chair	Non-Pecuniary Interest
				Dementia Programme governance Board, Public Health England	Co-Chair	Non-Pecuniary Interest
				Pharmacy and Public Health Forum, Public Health England	Chair	Non-Pecuniary Interest
				Liver Advisory Group, NHS Blood and Transplant	Lay Member	Non-Pecuniary Interest
				n/a	Spouse is a Communications Consultant	Pecuniary Interest
Randall	Anderson	13/06/2017	Member - City Integrated Commissioning Board	City of London Corporation	Deputy Chair, Community and Children's Services Committee	Pecuniary Interest
				n/a	Self-employed Lawyer	Pecuniary Interest
				n/a	Renter of a flat from the City of London (Breton House, London)	Non-Pecuniary Interest
				City of London School for Girls	Member - Board of Governors	Non-Pecuniary Interest
				Neaman Practice	Registered Patient	Non-Pecuniary Interest
Andrew	Carter	05/06/2017	Attendee - City Integrated Commissioning Board	City of London Corporation	Director of Community & Children's Services	Pecuniary Interest
				n/a	Spouse works for FCA (fostering agency)	Indirect interest
David	Maher	20/01/2017	Joint Deputy Chief Officer & Programme Director	City and Hackney Clinical Commissioning Group	Member of Cross sector Social Value Steering Group	Non-Pecuniary Interest
					Board member: Global Action Plan	Non-Pecuniary Interest
					Social Value and Commissioning Ambassador: NHS England, Sustainable Development Unit	Non-Pecuniary Interest
					Council member: Social Value UK	Non-Pecuniary Interest
Rebecca	Rennison	11/12/2017	Member - Hackney Integrated Commissioning Board	Target Ovarian Cancer	Director of Public Affairs and Services	Pecuniary Interest
				Hackney Council	Cabinet Member for Finance and Housing Needs	Pecuniary Interest
				Clapton Park Management Organisation	Board Member	Non-Pecuniary Interest
				North London Waste Authority	Board Member	Non-Pecuniary Interest
					Land Interests - Residential property, Angel Wharf	Non-Pecuniary Interest
					Residential Property, Shepherdess Walk, N1	Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Fabian Society	Member	Non-Pecuniary Interest
				English Heritage	Member	Non-Pecuniary Interest
				Chats Palace	Board Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Ruby	Sayed	13/12/2017	Member - City Integrated Commissioning Board	City of London Corporation	Elected member	Pecuniary Interest
				Sel-employed	Barrister	Pecuniary Interest
				Nirvana Capital Ltd	Founder & Shareholder	Pecuniary Interest
				Lavenham Priory, Suffolk	Owner/Proprietor	Pecuniary Interest
				Transition Finance (Lavenham) Ltd	Director & Shareholder	Pecuniary Interest
				Gaia Re Ltd	Non-Executive Director	Pecuniary Interest
				Folk2Folk Ltf	Spousal Interest	Indirect interest
				Asian Women's Resource Centre	Trustee and Chair	Non-Pecuniary Interest
				Bury St Edmonds Womens Aid	Trustee	Non-Pecuniary Interest
Jane	Milligan	02/01/2018	Member - Integrated Commissioning Board	NHS North East London Commissioning Alliance (City & Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge CCGs)	Accountable Officer	Pecuniary Interest
				North East London Sustainability and Transformation Partnership	Senior Responsible Officer	Pecuniary Interest
				n/a	Chartered Physiotherapist (non-practicing)	Pecuniary Interest
				n/a	Partner is employed substantively by NELCSU as Director of Business Development from 2 January 2018 on secondment to NHSE as London Regional Director for Primary Care	Indirect Interest
				Family Mosaic Housing Association	Non-Executive Director	Non-Pecuniary Interest
				Stonewall	Ambassador	Non-Pecuniary Interest
				Peabody Housing Association Board	Non-Executive Director	Non-pecuniary interest
Barbara	Newman	26/01/2018	Member - Integrated Commissioning Board	n/a	Residential property in Mountjoy House, Barbican	Non-Pecuniary Interest
					Residential Property in Upper Thames St, London	Non-Pecuniary Interest
				Livery Companies - Turners, Coopers, Tallow Chandlers, Arts Scholars	Member	Non-Pecuniary Interest
				Royal Society of St George	Member	Non-Pecuniary Interest
				Guild of the Freemen of the City of London	Member	Non-Pecuniary Interest
				City Livery Club	Member	Non-Pecuniary Interest
				Aldersgate Ward Club	Member	Non-Pecuniary Interest
				Neaman General Practice	Regitered Patient	Non-Pecuniary Interest
Ellie	Ward	22/01/2018	Integration Programme Manager, City of London Corporation	City of London Corporation	Integration Programme Manager	Pecuniary Interest

Meeting-in-common of the City & Hackney Clinical Commissioning Group and London Borough of Hackney

Hackney Integrated Commissioning Board

and the

Meeting–in- common of the City & Hackney Clinical Commissioning Group and City of London Corporation

City Integrated Commissioning Board

Meeting of 28 February 2018

ATTENDANCE FOR HACKNEY ICB

MEMBERS

Hackney Integrated Commissioning Committee

Cllr Jonathan McShane, Chair, Lead Member for Health, Social Care and Devolution, London Borough of Hackney

Cllr Rebecca Rennison, Cabinet Member for Finance & Housing Needs

Cllr Anntoinette Bramble, Lead Member for Children's Services, London Borough of Hackney

City and Hackney CCG Integrated Commissioning Committee

Clare Highton - Chair, City & Hackney CCG Governing Body

Honor Rhodes – Governing Body Lay Member, City & Hackney CCG

Jane Milligan - Accountable Officer, NHS North East London Commissioning Alliance

FORMALLY IN ATTENDANCE

Anne Canning – Group Director, Children, Adults and Community Health, London Borough of Hackney

Ian Williams - Group Director, Finance and Corporate Services, London Borough of Hackney

Mark Rickets - GP Member, City & Hackney CCG Governing Body

David Maher - Acting Managing Director, City & Hackney CCG

Philippa Lowe – Joint Chief Finance Officer, City & Hackney CCG

Haren Patel, GP Member, City & Hackney CCG Governing Body

STANDING INVITEES

Penny Bevan – Director of Public Health, London Borough of Hackney and City of London Corporation

Jake Ferguson – Chief Executive, Hackney Council for Voluntary Services

Jon Williams – Director, Hackney Healthwatch

OFFICERS PRESENT

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

Siobhan Harper - Planned Care Workstream Director

Helen Sargeant Dar - Head of Integrated Leading Disabilities Service

APOLOGIES

Devora Wolfson –Programme Director, Integrated Commissioning

ATTENDANCE FOR CITY ICB

MEMBERS

City Integrated Commissioning Committee

Cllr Randall Anderson – Deputy Chairman, Community and Children's Services Committee, City of London Corporation (Chair)

Cllr Dhruv Patel – Chairman, Community and Children's Services Committee, City of London Corporation

Cllr Marianne Fredericks – Member, Community and Children's Services Committee, City of London Corporation

City and Hackney CCG Integrated Commissioning Committee

Clare Highton - Chair, City & Hackney CCG Governing Body

Jane Milligan - Accountable Officer, NHS North East London Commissioning Alliance

Honor Rhodes – Governing Body Lay Member, City & Hackney CCG

FORMALLY IN ATTENDANCE

Andrew Carter - Director of Community and Children's Services, City of London Corporation

Philippa Lowe – Joint Chief Finance Officer, City & Hackney CCG

Mark Rickets - GP Member, City & Hackney CCG Governing Body

Gary Marlowe – GP Member, City & Hackney CCG Governing Body

STANDING INVITEES

Penny Bevan – Director of Public Health, London Borough of Hackney and City of London Corporation

Geoffrey Rivett - City of London Healthwatch

OFFICERS PRESENT

Simon Cribbens - Assistant Director of Commissioning and Partnerships, City of London Corporation

Mark Jarvis - Head of Finance, City of London Corporation

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

Siobhan Harper - Planned Care Workstream Director

Helen Sargeant Dar - Head of Integrated Leading Disabilities Service

APOLOGIES

Devora Wolfson –Programme Director, Integrated Commissioning

PUBLIC SESSION

1. Introductions

1.1. Randall Anderson welcomed members and attendees to the meeting. It was **NOTED** that decisions made by the two boards would be done so separately and independently, and this would be reflected in the minutes.

2. Declarations of Interest

2.1. Haren Patel declared that as a provider of some residential care services, he had an indirect interest in Item 5 and Item 6. It was noted that this did not constitute a material conflict of interest.

2.2. The City ICB **NOTED** the Register of Interests.

2.3. The Hackney ICB **NOTED** the Register of Interests.

3. Questions from the Public

3.1. There were no questions from members of the public.

4. Minutes of the previous Meeting

4.1. The City Integrated Commissioning Board:

- **APPROVED** the minutes of the Joint ICB meeting on 31 January 2017; and
- **NOTED** progress on actions recorded on the action log

4.2. The Hackney Integrated Commissioning Board:

- **APPROVED** the minutes of the Joint ICB meeting on 31 January 2017; and
- **NOTED** progress on actions recorded on the action log

5. Community Grants Scheme

5.1. Penny Bevan presented the report setting out the recommendations for the first year of the joint Community Grant Scheme. The Healthier City and Hackney Fund brings together two former grant funds; the CCG Innovation Fund and Hackney Council's Healthier Hackney Fund to provide £500,000 for grant making in 2018/19.

5.2. The report outlined the promotion of the scheme and shortlisting process, and the final list of recommended grantees.

5.3. The City Integrated Commissioning Board:

- **ENDORSED** the recommendations for the first year of the joint Community Grant Scheme.

5.4. The Hackney Integrated Commissioning Board:

- **ENDORSED** the recommendations for the first year of the joint Community Grant Scheme.

6. Business Case for Pooling Residential and Continuing Care

6.1. Siobhan Harper presented a report on proposals to expand current joint funding arrangements and pooled budgets between the CCG and the two local authorities. The report outlined the additional benefits this would create, and summarised progress made to date, specifically focusing on Learning Disability Services, where all partners faced significant cost pressures. This work was being led by the Planned Care workstream as part of a more proactive and sustainable approach, and would be piloted with a particular care group from 1 April 2018.

6.2. Philippa Lowe and Ian Williams outlined the financial case for action and asked the Boards to approve that the 3 Chief Finance Officers should agree the final financial details outside of the meeting. They noted that the timeline for proposals is ambitious, but supported by strong working relationships between

partners. The final revised business case will be brought back to the ICBs once agreement has been reached.

6.3. Honor Rhodes noted that this approach will enable us to better provide for the needs of individual patients and service users, and expressed her full support for the proposals, noting that they would also be a useful area to conduct evaluation work.

6.4. Jon Williams noted that it would be useful to contact service users as early as possible to advise them of changes, and to be very clear on how they will benefit.

6.5. Clare Highton asked whether there would be any changes to the governance of personal health budgets, etc. Siobhan Harper advised that partner organisations would retain their statutory duties on the delivery of Continuing Healthcare. Robust and transparent risk share agreements would be included in the s75 agreements.

6.6. Simon Cribbens, speaking as SRO for Planned Care, noted that proposals are ambitious, and there is still a lot of detail to address, but this is an opportunity to be genuinely transformative.

6.7. The City ICB:

- **NOTED** the work done to date to progress joint funding arrangements and pooled budgets locally with a particular focus on ILDS.
- **ENDORSED** extending pooling arrangements across CHCCG, LBH and CoL and the timetable for agreeing a new joint funding mechanism for ILDS.
- **ENDORSED** delegated authority to the Group Director of Finance and Corporate Resources at LBH, The Chamberlain at CoL and the Chief Finance Officer at CHCCG to finalise and agree the detailed financial arrangements for 2018/19 as part of the agreement of 2018/19 budgets, subject to normal governance approvals for each partner;
- **ENDORSED** the business case being submitted to NHS England to establish the extended pool for 2018/19 and the focused work on ILDS within this.

6.8. The Hackney ICB:

- **NOTED** the work done to date to progress joint funding arrangements and pooled budgets locally with a particular focus on ILDS.
- **APPROVED** extending pooling arrangements across CHCCG, LBH and CoL and the timetable for agreeing a new joint funding mechanism for ILDS.
- **APPROVED** delegated authority to the Group Director of Finance and Corporate Resources at LBH, The Chamberlain at CoL and the Chief

Finance Officer at CHCCG to finalise and agree the detailed financial arrangements for 2018/19 as part of the agreement of 2018/19 budgets, subject to normal governance approvals for each partner;

- **APPROVED** the business case being submitted to NHS England to establish the extended pool for 2018/19 and the focused work on ILDS within this.

7. Update on Neighbourhoods

7.1. Nina Griffith presented an update on the Neighbourhood Development programme, with a particular focus on governance and contracting arrangements. A full business case would be brought to the ICB in July 2018, with analysis of recurrent costs and benefits, and it is hoped that neighbourhoods will start to go live, based on a phased readiness approach, from August. There is a clear aspiration to put service users at the heart of neighbourhoods, and a patient-panel has been set up with the support of Healthwatch.

7.2. Members noted that the business case would need to include improvement targets on Better Care Fund metrics, and should show the commitment from HUHFT to decrease activity in secondary care. It was noted that beyond the £800k allocated to fund the design and implementation phase, the programme should be cost-neutral. Lessons should be learned from One Hackney, where costs had risen from initial projections as the programme entered operations.

7.3. Members asked for detail on the vision for an arms-length delivery organization. Nina Griffith reported that this was an option being considered, which would operate as a subsidiary, hosted by HUHFT to hold the budget for workforce for the set-up of the programme.

7.4. Anne Canning noted that the neighbourhoods model is being closely considered by the other workstreams to see how projects they are developing will fit in. The workstreams are keen, therefore, to know what the KPIs will be in the business case. It was agreed that the next report would include reflection on how the other workstreams will interact with and contribute to the neighbourhoods model.

7.5. **ACTION ICBFeb18-1:** To discuss with the other workstreams how they will interact with and contribute to the neighbourhoods model, and to include content on this in the next report to the ICB (NG)

7.6. The City Integrated Commissioning Board:

- **NOTED** the update from the City and Hackney Neighbourhood development programme; in particular:

  - Formal governance arrangements for the design and planning phase of the City and Hackney Neighbourhood development programme
  - Summary of the key milestones for this phase of the programme
  - Description of the contracting and assurance arrangements for the committed resources
- **NOTED** that funds will be released to each provider in March 2018 subject to:
  - A formal contract being agreed between the CCG and the provider
  - The production of a service specification for each provider to accompany the contract based on the model template included in Section 4

7.7. The Hackney Integrated Commissioning Board:

- **NOTED** the update from the City and Hackney Neighbourhood development programme; in particular:
  - Formal governance arrangements for the design and planning phase of the City and Hackney Neighbourhood development programme
  - Summary of the key milestones for this phase of the programme
  - Description of the contracting and assurance arrangements for the committed resources
- **NOTED** that funds will be released to each provider in March 2018 subject to:
  - A formal contract being agreed between the CCG and the provider
  - The production of a service specification for each provider to accompany the contract based on the model template included in Section 4

8. Procurement of Out of Area Termination of Pregnancy Services

8.1. Siobhan Harper presented a proposal to procure alternative Termination of Pregnancy (ToP) services under an Any Qualified Provider (AQP) model for patients that do not wish to attend the Homerton Hospital. These services would provide improved choice to woman and create cost savings of approximately £120k to the overall health economy.

8.2. The City Integrated Commissioning Board:

- **ENDORSED** the procurement of alternative Termination of Pregnancy Provider(s).

8.3. The Hackney Integrated Commissioning Board:

- **ENDORSED** the procurement of alternative Termination of Pregnancy Provider(s).

9. External Engagement & Communications

9.1. Jon Williams presented an update on upcoming planned communications and engagement activities with stakeholders and the wider public over the coming months.

9.2. Clare Highton noted that there was a political role for councilors to foster patient and public involvement in Integrated Commissioning, and also suggested that patient leaders could take part in the ICB.

9.3. It was noted that further consideration should be given to how to effectively engage with and involve patients and public in the work of integrated commissioning, and to improve the current level of engagement within the care workstreams.

9.4. The City Integrated Commissioning Board:

- **NOTED** the planned media, communications and engagement activities.

9.5. The Hackney Integrated Commissioning Board:

- **NOTED** the planned media, communications and engagement activities.

10. Integrated Commissioning Risk Register

10.1. Matt Hopkinson presented the summary of risks escalated from the four care workstreams and from the Integrated Care programme. The risk register represents a first iteration of scoping and defining the risks in the workstreams, and the workstreams will continue to focus on identifying and managing risks as a core part of their role. It was noted that further work will be undertaken to align risks to the over-arching objectives of the IC programme and to defining overall risk appetite.

10.2. The City Integrated Commissioning Board:

- **CONSIDERED** the Integrated Commissioning Escalated Risk Register; and
- **NOTED** progress to date on formalising the management of risk within the Integrated Commissioning Programme.

10.3. The Hackney Integrated Commissioning Board:

- **CONSIDERED** the Integrated Commissioning Escalated Risk Register; and
- **NOTED** progress to date on formalising the management of risk within the Integrated Commissioning Programme.

11. Indicative Workstream Budgets 2018/19 and agreed QIPP and Savings Proposals

11.1. Philippa Lowe, Ian Williams and Mark Jarvis presented the budget plans for 2018/19 to 2020/21, analysed across the four care workstreams. For the City of London Corporation and the London Borough of Hackney, these budgets are subject to approval by the Court of Common Council and Full Council, respectively.

11.2. The City Integrated Commissioning Board:

- **NOTED** and **ENDORSED** the indicative Integrated Commissioning budgets for the commissioning partners over the three years 2018/19 to 2020/21.

11.3. The Hackney Integrated Commissioning Board:

- **NOTED** and **ENDORSED** the indicative Integrated Commissioning budgets for the commissioning partners over the three years 2018/19 to 2020/21.

12. Integrated Finance Report - Month 10

12.1. Philippa Lowe, Ian Williams and Mark Jarvis presented the update on finance (income & expenditure) performance for the period from April to December 2017 across the CoLC, LBH and CCG Integrated Commissioning Funds. The forecast variance for the Integrated Commissioning Fund as at Month 09 (December) is £3.6m adverse. This is a favourable movement of £0.2m on the Month 8 position. Driving the overall adverse forecast outturn is the London Borough of Hackney due to Learning Disabilities commissioned care packages, as had been previously reported to the ICB.

12.2. The City Integrated Commissioning Board:

- **NOTED** the report.

12.3. The Hackney Integrated Commissioning Board:

- **NOTED** the report.

13. Reflections on Meeting

13.1. **ACTION Feb18-2:** To ensure that there is a clear blank page separating reports within the ICB agenda papers, for ease of navigation. (MH)

14. Any Other Business

14.1. There was no other business.

City and Hackney Integrated Commissioning Boards Action Tracker - 2017/18

Ref No	Action	Assigned to	Assigned from	Assigned date	Due date	Status	Update	Update provided by
HICB 1709-1	To present an analysis of the impact of Universal Credit introducition to a future ICB.	Ian Williams	Hackney Integrated Commissioning Board	20/09/2017	TBC	Open	To be scheduled for TB and ICB following further guidance on the timeline for further roll out	Ian Williams
ICBJan18-1	To consider ICB input into the LBH review of advice services and discuss with Sonia Khan, Head of Policy & Partnerships	Devora Wolfson	Hackney Integrated Commissioning Board	31/01/2018	21/03/2018	Complete	Please refer to Agenda Item	
ICBJan18-2	To ensure that the FPC is included in the workstream assurance review processes.	Devora Wolfson	City and Hackney Integrated Commissioning Boards	31/01/2018	21/03/2018	Complete	This has been added to the FPC forward plan for March 2018.	
ICBJan18-3	To look into alternative venues in Hackney and the City for future meetings of the Integrated Board	Matt Hopkinson	City and Hackney Integrated Commissioning Boards	31/01/2018	21/03/2018	Open	Ongoing. Arrangements are currently being made to alternate the venue between LBH, CoLC and the CCG.	Matt Hopkinson
ICBFeb18-1	To discuss with the other workstreams how they will interact with and contribute to the neighbourhoods model, and to include content on this in the next report to the ICB	Nina Griffith	City and Hackney Integrated Commissioning Boards	28/02/2018	14/06/2018	Open		

Title:	Outpatient Transformation
Date:	21st March 2018
Lead Officer:	Siobhan Harper – Planned Care Workstream Director Gary Marlowe – Planned Care Workstream Clinical Lead
Author:	River Calveley, City & Hackney CCG
Committee(s):	Integrated Care Board – for decision – 21st Mar 2018 CCG Governing Body – Approval –23rd March 2018
Public / Non-public	Public

Executive Summary:

Outpatient Transformation is one of 'Asks' of the Planned Care Workstream and a plan has been developed for the Homerton and partners to systematically review up to 12 outpatient specialties from April 2018 to September 2019 (18 months).

The reviews will focus on:

- Specialty administration – discharge/referral/patient or GP information
- Advice & Guidance/Education to primary care
- First and follow up arrangements
- Clinical pathways
- Linked community services

Additional Resources

Specific Additional Funding Requirements	**Annual Cost**	**Maximum Cost**
3 x 8a Improvement Managers for HUH	£180K - £208k	£312K
1 x Project Manager CCG	£60k	£90K
HUH/CCG Clinical Backfill (2 session per week)	£32k	£48k
	Total	£450k

It is recommended that the Hackney ICB delegate authority to approve investment in the context of these proposals to the CCG Joint Director of Finance, with oversight by Dr Mark Rickets. An update will be brought back to the ICBs in due course.

The proposed plan schedules 12 specialties/areas, however, these will need to be agreed and finalised to ensure the most effective outcomes can be achieved within the resources and time constraints.

It will look to achieve changes in how outpatient care is being delivered by providing:

- Increased enablement for primary care management
- Increased variety in the way first attendance with a specialist is provided
- Increased variety in the way follow up attendances are provided
- Increased patient activation in self-care and self-referral
- Greater activity in community services
- Improvements in the effectiveness of administrative systems
- Improvement in communications with patients and clinicians that will support the delivery of improved clinical outcomes.

The plan has set milestones linked with the STP incentive to ensure the work is completed.

The delivery of this transformation of outpatients will be key to maintaining efficient and effective services and keeping financial balance across the healthcare sector.

Summary of Transformation Board Discussion

1.1 The direction of travel was supported however some questions were raised about whether the timescales are realistic, given that consultants do not have much flexibility to commit time to this.

1.2 It was noted that in a broader context, City and Hackney is a very successful health economy in terms of outpatients, and there is already significant momentum for this way of working.

1.3 Healthwatch asked how patients are to be engaged in this work. It was explained that there is a PPI representative on the Planned Care workstream board, and discussions would take place with a patient panel, perhaps via the PPI Committee or PUEG.

The Chair noted that there was overall support amongst Board members for the principle and ambition of the plans for outpatient transformation, but there were concerns amongst HUHFT colleagues about the timing of proposals.

These areas have been mitigated by revising the plan's timescales and allowing for additional flexibility in plan delivery.

Recommendations:

The Hackney Integrated Commissioning Board is asked to:

- To **CONSIDER** and **APPROVE** the proposal and project plan
- To **APPROVE** the delegation of decisions regarding investment in the context of these proposals to the CCG Joint Director of Finance, with oversight by Dr Mark Rickets.

The City Integrated Commissioning Board is asked to:

- To **CONSIDER** and **APPROVE** the proposal and project plan
- To **ENDORSE** the delegation of decisions regarding investment in the context of these proposals to the CCG Joint Director of Finance, with oversight by Dr Mark Rickets.

Links to Key Priorities:

This document sets out a programme of work derived from the Transformation Board 'asks' of the Planned Care Workstream. The specific 'ask' it addresses is **Outpatient Transformation** where system partners will work to agree and implement a programme of modernisation and improved outpatient care on a pathway basis.

Specific implications for City

Although less than Hackney patients due to focus with Homerton outpatient services, the key implications will be:

Improved Homerton Outpatient services across 12 main specialties

- Wider improvements in support to GPs
- Support to patients and reduced unnecessary follow up activity available at the Homerton
- Improved communications across primary and secondary care
- Better outpatient integration with community services (CCG & City)

Specific implications for Hackney

Improved Homerton Outpatient services across 12 main specialties

- Wider improvements in support to GPs
- Support to patients and reduced unnecessary follow up activity available at the Homerton
- Improved communications across primary and secondary care
- Better outpatient integration with community services (CCG & City)

Patient and Public Involvement and Impact:

A plan of patient engagement has been agreed in principal by the Workstream that ensures:

- Patient representatives are engaged for each specialty project group
- Where minor changes to pathways/services are proposed then these are discussed with wider patient groups for that specialty
- Where significant changes to pathways/services are proposed then a full plan of engagement will be required.

Clinical/practitioner input and engagement:

The proposed plan will ensure that clinical leaders from both the Homerton and primary care will be engaged in the transformation work. Each task and finish group will have a minimum of a GP and Specialist leading the process supported by associated health professionals relevant to the work area.

There will be a clinical consensus for any proposed changes to be implemented to the patient pathway or the service models of delivery.

Impact on / Overlap with Existing Services:

This is a review of current outpatient services to inform the transformation process and changes could impact on many areas but each will have to be evaluated and agreed (perhaps as a separate project).

Key areas for overlap as follows:

- Community Services that link in with the specialties eg Community Dermatology, ENT, Locomotor, Foothealth and other services.
- Elements of the GP - Clinical Commissioning and Effectiveness Contract
- GP Confederation - Long Term Conditions Contract
- GP/Primary Care
- Advice and Guidance Services from the Homerton

Main Report

Background and Current Position

City and Hackney has worked closely with the Homerton on improved pathways which was the focus in 2017-18 of the Clinical Leadership Programme. This programme established a number of clinical pathways and patient centred service changes.

The Transformation Board has identified the key ask of the Planned Care Workstream to deliver improvements in the delivery of outpatient services which builds on the work of the Clinical Leadership Programme developing and expanding on it to deliver more efficient and effective services which will improve the patient

experience and deliver economies in the local health system.

The proposal for transformation has been widely discussed including at the Homerton senior management team meetings and there has been stated support that such an approach could provide positive outcomes in how services are delivered.

Options

The Workstream has developed a plan with input from the Homerton management to systematically review 12 outpatient services over a 12-18 month period. This will include reviewing the administrative systems that support them, patient and clinical pathways and the related community/primary care services if applicable. The aim will be to improve the effectiveness and efficiency of these services with a clear patient focus of any changes.

The following core principles and commitments of the transformation work are:

Core Principles

- Strengthening knowledge exchange and self-management in the community with the patient at the centre for example: increasing specialist community support to patients via group sessions where patients can relate issues and self-care expertise with clinician support;
- Accessing decision support, care planning and care services in the community wherever safe and appropriate;
- Emphasising competency-based roles in secondary care, to focus Consultant resource on more complex patients, and recognising the role of the GP as the 'expert clinical generalist' and raising the profile and enhancing the role of the wider multidisciplinary team of community-based practitioners for example – introducing Condition specific pathways which triages patient to the right clinician first time (in the right service) and reduces unnecessary delays;
- Optimising e-Health and digital opportunities at the primary/secondary care interface as the norm;
- Reducing widespread variation in secondary care return appointments and review processes, wherever clinically appropriate.
- Reducing widespread variation in primary care by reviewing and supporting clinical pathways for improved decision making for GPs and patients, proposed beneficial outcomes and assessments of risk.

Commitments:

- Patients will receive timely access to advice, treatment and support.
- Patients will not incur unnecessary inconvenience when accessing outpatient services
- Patients will gain access to outpatient services when it is clinically appropriate

The transformation work is expanded upon in the Project Scope proposal document and plan below:

Planned Care - Outpatient Transformation –

Homerton University Hospital Trust

Project Plan

This Transformation project plan is based on:

1. **The project scoping document and the discussions with the CCG and Homerton as part of the Planned Care Workstream asks**
2. **The transformation aims of providing improved specialist advice/education in primary care, removing unnecessary follow ups or replacing them with non-face to face where appropriate, increasing opportunities for patient self-management and improving the utilisation of community services/education/support services as part of the overall patient pathway.**
3. **The principles of:**
    - The assumption that an agreed terms of reference will ensure that all relevant stakeholders are consulted for cross agreement (Homerton/CCG/Heathwatch etc)
    - Where applicable, community services, either provided by HUH or not will be included in specialty level investigations.
    - Current National CQUINs that will assist transformation will be achieved (e-RS and Advice and Guidance specifically) during 18/19.
    - Task and Finish Groups (TFGs) will all have Workstream/Provider clinical & Management representation with patient representatives
    - There is no requirement for further savings on agreed activity within year than those already set out in the agreed contract activity plan for 18/19.
4. **The end outcome should ensure that overall activity levels for the agreed 12 specialties is maintained within the contracted activity plan and the principles of transformation can be supported and built upon across the remaining specialties in subsequent years**
5. **The proposals are dependent on sufficient funding for key posts to support the programme being made available – see resource requirements below**

Key Transformation Areas:

a) Prevent unwarranted first attendance/referral:

Advice and Guidance – align with training. FAQs etc, MDT/GP discussion and feedback, triage to community/primary care/other, pathways, GP Education/Training, Patient self-management.

b) Reduce unnecessary routine face to face follow ups:

Minimise variation within specialties. Routine test results provided as non-face to face, with supporting information as the norm. Explore follow ups in the community or primary care services. Patient centred tools, enable self-management, virtual/telephone/primary care follow up

c) Optimise what should be done in secondary care and by whom:

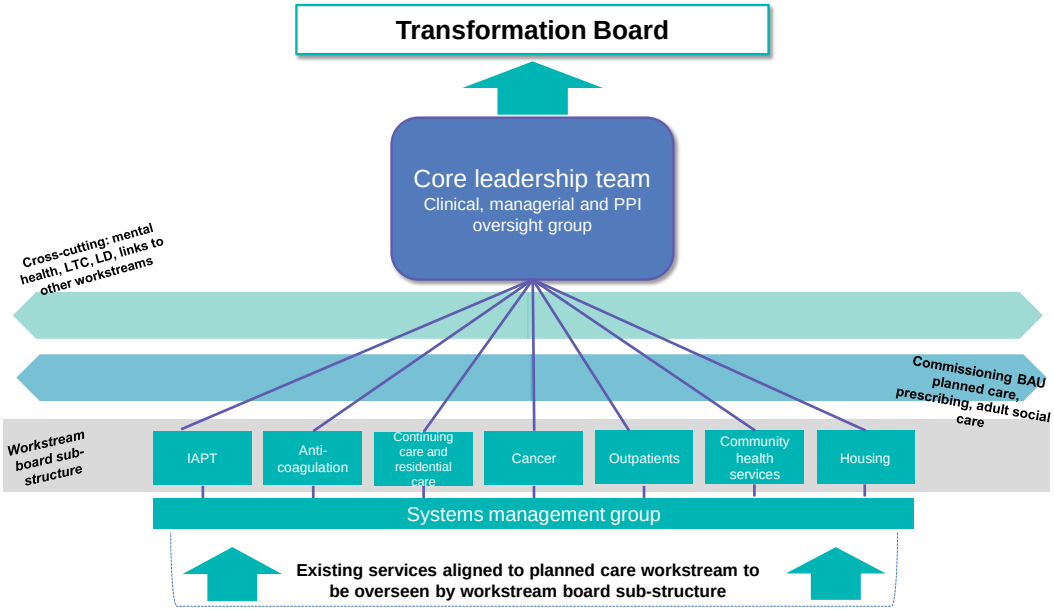
Links across specialties to avoid reduce internal C2C (review mgt and integration)
E consultation (virtual) in patient home/GP premises. Group consultation where similar patients are consulted in a group. Extended scope practitioners/Advanced nurse practitioners/Specialist nurse for targeted follow up allowing consultants to focus on complex and surgical work. Integration of relevant mental health service support across the clinical pathways.

d) Maximise the utilisation of community service resources

Integration of clinical pathways across community and secondary care specialties/services, enabling staff to work multidisciplinary and collaboratively rather than is separate services. We can look at shared governance arrangements, pathways, assessments, clinical and administrate teams where appropriate.

Governance

Planned care workstream proposed outline governance



Programme Monitoring – A tool will be developed to measure the impact on activity and outcomes as the changes are implemented. A steering group will be set up to meet and report monthly to the Workstream on the progress and impact of the programme. They will agree project actions/changes and where appropriate escalate to Workstream for further decision/approval.

Programme Flexibility – Changes to plan elements and specific asks must be proposed to and agreed by the Workstream CLG. These should usually be proposed in good time to update and plan the programme. Timelines can be altered/extended with agreement of the Workstream CLG, however, resources are finite and any such proposals should take that into account and be cost neutral. Incentive payments may be delayed up to 3 months for late achievement.

Investments – Where investments are identified as required to make significant change. Business cases must be submitted that have taken into account stakeholder views for clinical appropriateness and resourcing.

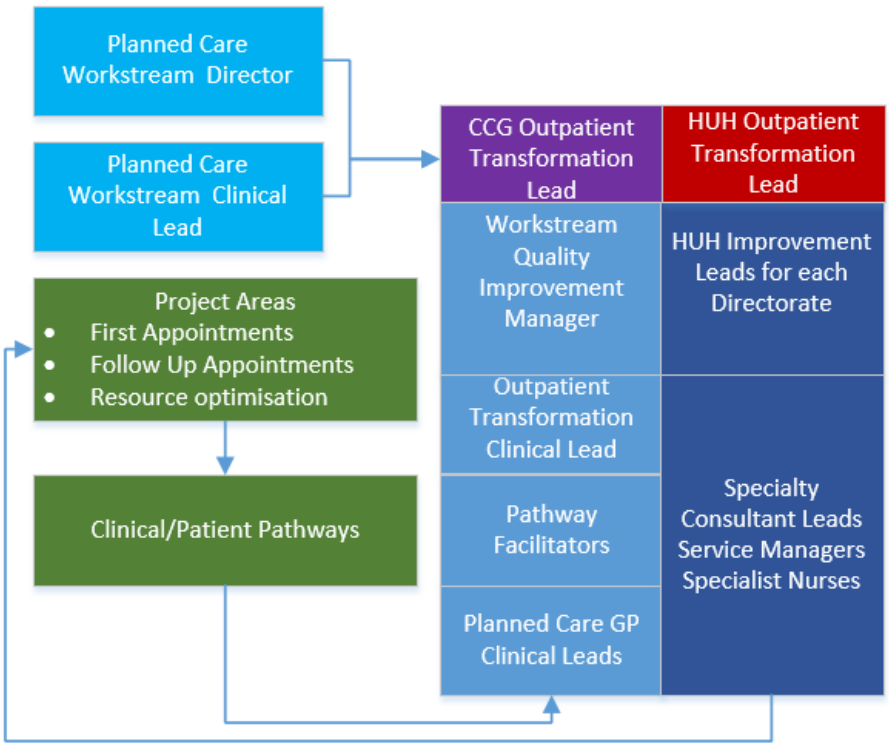
Note: Where proposals for patient pathways to change are made in favour of a community or primary care service which are outside the normal criteria/scope of said services, will need to be agreed by the relevant parties and resourced appropriately. A business case will be required as per investments above.

Patient Involvement

Plan to be decided and agreed by each work area to involve patients throughout transformation and to engage where transformation has a significant change in patient pathways and/or services.

To be in line with the *Co-Production Charter for Health and Social Care – City and Hackney*

FINANCE - Project Resources requirements



Funding will need to cover core staff for both parties plus additional for patient participation.
Core staffing for additional funding:

- Up to 3 transformation managers for the Homerton.
- Additional project support for the CCG Workstream.

Each organisation should provide an overall Programme Lead and clinical lead (could be the same person). These are expected to come from existing staff members.
The CCG has already allocated 2 x band 6 from existing resources to support the programme.
Specialty specific Clinical leadership should come from the existing consultant leadership and from the CCG GP clinical leadership.

It is important to note that maintenance of the agreed activity levels for the 2018/19 contract and QIPP delivery is linked to the additional investment and incentive achievement.

Specific Additional Funding Requirements	Annual Cost	Project – Maximum Cost
3 x 8a Improvement Managers for HUH	£180K - £208k	£312K
1 x Project Manager CCG	£60k	£90K

HUH/CCG Clinical Backfill (2 session per week)	£32k	£48k
	Total	£450k

The funding will be held by the CCG; the Homerton will invoice as and when appropriate staffing and expenditure has been realised.

The Outpatient Transformation Project Plan is dependent on funding of staff to cover core staff from Homerton Hospital and CHCCG. This is the maximum cost based on recruitment at the top of the An overall Programme Lead and Clinical Lead will be provided from existing staff members and additional project support will be provided by the Integrated Commissioning Planned Care Workstream.

The project will be delivered within a robust Assurance framework.

Timeline – Dependant on staffing recruitment, however, there is flexibility built into the programme.

Homerton Outpatient Transformation	Project Set Up	Resources/Outcome description
Milestone 1	**April - June 2018**	***Funding – Staffing to be agreed for project period***
Focus of Work	• Terms of reference • Appoint/Recruit Transformation Managers • Agree baseline Data and benchmarking • Agree patient engagement • Agree Specialties for Q2 • Agree specific but general overall target trajectories for activity changes • Agree principles/Scope of wider transformations in general manager & Admin • Set-up Task and Finish Group groups with relevant members ➢ *Core staff should be allocated to the project 12-18 months* ➢ *Baseline data and benchmarking should represent the best opportunities in England and not seek to mirror local trusts only.* ➢ *Specialties should be chosen to achieve the optimum opportunities in reducing unnecessary or changing activity*	By end of June 2018 we should have the following agreed and in place: **Key staff appointed** (the number and type will depend on funding) **Four Specialties** will be agreed for transformation in Q2 **Trajectory of activity changes agreed** – these will relate to appointments (First and/or FU) that can be converted to either (Virtual/Non Face to Face/other) and based on benchmarking **Task and Finish Group members identified** and agreed for Management & Admin review and for each specialty proposed for Q2 *No Incentive or funding will be available in April apart from any agreed additional staff salary costs.*
Milestone 2	**July to September 2018** (Q2)	***Funding: 20% Incentive (STP) for completion of outcomes?***

Focus of Work	1. Management and Administration Overview 2. Outpatient specialty Review (as agreed in milestone 1) Four key specialties that will deliver the most impact.	
Management and Administration	HUH will review management and administrations covering: Service organisation • Referral Management • Appointment systems • Discharge and Patient/GP information An initial overall review will be to identify any overall changes that can be investigated for implementation across specialties and other services – these may cover areas such as: • e-Referral System/T-Quest • Hospital Systems • Communications to patients/GPs • Transport • Best practice from other trusts	By end of September 2018 we should have the following outcomes from this review for transformation: An agreed plan for any overall changes to management and administration – it will cover ➢ IT changes ➢ System Cost/Benefit analyses ➢ Implementation proposals & Timeline ➢ Quick wins

Four Specialties Q2 • To be finalised	Each Specialty will have a bespoke Task and Finish Group group with the relevant membership facilitated by the project leads: • Review First Appointment Criteria and opportunities for amending e.g. Non Face to Face/Virtual/alternative pathways – community etc. • Review Follow up criteria and opportunities for changing to Non Face to Face, discharging for follow up in primary care/ community services or patient self-referral/management • Review discharge protocols • Audit work validate changes • Review existing schemes for possible implementation e.g. T & O virtual/Urology FU[1] etc • Identify alternative clinical pathways for specific clinical criteria's	By end of September 2018 we should have the following outcomes from this review of each specialty for transformation: Provide an agreed plan that covers ➢ Changes to Face to Face First appointments ➢ Alternatives to GP referral ➢ Changes to discharge and non-face to face FU ➢ Specific schemes identified ➢ Cost/Benefit/analysis ➢ Target analyses ➢ Quick wins ➢ Clinical Outcome improvements ➢ Implementation and timeline Agree 4 specialties for Phase 3
Milestone 3	**October to December 2018 (Q3)**	***Funding 20% of Incentive***
Focus of Work	1. Implementation of agreed managerial and administration transformations 2. Implementation of agreed Specialty transformations from Q2 reviews 3. Outpatient specialty Review (as agreed in milestone 2) Four key specialties that will deliver the most impact.	
Implementation Q2	As agreed in Q2	Achievement of agreed implementation Funding 50% of Incentive for Q3 Funding

[1] Imperial College have recently reduced FU rates in Urology

Four Specialties Q3 • To be finalised	Each Specialty will have a bespoke Task and Finish Group with the relevant membership facilitated by the project leads: • Review First Appointment Criteria and opportunities for amending e.g. Non Face to Face/Virtual/alternative pathways – community etc. • Review Follow up criteria and opportunities for changing to Non Face to Face, discharging for follow up in primary care/ community services or patient self-referral/management • Review discharge protocols • Audit work validate changes • Review existing schemes for possible implementation • Identify alternative clinical pathways for specific clinical criteria's	By end of December 2018 we should have the following outcomes from this review of each specialty for transformation: Provide an agreed plan that covers ➢ Changes to Face to Face First appointments ➢ Alternatives to GP referral ➢ Changes to discharge and non-face to face FU ➢ Specific schemes identified ➢ Cost/Benefit/analysis ➢ Target analyses ➢ Quick wins ➢ Clinical Outcome improvements ➢ Implementation and timeline Funding 50% of Incentive for Q2 Funding
Milestone 4	**January to March 2019 (Q4)**	***Funding 20% of incentive***
Focus of Work	1. Implementation of agreed Specialty transformations from Q3 reviews 2. Outpatient specialty Review (as agreed in milestone 3) Four key specialties that will deliver the most impact.	
Implementation Q3	As agreed in Q3	Achievement of agreed implementation Funding 50% of Incentive for Q3 Funding

Four Specialties Q4 • To be finalised	Each Specialty will have a bespoke Task and Finish Group group with the relevant membership facilitated by the project leads: • Review First Appointment Criteria and opportunities for amending e.g. Non Face to Face/Virtual/alternative pathways – community etc. • Review Follow up criteria and opportunities for changing to Non Face to Face, discharging for follow up in primary care/ community services or patient self-referral/management • Review discharge protocols • Audit work validate changes • Review existing schemes for possible implementation • Identify alternative clinical pathways for specific clinical criteria's	By end of March 2018 we should have the following outcomes from this review of each specialty for transformation: Provide an agreed plan that covers ➢ Changes to Face to Face First appointments ➢ Alternatives to GP referral ➢ Changes to discharge and non-face to face FU ➢ Specific schemes identified ➢ Cost/Benefit/analysis ➢ Target analyses ➢ Quick wins ➢ Clinical Outcome improvements ➢ Implementation and timeline Funding 50% of Incentive for Q4 Funding
Milestone 5	**April to June 2019**	***Funding: 40% of Incentive***
Focus of Work	1. Implementation of agreed Specialty transformations from Q4 reviews 2. Implementation of remaining agreed plans e.g. things that took longer to finalise and agree from Q2-Q3 Management & Administration and specialty reviews 3. Outpatient Transformation Review & Evaluation 4. Plans for 19/20 as applicable	
Implementation Q4	As agreed in Q4	Achievement of agreed implementation Funding 25% of Incentive for Q1 19-20 Funding

Remaining implementation from Q2-3	As agreed from Q2-3	Achievement of agreed implementation Funding 25% of Incentive for Q4 Funding
Outpatient Transformation Review & Evaluation	A full review and evaluation will be undertaken with the workstream and other stakeholders. This will include • Outcome Achievement (Trajectory achievement) • Impact of changes on activity in 2019/20 • Changes to clinical pathways • Issues or problems to be resolved • Investment/Cost benefit analyses • Patient Engagement Evaluation • Outstanding elements • Plans for 2019/20	By end of June 2019 we should have the following outcomes from this review of each specialty for transformation: ➢ A final report ➢ Presentations of achievements to: o Patient Groups o GP stakeholders o Workstream ➢ Draft cases of QIPP/CIP savings delivered by the transformation for publishing later in 2019 There is a 3 month flexibility built into this to allow for finalisation by Sep 2019 if required. Funding 25% of Incentive for Q1 19/20
Claims for Incentive achievement	A report to be submitted to the Planned Care Workstream Board at the following stages: Milestone 2 – by end of October 2018 Milestone 3 – by end of January 2019 Milestone 4 – by end April 2019 Milestone 5 – by end of September 2019 The report must address all outcome requirements. Update on any ongoing work and provide evidence for the payment of the incentive in accordance with the plan.	
Rules for partial achievement of the transformation work in any or each of the phases	To be agreed dependant on funding requirements. Based on outcome of reviews and Implementation of agreed plans but must not exceed 75% of the available incentive.	

Equalities and other Implications:

The programme of work will involve using technology, patient education and improved communication to reduce the need for face to face appointments, however, these changes will need to be balanced to ensure that inequalities in service do not creep into the system. Some changes could discriminate against people with learning, hearing or other disabilities and those who require different language support.

It will be important to ensure that the project addresses any change to an element of service with an evaluation of how it can address any challenges to an equal service for all. Individualising the service around the patient will be paramount to addressing any inequalities.

Interpretation and translation services will need to be considered regarding self-management, virtual clinics and e-communications with patients.

The patient access and their ability to use technologies that introduced must be assessed as a change may never be one to fit all the users and patient choice to how they want to receive the service must be considered.

All cases for change must be approved by Workstream and relevant committees before adoption.

The programme has a 12 month timeline with some limited flexibility (6 months) but it may over run due to staff availability or other issues. The 12 provisionally proposed specialties do not cover all of outpatients and there must be an expectation to extend the programme to deliver a total transformation.

Proposals

The proposed project plan for the transformation programme, is key to the modernisation of our local outpatient services. It will be instrumental in identifying and shifting the focus of activity from being routinely seen in an acute hospital setting to ensuring there are a variety of options that are available to the patient that may improve outcomes. These will range from different patient groups, depending on factors such as age, education, disabilities and across the types of ill health being treated but it will be focussed on the individual needs.

The investment and incentive for the transformation will aim to produce outcomes that will reduce the dependence on face to face consultations with specialists.

These will range from:

- Increased enablement for primary care management
- Increased variety in the way first attendance with a specialist is provided
- Increased variety in the way follow up attendances are provided
- Increased patient activation in self-care and self-referral
- Greater activity in community services
- Improvements in the effectiveness of administrative systems

- Improvement in communications with patients and clinicians that will support the delivery of improved clinical outcomes.

We will see benefits in how Payment by Result (PBR) activity changes within the acute contract with more activity with local prices for virtual/telephone/group consultations and supporting services such as focussed advice & guidance, MDT forums and education (primary care and patient focussed). There will also be a change of investment from PBR services into community and primary care led services with specialist support.

Conclusion

The Outpatient Transformation proposals will begin the process of modernisation that will result in real change for patient care. It aims to work with all the stakeholders to create this change and will be provider led. It is supported by the Homerton management team who feel that it may have a positive impact on service delivery.

It aims to introduce new practices that make patients more involved in their own care and how they want it to be delivered.

The plan has clear milestones linked to an existing STP CQUIN incentive and the proposed 12 specialties will cover the majority of GP referred adult patient activity.

The plan has a clear focus, key milestones, has provider support, appears realistic in what work it has set out to do and is trackable so progress can be monitored.

The outcomes proposed will ensure change to the how services are accessed and delivered locally.

Supporting Papers and Evidence:

Outpatient Transformation - Project Proposal Document - *Available on Request*

Sign-off:

Workstream SRO _____ Simon Cribbens, Assistant Director of Commissioning and Partnerships London Borough of Hackney _____Anne Canning, Group Director of Children, Adults and Community Health City of London Corporation _____Simon Cribbens, Assistant Director of Commissioning and Partnerships City & Hackney CCG _____David Maher, Acting Managing Director

Title:	London Borough of Hackney Advice and Debt Review
Date:	21 March 2018
Lead Officer:	Sonia Khan - Head of Policy, London Borough of Hackney
Author:	Joanne Blackwood-Policy Advisor, London Borough of Hackney
Committee(s):	Integrated Commissioning Board - for noting - 21 March 2018
Public / Non-public	Public

Executive Summary:

The purpose of this report is to provide an update on the Advice and Debt review carried out by Hackney Council and grant funded Social Welfare advice providers and set out the next steps as we move towards a newly commissioned service in April 2019.

LB Hackney's Voluntary and Community Sector Grants Programme includes ring-fenced funding of £750k for advice services which are delivered by voluntary and community sector organisations.

Given the challenges facing advice services in the wake of unprecedented and ongoing welfare reforms, the Council has been working with the three main grant funded advice providers, to carry out a systems review of advice services.

The need for a new approach is increasingly relevant as public services are evolving in an attempt to respond to complex social problems and the complexity of people's lives.

This approach starts with analysing services from the customer's perspective to gain an understanding of how the system works and identifying weaknesses and inefficiencies caused by the current system design.

The work so far has found that:

- The point at which residents access advice services could be arbitrary and accidental
- Mapping people's journeys through the system shows that people don't always know how to access services and when they do triage and signposting lead to repeat visits leading to fragmented services
- Advice is sometimes transactional, looking at the presenting problem only

Experimentation has started with the principle funded advice organisations to test out different design principles to focus on trying to achieve 'resolution' for people at the earliest stage and ensuring that issues are addressed as fully as possible without having to refer to other services or through numerous separate appointments.

Next steps

- Continue with the review of advice services looking at how we can help people solve their problems
- Work with public services that drive demand into advice services
- Integrate how we respond to debt into this work

Use this learning to re-design an advice model from April 2019.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the work carried out on the review so far particularly the analysis and methodology and the new approach to working with providers.

Links to Key Priorities:

This report links to the re-commissioning of advocacy services at the London Borough of Hackney.

Specific implications for City

The advice and debt review effects only services provided within Hackney. There are no direct implications for the City of London.

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

This approach starts by analysing services from the customers perspective to gain an understanding of how the system as a whole works and identifying weaknesses and inefficiencies caused by the current system design. This involves listening to what users of services ask for in their own words and finding out what matters and how services could respond to enable this to be achieved.

The learning from this will be used to co-design the new service.

Clinical/practitioner input and engagement:

The new grant from 2019 will be co-designed with the advice sector so they will have an equal say in the grant framework. Once the initial framework has been co-designed we will consult widely both internally and with external stakeholders.

Impact on / Overlap with Existing Services:

How this interacts with advocacy services will be considered as part of the co-design process.

Main Report

Background and Current Position

LB Hackney's Voluntary and Community Sector Grants Programme includes some ring-fenced £750k funding for advice services in the borough which are delivered by voluntary and community sector organisations.

In 2014/15 LB Hackney carried out a broad review of advice services which enabled us to identify the main strengths and weaknesses of provision in the borough. The findings from this review were used to deliver some quick wins and informed the design of new advice grants for 2016/17-17/18.

However given the challenges facing advice services in the wake of unprecedented and ongoing welfare reforms it was necessary to seek to address the ongoing weaknesses of advice provision. Since October 2016 the Corporate Policy and Partnerships team have been working with the three main grant funded advice providers, Citizens Advice, Hackney Community Law Centre and deafPLUS and a consultant from Advice UK to carry out a systems review of advice services.

The project is using a systems thinking methodology which radically examines systems to reframe thinking on shared problems.

There is a presumption in current system design that specifying service delivery methods, setting standards and monitoring and managing performance against pre-determined standards improves performance. This is increasingly being challenged within public services as the intended outcomes for recipients of services are not realised. In fact, studying systems of work shows that current system design drives a rigid compliance culture in which frontline staff and managers are incentivised to focus on the achievement of arbitrary standards and targets, and in many cases are not encouraged to seek meaningful and sustainable outcomes for the people using the service.

The need for a new approach is increasingly relevant as public services are evolving in an attempt to respond to complex social problems and the complexity of people's lives.

There is also political commitment to continue to invest in independent advice services while recognising the need for a new approach for services that are fully able to support residents and address in a sustainable way the complex and often challenging issues they face, especially in the wake of unprecedented and ongoing welfare reform.

The aspiration for the new model is an integrated debt and advice service which helps people resolve their problems at the earliest stage and find ways to help people address wider issues to help them live a happier more fulfilled life. Advice providers will work together to deliver a single service, working across institutional boundaries.

The systems approach starts by analysing services from the customer's perspective to gain an understanding of how the system as a whole works and identifying weaknesses and inefficiencies caused by the current system design. This approach questions and challenges current design assumptions to establish new ways of working.

Through this work we have been:

- Listening to what people actually ask for in their own words, e.g. the demand
- Finding out what matters to them about how services work with them and asking them what a 'good life' looks like and how the services could respond to enable this to be achieved
- Working to understand value demand vs. preventable demand and how this is generated and impacts upon individuals
- Analysing this information
- Mapping residents' journeys into and through advice services and creating system pictures of individual services and advice provision as a whole

The new approach outlined has informed the thinking for the new Voluntary and Community Strategy which aims to support the transformation of the VCS and relationships with the statutory sector. This will include closer and more collaborative working to develop more sophisticated responses to the complex social problems facing Hackney. The strategy will address the infrastructure needs of the sector including property and accommodation, and advice and debt services are an area where the options for co-location will be explored.

Key findings

The Vanguard approach uses a cyclical approach to improvement which involves:

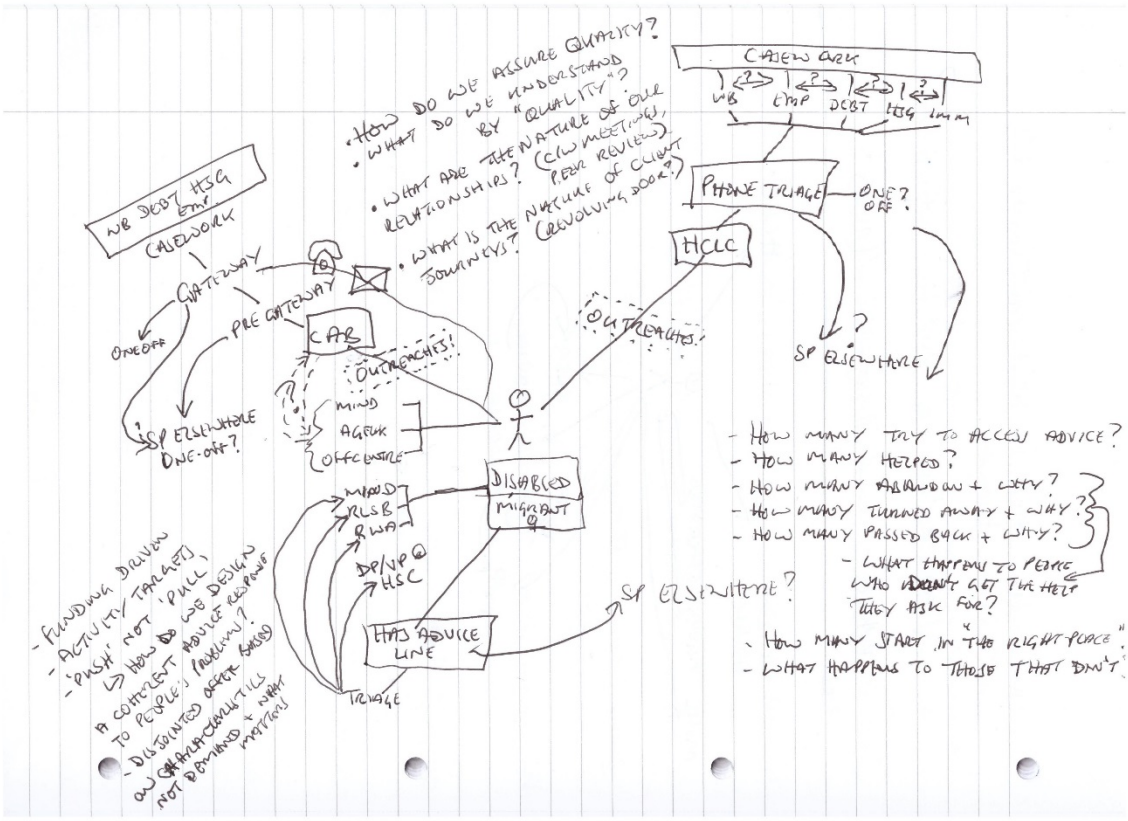
- Studying to understand the system 'outside in' from the perspective of the

people who use it
- Experiment – learn how to do 'perfect' one person at a time
- Redesign- Learn how to make this the normal way of doing things

Initial observations in advice services showed that there were some excellent examples of advisers doing their best to help people address their issues, but the system as a whole was fragmented and confusing. The point at which residents access advice services was arbitrary and accidental, based on:

- Their own awareness (or otherwise) of services;
- Word of mouth of friends or family members who had previously been helped; or
- Signposting from other agencies – in many cases inappropriately or raising false expectations of what advice services could or would do.

As the image below suggests, for a resident there is a bewildering array of service options, some targeted on individual characteristics, such as disability, mental ill-health, age or gender.



Mapping people's journeys through the system shows that people don't always know how to access services and when they do triage and signposting lead to repeat visits. Subsequently the service they receive is often fragmented and unable to

support them to learn about and navigate systems for themselves. Advice is sometimes transactional, looking at the presenting problem only. However people experiencing social welfare law problems rarely face a single problem, particularly those experiencing severe and multiple disadvantage who, by definition, face a complex mix of issues impacting, amongst other things, on their housing; benefit entitlements and claims history; their physical and mental health and wellbeing; their capability to interact with impersonal service provision and remote decision-making; and discrimination in various forms. The mapping showed that it could take a long time to reach resolution, spanning many months and that the journey could be messy.

This reflected the complexity of people's needs, and the ways that problems could compound and escalate. However in reviewing the journeys, it was clear that there was a great deal of waste, with time was being spent responding to systems failure and preventable demand.

There is also a perceived distinction between what is characterised as "generalist" and "specialist" advice. We found that these functional specialisms are utterly meaningless in the context of people's lives and create perverse service designs. So the potential for arriving at the "wrong" front-door and not being able to access the help required is significant, whilst at the same time amplifying the perceived demand on services as individuals have to re-present to see different specialists.

Demand

As stated above a key feature of this method is to listen and record what people actually ask for in their own terms when they approach a service.

The charts in appendix 1 shows the analysis of verbatim demand of what people asked services to do for them and the demand data by subject area.

This shows that welfare benefits and destitution / financial hardship are the two biggest drivers for people seeking advice. Debt is also one of the key factors with people presenting with problems such as issues with rent arrears, utilities bills and bailiffs. Consideration of welfare reforms and the roll out of Universal Credit is therefore central to the redesign of current advice services as well as the design of a future funding model.

When analysing demand using the vanguard method, a key consideration is the extent to which demand is preventable- failure demand. This occurs when a service or another part of the system fails to do something or fails to do it right for a citizen. The experiment found that 68% of demand into the system was preventable. People had shown great resilience in trying to address their problems. However many had struggled, hence their presentation at an advice service.

The review has found that the capacity of advice services is constrained by failures

within a range of public services and the impact these cause both in driving excessive levels of demand into advice services, and in making it difficult for the advice services to themselves establish communication and resolve these problems. 66% of the preventable demand above was created by external agencies. See appendix 2 for a breakdown for demand by agency.

Purpose

An important element of the initial study phase is to encourage participants to think clearly about the purpose of their service from the perspective of the people who seek help from it.

Based on what we have learnt through observations, demand information and what matters to residents, a new working definition of a purpose for advice services has been agreed:

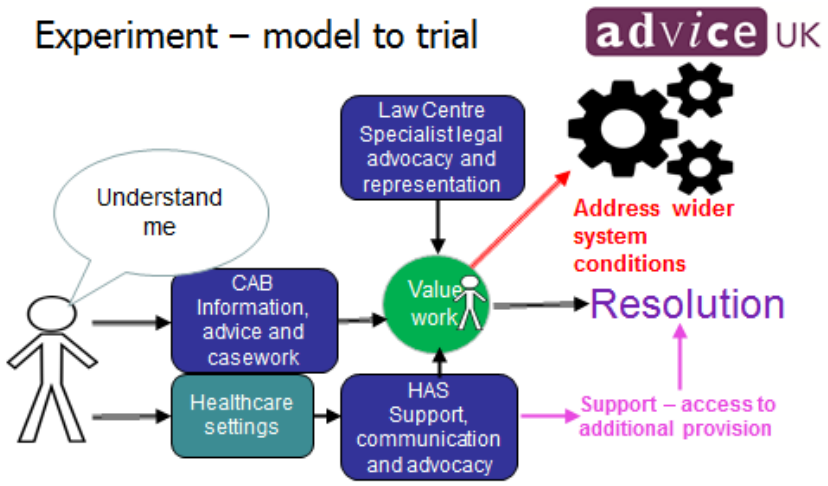
> **Help people solve their problems by promptly giving the right advice, support and knowledge**

We have also started to look at the way the grants are managed, prompting a more relational approach to contract management. The way we measure the grants is changing to look at access, demand and capability. These new measures will be used to enable us to understand how well the service is achieving its purpose in supporting people to manage and avoid future crisis rather than just to benchmark or measure performance.

Feedback from experiments to date – findings so far

Experimentation has started with the principle funded advice organisations to test out different design principles to help us meet this new purpose.

This has involved a focus on trying to achieve ‘resolution’ for people at the earliest stage and ensuring that issues are addressed as fully as possible without having to refer to other services or through numerous separate appointments.



The principle points of access in this model are through Citizens Advice and HAS.

The Gateway process used by Citizens Advice

The experiment at Citizens Advice looked at the gateway model they use. The purpose of the Gateway is primarily assessment of whether the service can help and, if so, the correct point in the service to refer to. As part of the experiment an initial conversation was held with people presenting to understand their demand/need in the context what matters to them and what would make their life better. This helped to identify and initiate the work that was of value that would help them move towards this, rather than just dealing with the presenting issue. This also enabled the adviser to work in a relational rather than a transactional way.

An experienced advisor was also available during Gateway hours to offer a fuller service. In addition for four of the experiment days, a solicitor or experienced advisor from the law centre was also on site to offer advice should the need arise. Outside of the experiment if legal expertise is needed people are 'handed off' through a referral system.

We found that people waited on average just under 22 minutes to be seen, as opposed to the normal average wait for Gateway of 3 hours and 7 minutes, and in only 19% of cases were people signposted out of the service compared to 39% in a gateway session.

The learning suggests that fewer follow-up appointments might be needed if more capacity is available on the front line.

Collaboration between agencies

For example, working relationships have improved between the lead agencies. They are attending each other's staff meetings which has given them a better understanding of how each organisation works, and the best way to work together. Law centre staff have also co-located at Citizens Advice and staff fed back that this has worked very well from the client's perspective where issues are addressed as fully as possible without having to refer to other services or through numerous appointments.

Learning from the initial experiments has enabled study team members to explore further a number of the underlying issues with redesigning access into advice, and identified opportunities for further work.

- **Resolution**- the focus on trying to achieve a 'resolution' for people at the earliest stage
- **Frontline skills/experience -** including sufficient advice experience to address immediate issues taking into account the difficulty and time taken in contacting public agencies
- **The impact of restricted access** and how this amplifies demand across the system
- **Whole system experiment** exploring the potential for advice services to take a fully co-ordinated, whole systems approach to supporting local residents
- **The impact of external failure demand**

Financial implications

This approach aims to release capacity in the advice sector by preventing repeat visits and building capability and prevent unnecessary cost. This will create a sustainable way of delivering advice and allow us to use the current ring-fenced grant more effectively to resolve issues.

Legal implications

Procurement have been briefed and are supportive of this approach. Changing the way we work with advice providers and the way we monitor the grant will allow us to measure outcomes rather than outputs and have a richer more sophisticated understanding of service delivery.

Risk implications

The review and re-design is intended to address risks around external pressures, such as welfare reform including the implementation of Universal Credit, with an advice sector which is more able to support people with complex needs.

The co-design process will be reliant on providers being willing to work in partnership, challenge current design and look at new ways of working.

Equalities and other Implications:

The new grants model for 16/17 was established to best meet the advice needs of residents and ensure advice services remain fit for purpose within a changing

external landscape of welfare benefits and funding and to reflect the new priorities of the Voluntary and Community Sector grants.

Through the assessment process for the grant a decision was made not to fund the Hackney Advice Partnership led by Social Action for Health (SAfH). However following an Equalities Impact Assessment of this decision funding was made available to mitigate against particular and significant disadvantage in relation to particular client groups and/or the provision of complex advice who previously accessed advice from the culturally specific organisations in the Hackney Advice Partnership. The following organisations were funded.

	Identified equality issue
Agudas Israel	Advice provision for complex cases requiring advice on multiple issues and specific knowledge on issues relating to the Charedi community and associated cultural sensitivities
City and Hackney Cares centre	Advice provision for complex cases requiring advice on multiple issues and cases which require specific knowledge on issues relating to disabled children/dependents. The funding is for parent-carers as these cases are complex due to the parent-carers circumstances
Derman	Multiple disadvantage by being older, more likely to be disabled, e.g. mental health issues and also face barriers linked to ethnicity such as language and lack of integration. The funding is primarily for service users who are in the 50+ age group due to the multiple disadvantages they face.
North London Muslim community centre	Multiple disadvantage by being older, more likely to be disabled e.g. mental health issues and also face barriers linked to ethnicity such as language and a lack of integration. The funding is primarily for service users who are in the 50+ age group due to the multiple disadvantages they face

Grants have been extended to March 2019 to ensure our equality duty continues to be met. These organisations will now have the opportunity to be a part of the review and co-design process to help us address these issues and ensure access for these

groups is considered as part of the new grant.

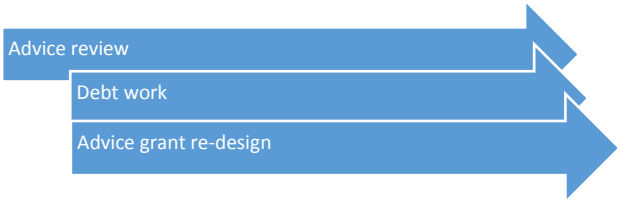
Options //Next steps

The work so far has concentrated on the three main advice providers. We have held an initial workshop with the wider advice sector who were keen to be involved. This will help us to address access issues and reduce signposting by encouraging partnership working as well as ensuring that a wider group have access to the learning and inform the design of the new system.

An analysis of data from the review highlighted that debt and money management is a significant driver of demand for advice services. In response to this we want to look systemically at the range of drivers for debt and then co-design with providers an intervention that better meets people's needs by focusing on prevention but also targeted advice when needed. The work so far has taught us that advice designed around categories such as debt is problematic as people and their problems are not packaged in this way. This work has not started yet, but will take place alongside the continued review work.

We will:

- Continue with the review of advice services looking at how we can better meet the agreed purpose for advice
- Work with public services that drive demand into the advice services
- Integrate how we respond to debt into this work.
- Use this learning to re-design an advice model for April 2019



The main aims of the next phase of work will be to:

- Understand the range of drivers for debt and the potential for prevention
- Continue to explore a new integrated debt and advice model which meets the agreed purpose for advice: Help people solve their problems by promptly giving the right advice, support and knowledge. This will involve:
  - A focus on resolution for people at the earliest stage
  - Addressing access and identifying ways to address any gaps and equality concerns in the current provision
  - Understanding value demand vs. preventable demand and how this is generated and impacts upon individuals
  - Looking at how providers pull in additional support rather than individuals

being ‘handed off’ through referral or signposting

- Exploring ways of addressing how LBH systems drive demand into advice services
- Share and exchange practice within the Council, with local partners and with other areas that are adopting similar approaches and link to wider systems change work

Relationship with the advice sector

Reframing the relationship between the advice sector and public services will be an important element of the review’s ongoing work. This will require a culture change in both advice and public services moving from a contractual to a relational culture in order to deliver a journey of continuous service improvements. We will work collaboratively with providers to support them to deliver the service and address the drivers of demand for advice. The co-design process will help with this.

4 **Time scale for the review and recommissioning process**

The table below sets out the timescale for the next stage of the review which will help us to meet the aims above. However the work so far has already started to achieve improvements in current service delivery.

The systems method of working means that experimentation and learning happens within the work. This will continue during the next stage of the review and re-design with an expectation that by April when we are developing the framework for the new contract, advice agencies will have put what we have learned into practice ***by October***, which will ensure services are prepared for the introduction of Universal Credit.

Date	Activity	Outcome
January	Working with systems consultant and three providers to continue with experimentation in these services	Renewed focus on solving people's problems.
February	Recruiting advice providers to be part of the study group. Work to study and experiment to feed into co-design	This will help to build a coalition of organisations who can co-design alongside the Council, learning as we go, moving towards an integrated service model
March	Work to study and experiment Co-design	
April	Co-design and develop framework	Set overarching expectations, based on what has been learned by studying. Collaboratively creating a service that works for local people. Expectation that learning will be put

		Continuous development	into practice during this period.
	May **June**	Consultation on framework	Input from wider sector and other stakeholders
	July	Design assessment process Continuous development	Working to the new purpose of advice
	August/September	Launch grant	
	October	Applicants who intend to apply will need to demonstrate how they are working to the new framework in the next stage.	Working to new purpose of advice and having a system in place that is: **Responsive**- provision of timely and accurate advice that customers have confidence in. Understanding resident demand and providing an appropriate level and type of service to meet the variety of need presented. **Learning**- continuous learning and improvement is integral to how the service operates, with a focus on learning what matters to residents and how to do exactly and only that. **High quality**- advice and support are provided in a welcoming and respectful environment and the process is as convenient and smooth as possible, enabling residents to quickly access the help, advice and support they need

			with minimal hand-offs, internally or to other agencies. **Professional** - employing suitably qualified, recruited and trained staff, with the interpersonal and technical advice and legal skills to engage positively with customers and meet their needs **Flexible**- a service that can offer and/or draw on a variety of responses to different needs including non-advice support **Enabling**- supporting residents where possible to increase their confidence and resilience to be better able to deal with future problems **Collaborative**- working with other agencies to share and act on learning about what works in the provision of advice and seeks to address and reduce the causes of demand for advice
	November	Assessment process- applicants will need to demonstrate: • How they have gathered evidence of demand • How they have gathered evidence on what matters to service users • A proposal that increases their capability to respond to demand and	Funding a single, integrated advice system that provides clear, simple and open access, including to residents who face barriers to accessing services, and minimises hand-offs between advisers and providers.

		continuously learn and improve	
	December	Initial notification to recommended providers	
	January	Final notification after cabinet	
	February	Contract negotiation	
	March	Contract negotiation	
	April	Contract start	

Conclusion

Given the challenges facing advice services and the people who use those services the Corporate Policy and Partnership team have been working with grant funded advice providers to carry out a systems review of advice services that are funded through the Voluntary and Community Sector Grants Programme. The main aims of this work are to understand the range of drivers for debt and the potential for prevention and to continue to explore a new integrated debt and advice model which meets the agreed purpose for advice: Help people solve their problems by promptly giving the right advice, support and knowledge.

Supporting Papers and Evidence:

Appendix 1 – Analysis of verbatim demand of what people asked services to do for them

Appendix 2 – Table showing preventable demand breakdown by agency

Sign-off:

London Borough of Hackney___Sonia Khan, Head of Policy and Partnerships – paper signed off by Group Directors

City & Hackney CCG _____David Maher, Acting Managing Director

ICB Paper- Advice review Appendixes

Appendix 1- Analysis of verbatim demand of what people asked services to do for them

Verbatim demand	CAB	HCLC	HAS	Total	Initial Demand	All Demand
I need help	14	2	2	**18**		
Can you help me apply for…	12		4	**16**		
I need help with form filling	8	1	2	**11**		
I need help to call / speak to (external agency)	3			**3**		
I want / need help to write to…	7			**7**		
Someone told me you could help / to come here	5	5		**10**		
Can you represent me?		1		**1**		
I need help….	**49**	**9**	**8**	**66**	**40.24%**	**28.70%**
I want to know….	5	2	1	**8**		
I want to know who can help	4	1		**5**		
I want someone to tell me	2	1		**3**		
I need to know my rights	5			**5**		
Am I entitled to….?	3			**3**		
Advice on where to go from here		1		**1**		
I want information	**19**	**5**	**1**	**25**	**15.24%**	**10.87%**
I want my benefits to be paid	3			**3**		
I want to arrange repayments	2			**2**		
I can't pay them	1			**1**		
I want to be paid	1			**1**		
I don't want to get into trouble with my landlord	1			**1**		
I want support with	**8**	**0**	**0**	**8**	**4.88%**	**3.48%**
I want to dispute it	3	1		**4**		
I want to appeal	2			**2**		
I want the mistake corrected	4			**4**		
I want my money back	5			**5**		
I think there's been a mistake				**0**		
I want to dispute it	**14**	**1**	**0**	**15**	**9.15%**	**6.52%**
I need money / help for food / voucher	14			**14**		
I need furniture	7			**7**		
I want a Council flat / to move / better accommodation	4		2	**6**		
I want / need something practical	**25**	**0**	**2**	**27**	**16.46%**	**11.74%**
Can I speak to / see (on-going case)	1	54		**55**		
I need to cancel my appointment		3		**3**		
I want / need / can I see someone (new)		7		**7**		
I am running late / appointment query		3		**3**		
I need an interpreter for my appointment (new)		1		**1**		
What are your opening / drop-in times (new)		1		**1**		
Need to update my contact details		1		**1**		
Update you on my case		2		**2**		
I want to know about (on-going case)	1	1		**2**		
Appointment / service based issues	**2**	**73**	**0**	**75**	**5.49%**	**32.61%**
I've got a query				**0**		
I don't understand	6			**6**		
I need a second opinion	1			**1**		
Is it right that it's so much?	2			**2**		
I want another GP	1			**1**		
I want to make a compliant about the Council / HA / JCP	3	1		**4**		
Other	**13**	**1**	**0**	**14**	**8.54%**	**6.09%**
	Initial Demand			**164**	**71.30%**	**-**
	All Demand			**230**	**-**	**100.00%**

Demand data by subject area

Benefits	**39%**
Destitution / food / furniture	**18%**
Housing / homelessness including arrears	**16%**
Employment	**12%**
Council Tax	**6%**
Debt excluding arrears	**4%**
Debt including arrears	**9%**
Immigration	**6%**
Other e.g. Family law, solicitor queries, freedom passes	**8%**

Appendix 2 -Preventable demand by agency and issue

Preventable demand breakdown by agency

Department of Work & Pensions / JobCentre Plus	42%
LB Hackney	19%
Housing (tenancy)	10%
HMRC	6%
Employment	6%
Immigration	4%
Utilities	4%
Other	10%

Preventable demand by issue

Employment & Support Allowance	14%
Food vouchers / furniture	10%
Personal Independence Payment	9%
Housing Benefit	7%
Council tax	5%
Jobseeker's Allowance	2%
ESA / Jobseeker's Allowance	2%
JobCentre Plus staff	2%
Housing Benefit & Council tax	2%
Disability Living Allowance	0%

Title:	Report on Workstream Assurance Point 3 and CYPM assurance review point 2
Date:	21 March 2018
Lead Officer:	David Maher, Anne Canning, Simon Cribbens
Author:	Devora Wolfson, Programme Director: Integrated Commissioning
Committee(s):	Transformation Board: 9 March 2018 Integrated Commissioning Board: 21 March 2018
Public / Non-public	Public

Executive Summary:

The purpose of this report is to update members of the Integrated Commissioning Board on the progress that the care workstreams are making and their plans for the coming year.

The report includes the submission by the Children, Young People and Maternity Services workstreams for Assurance Review 2 and submissions from the Prevention, Unplanned Care and Planned Care workstreams for Assurance Review Point 3 (**Appendices 1-4**).

The submissions have been reviewed by members of the Integrated Commissioning Steering Group (ICSG) and a summary of the points made by ICSG members are set out in the main report. The Transformation Board reviewed and endorsed the submissions at the meeting on 9 March 2018.

Future review points will focus on Business as Usual and Delivery of QIPP and local authority savings, as well as transformation, in order to provide assurance.

The requirements for each of the 4 workstreams for 2018/19 are summarised in the 'asks' documents (**Appendix 5**). This should reflect all of the mandatory responsibilities / deliverables for the statutory organisations as well as the priorities for transformation, service/quality improvement, improving outcomes for residents and how to ensure most effective/efficient use of resources across the system as well as behaviours for the workstream.

Recommendations:

The City Integrated Commissioning Board is asked to:

- **APPROVE** the responses from the Children, Young People and Maternity Services for Assurance Review point 2 (Appendix 1);
- **APPROVE** the responses from the Prevention, Unplanned Care and Planned Care workstreams for Assurance Review Point 3 (Appendix 1);
- **NOTE** the progress that has been made by the workstreams;
- **APPROVE** the proposal that the Transformation Board receives quarterly reports on performance against key workstream metrics and that summary reports and any recovery plans are submitted to the ICB.
- To **APPROVE** the requirements set out in the asks for each workstream (including ensuring that nothing is missing from the document that needs delivering in 2018/19)

The Hackney Integrated Commissioning Board is asked to:

- **APPROVE** the responses from the Children, Young People and Maternity Services for Assurance Review point 2 (Appendix 1);
- **APPROVE** the responses from the Prevention, Unplanned Care and Planned Care workstreams for Assurance Review Point 3 (Appendix 1);
- **NOTE** the progress that has been made by the workstreams;
- **APPROVE** the proposal that the Transformation Board receives quarterly reports on performance against key workstream metrics and that summary reports and any recovery plans are submitted to the ICB.
- To **APPROVE** the requirements set out in the asks for each workstream (including ensuring that nothing is missing from the document that needs delivering in 2018/19)

Links to Key Priorities:

Assurance Review point 2 and 3 focus on workstream progress against partners' key priorities.

Specific implications for City

Workstream plans focus on delivery across City and Hackney although some of the specific delivery plans relate to City specifically, for example, Business Healthy Networks.

Specific implications for City and Hackney

Workstream plans focus on delivery across City and Hackney although some of the specific delivery plans relate to Hackney specifically, for example, the remodelling of the Learning Disabilities Service.

Patient and Public Involvement and Impact:

Workstreams have included their approach to patient and resident engagement in their plans.

Clinical/practitioner input and engagement:

Clinical and practitioner engagement is embedded within each of the workstreams.

Impact on / Overlap with Existing Services:

No service specific issues or recommendations

Supporting Papers:

Appendix 1 - CYPM Assurance Review Point 2 Appendix 2 - Planned Care Assurance Review Point 3 Appendix 3 - Unplanned Care Assurance Review Point 3 Appendix 4 - Prevention Assurance Review Point 3 Appendix 5 - Care Workstream Asks 2018/19 The following supporting papers can be found on the CCG website at the following location: http://www.cityandhackneyccg.nhs.uk/about-us/integrated-commissioning-board.htm Annex 1 - Planned Care Appendices Annex 2 - Unplanned Care Appendices Annex 3 - Prevention Appendices

Sign-off:

Workstream SROs _____[Tracey Fletcher, Simon Cribbens, Anne Canning] London Borough of Hackney _____Anne Canning, Group Director of Children, Adults & Community Health City of London Corporation _____Simon Cribbens, Assistant Director or Commissioning & Partnerships City & Hackney CCG _____ David Maher, Acting Managing Director

Main Report

1. Review of Submissions by the Integrated Commissioning Steering Group (ICSG)

The ICSG reviewed the workstream submissions from each of the care workstreams.

An initial desktop review was undertaken ICSG members on 1 March 2018 and feedback was given to the workstream directors and SROs.

Revised submissions were considered by members of the ICSG on 7 March 2018 and a summary of the discussion is set out below.

2. Feedback on Submissions

CYPM: Assurance Review Point 2

The governance structure for the CYPM workstream is clear and the submission sets out the delivery framework for the 4 key priorities:

1. Consolidation and streamlining of finance and budgets
2. Reworking of children's health governance
3. Delivery of transformational priorities; –
   - *improving emotional health and well-being*
   - *strengthened support for vulnerable groups*
   - *improving care in maternity and early years*
4. Broad oversight of performance and BAU.

The plans for the delivery of the key transformation priorities are clearly laid out and the submission and progress is being made on streamlining finance and budgets

ICSG felt that it would be useful to see more details about how the Business and Performance, Oversight Group is managing the Business as Usual work. ICSG would also like to see more details about further plans for aligning budgets as part of CYPM's submission for Assurance review Point 3 in May 2018.

Planned Care: Assurance Review Point 3

The plans for the workstream transformational priorities during 2018/19 are clearly set out; the business cases for learning disabilities transformation and pooling of budgets for continuing healthcare (CHC) and adult social care has already been through the integrated commissioning governance and a report on outpatients' transformation will be considered by ICB this month.

Planned care's submission focuses on actions to address underperformance against the 62 day cancer constitution standard which ICSG members welcomed. The plans for streamlining CHC and truly integrating mental health expertise with general

medicine were also fully supported.

The workstream has begun work on a systems action plan for their big ticket item on Housing including Better use of the Disabilities Facilities Grant and collaborative commissioning in partnership with Housing including support for people in temporary accommodation.

It is clear within Planned Care's submission that they will need resources to deliver their transformational priorities, in particular outpatients' transformation and the alignment of assessment and commissioning of services in order to deliver efficiencies through the pooling of CHC and adult social care budgets.

The partners are currently looking at how these resources will be identified.

Unplanned Care: Assurance Review Point 3

Again, the plans for the three workstream transformational priorities (i. neighbourhoods, ii. urgent care and iii. discharge) during 2018/19 are clearly set out including the ambition, progress and expected outcomes. The governance structure to oversee the delivery of the priorities is well developed.

Whilst recognising that the neighbourhood model is at a very early stage, ICSG members wanted to understand more about how the design phase of the neighbourhood model would incorporate the requirements of the prevention, planned care and CYPM workstreams, beyond the attendance of the workstream directors at the Neighbourhood Steering Group.

The workstream set out the support required from other parts of the system as ICT, workforce development and technical skills. The first two are being considered through the enabler groups however the workstream makes a request for specific communications, informatics and financial modelling resources from across the system to support them in their work.

In terms of contracting and commissioning, ICSG members noted that unplanned care would be using a range of contracting mechanisms including use of existing contracts, MOUs, partnership contracts and alliance agreements. ICSG wanted to ensure that the workstream had sufficient access to the contracting resources from across the commissioning partners to deliver these.

Prevention: Assurance Review Point 3

The delivery framework for the prevention ask is clear within the submission including the current performance and the trajectory against the key outcomes. Similarly progress with the big ticket items is described clearly. Prevention has also set out how it is supporting the other workstreams to embed prevention principles in their plans.

The 2018/19 commissioning intentions for prevention are well defined.

It is clear from the submission that Prevention will need additional resources to deliver their transformational priorities, including Making Every Contact Count (MECC), personal resilience and self-care and within supported employment.

The partners are currently looking at how these resources will be identified.

3. Regular Reporting on Workstream Performance against Key Outcomes

Whilst the assurance review submissions included performance against some key targets, it is felt that there needs to be a stronger focus on overview of workstream performance.

It is proposed that the Transformation Board receives quarterly reports on performance against key workstream metrics, including progress on savings, from 2018-19 onwards and that summary reports and any recovery plans are submitted to the ICB.

Future review points will focus on Business as Usual and Delivery of QIPP and local authority savings, as well as transformation, in order to provide assurance.

Integrated Commissioning Care Workstream: Assurance Review Point 2 Submission

Children, Young People and Maternity Workstream

February 2018

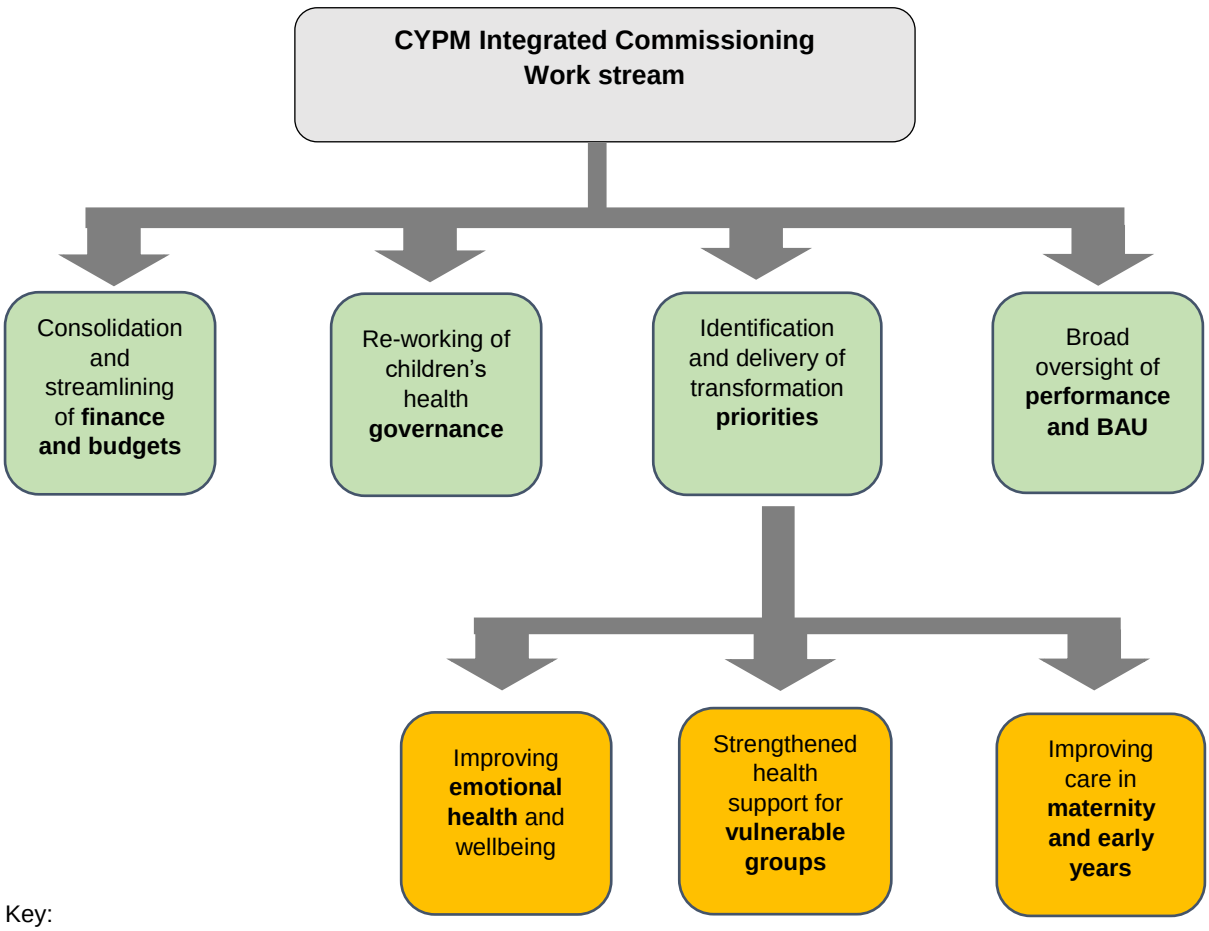
Workstream Leads: Angela Scattergood (Workstream Senior Responsible Officer)

Amy Wilkinson (Workstream Director)

1.0 Plans and Priorities

The Children, Young People and Maternity Workstream is delivering on the following 4 key functions, and within this has agreed 3 high level priorities for collaborative transformation. Our big ticket items are identified as part of the transformation priority areas.

CYPM Workstream Delivery Framework:



The table below outlines key transformation priorities being delivered through the CYPM work stream. This does not reflect the breadth of the 'Business as Usual' work being delivered on a day to day basis through the CCG, LBH or the CoL, in an increasingly integrated way. This work is now managed by the work stream through its 'Business and Performance Oversight Group'. See contract and commission list in Appendix 2 for detail.

Table 1: Plans and Priorities

Priorities and "Big Ticket" Items ***(BT) Big ticket**	**Links to shared priorities in the Strategic Framework**	**Progress on identifying key outcomes and impact on future outcomes**	**Additional budgets that can be pooled or aligned**	**High level workplans and milestones**
Priority 1: Improving Children and Young People's Emotional Health and Wellbeing across the system				
Ensure the development of a clear prevention offer, with an emphasis on wellbeing, and young people getting support where needed Deliverables: Oversight and support implementation of the CAMHS transformation plans, including schools work* (BT)	This priority and supporting deliverables link to the following shared priorities in the Strategic Framework: - Improve the health and wellbeing of local people with a focus on prevention and public health, -Deliver a shift in focus and resource to prevention and proactive community based care; -Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value; -Ensure we deliver parity of esteem between physical and mental health -Promote the integration of health and social care through our local delivery system as a key component of public sector reform; -Build partnerships between health and social care for the benefit of the population	This priority will contribute to progress against the following outcome indicators: -CAMHS Transformation Indicator (IAF) -Emotional Health and wellbeing of Looked After Children (PHOF) -Self Harm indicator (PHOF) -Local CQUIN: Transition of CAMHS to adult services (HUFT and ELFT)	Possibilities include CAMHS Transformation Funding, Non recurrent CCG funding for CYP mental health, LHB CYPS Clinical budgets. There are some national pilots providing small amounts of resource currently, and some tri-borough arrangements, with possibilities for some NEL level collaboration.	Work commenced through sign off of CAMHS transformation plans by WS, award of additional funding through WS and CCG. Delivery of first element of schools strand commenced Feb 2018, with Anna Feud Workshops. 40 schools engaged. LBH O&S also interested in possible review on prevention.
Review and consolidate service delivery	As above	-CAMHS Transformation Indicator (IAF)	As above	To commence 2018/19 for recommendations

Deliverables: Re-design of service system		-Local CQUIN: Transition of CAMHS to adult services (HUFT and ELFT)		and proposal Dec 2018.Possilble re-working from April 2019.
Investigate the increase in self-harm presentations Deliverables: Identify key trends / issues and making recommendations to address	As above	-Self Harm indicator (PHOF)	As above	Initial scoping to begin April 2018. This work is cross referenced to the Prevention offer and the CAMHS transformation work underway currently on implementation of increased crisis support from April 2018.
Improve awareness and access to a clear offer of support to improve children and young people's EHWB in the City of London Deliverables: Improve the offer in schools and increase parity of access, including: - clarifying pathways for residents and non-residents - improving access to support for crisis -work with schools around self-harm, - supporting implementation of their mental health strategy following audit.	As above	-CAMHS Transformation Indicator (IAF) -Emotional Health and wellbeing of Looked After Children (PHOF) -Self Harm indicator (PHOF) - Local CQUIN: Transition of CAMHS to adult services (HUFT and ELFT)	TBA	Scoping work to begin asap. CoL also part of CAMHS Transformation and prevention offer.
Priority 2: Strengthening the Health and Wellbeing offer for Vulnerable groups to reduce health inequalities and the impact of adverse childhood events				
Improve the health offer for Looked After Children* (BT) Deliverables: Re-design and procure integrated HLAC provision Further integrate LAC pathways with health pathways, particularly for those CYP with complex health needs, mental health needs	This priority and supporting deliverables link to the following shared priorities in the Strategic Framework: -Improve the health and wellbeing of local people with a focus on prevention and public health - Ensure we maintain financial balance as a	This priority will contribute to progress against the following outcome indicators: -Emotional Health and wellbeing of Looked After Children (PHOF) -Health and Wellbeing of LAC (timeliness of health assessments, up to date immunisations and those in treatment	There is currently an aligned funding arrangement for Health of LAC - under review across all commissioners.	Scoping of current context and modelling started Jan 2018 (Student). Recommendations to be delivered end March 2018. New commissioning arrangement in place for Sep 2018.

and challenging behaviour needs	system and can achieve our financial plans; - Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value; -Ensure we have tailored offers to meet the different needs of our diverse communities; -Promote the integration of health and social care through our local delivery system as a key component of public sector reform; -Build partnerships between health and social care for the benefit of the population - Achieve the ambitions of the NEL STP	for substance misuse (903 DfE return)		
Oversight of the health elements of the SEND offer and targeted joint work as appropriate* (BT) Deliverables: Focussed work on: ▪ ensuring clear and effective pathways particularly around the offer at early years ▪ the offer of support at key transition points ▪ Implementation of use of personal health budgets Continue to work with partners including the OJ community to support access to provision	As above	-Improving CYP experience of healthcare (NHSOF in development) -Personal Heath budgets for children (IAF) -Child Development at 2 – 2.5 and School Readiness indicators (DfE)	CCG and LBH CYPS budgets in scope for alignment. Possibly CoL.	Recommendations from SEND inspection articulated and project plan to be developed asap. Current conversations with Planned Care and ASC around transition and continuing health care providing opportunities to look at new financial and delivery arrangements. Initial conversations being held with community and through WS. May be taken forward as a joint position across all workstreams.

Support work to reduce childhood obesity amongst vulnerable groups: Deliverables: Development of a maternal obesity pathway (linked to priority below)	As above	- Avoiding excess weight at 4-5 years an 10-11years (PHOF) -Contribution to maternity indicators below	LBH PH budget, some possibly non recurrent CCG funding to be submitted for. Cross workstream.	Re-commission of tier 2 childhood obesity services delivered. New services in place for Sep 2018. Joint submission to system PIC (April 18) with Prevention work stream to look at whole tier 3 / 4 pathway underway**.**
Support work with children to manage Long Term conditions Deliverables: Support STP Integrated Asthma provision work Support delivery of Primary Care Vulnerable Children's contract, including work to support Young Carers	As above	-Personal Heath budgets for children (IAF)	CCG and LBH CYPS budgets in scope for alignment. Possibly CoL. Possibility of NEL level collaboration / resource. CCG non recurrent funding.	WS a key part of NEL discussions around joint plans. See above commentary on Continuing Health Care, linked with Planned Care WS. Submission to CCG PIC successful for ongoing delivery of Primary Care Vulnerable Children's Contract (Jan 2018).
Scope potential for joint work across the CSE, harmful sexual behaviours and CSA agenda Deliverables: Deliver on STP proposals for development of CSA hub Explore opportunities to focus on building resilience	As above		To be discussed.	WS key part of NEL plans for STP level child house (CSA.). Submission to go to system PIC April 2018 for C&H contribution. Scoping on earlier elements of the CSE pathway to commence April 2018.
Support integration and groups with disparities in health outcomes and higher levels of coming into contact with the Youth Justice system Deliverables: Explore use of technology as a medium for communicating health messages and increasing access to services	As above	-Health of those in the Youth Justice System -FTE to YJS?	LBH funding, possibility of enabler support.	Early conversations held with HCVS Dec 2017. Plans to be drafted.

Explore links to reducing exclusions Support delivery of health aspects of the LBH Young Black Men's work programme		TBC		YBM Workshop day planned for HWB Board. Proposal for strengthening health delivery of programme underway.
Improve the health and wellbeing offer for the most vulnerable groups of City of London children and young people Deliverables: In addition to focussed work on re-designing and procuring the offer for Looked After Children (particularly for those placed out of borough), to: -explore improving the health and wellbeing of boys with autism -explore establishing parity of access to therapies, ie. SLT for those in independent schools.	As above	-Emotional Health and wellbeing of Looked After Children (PHOF) -Health and Wellbeing of LAC (timeliness of health assessments, up to date immunisations and those in treatment for substance misuse (903 DfE return) -Personal Heath budgets for children (IAF) -Child Development at 2 – 2.5 and School Readiness indicators (DfE)	CoL budget for children with disabilities maybe in scope for alignment with partners.	Cross reference to HLAC deliverable above. To begin April 2018.
Priority 3: Improving the offer of care across Maternity and Early Years				
Explore and propose work to reduce rates of infant mortality: Reduction in rate of stillbirths, neonatal and maternal deaths Deliverables: Deliver a review of variables to identify if, and where, there may be an issue and opportunity to improve Explore and evaluate data around re-admissions and identify action plan	This priority and supporting deliverables link to the following shared priorities in the Strategic Framework: -Improve the health and wellbeing of local people with a focus on prevention and public health - Ensure we maintain financial balance as a system and can achieve our financial plans; -Deliver a shift in focus and resource to prevention and proactive	This priority will contribute to progress against the following outcome indicators: -Maternity Clinical Priority Area Rating (IAF indicator) -Neonatal mortality and stillbirths (IAF) -Women's experience of maternity services (IAF) -Unplanned births at home -C Section rate	TBC. Largely CCG recurrently funded at present.	To begin April 2018. Underway currently.

	community based care -Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value; -Ensure we deliver parity of esteem between physical and mental health; -Ensure we have tailored offers to meet the different needs of our diverse communities; -Contribute to growth, in particular through early years services; -Achieve the ambitions of the NEL STP	-Unplanned NICU admissions for term babies -% of women booked by 10 weeks and 12+6 (NHS OF) - Maternity 5YFV (Better births indicators)		
Reduce rates of smoking in pregnancy Deliverables: Embed HUFT maternal smoking pathway and explore UCL pathway Support smoking in pregnancy prevention programme	As above	-Maternal Smoking at time of delivery (IAF & PHOF)	CCG, CoL and LBH PH alignment potential	Project team identified and work started.
Support work to improve rates of immunisations Deliverables: Support work to improve rates of antenatal flu and pertussis vaccine Support work to improve rates of immunisations at 1 and 2 years Explore options for a devolved commissioning role	As above	-There are a number of PHOF indicators measuring take up of Childhood Imms in neonates, infants, at 1 year, 5 years and adolescence. (PHOF). TBC.	Non re-current CCG funding at present.	Successful submission to CCG PIC (Jan 2018) for continuation of Primary Care Immunisations work. Conversations to begin asap.
Support work on choice of maternity care and	As above	-Choice in maternity services (IAF)	CCG and LBH PH budgets in scope.	

perinatal mental health Deliverables: Explore options for development of a 'supporting parents' pathway, linked to substance misuse Look at evaluation linked to the 5YFV work.		-Low birthweight babies (PHOF) -Breastfeeding initiation (NHS /PHOF) -Breastfeeding 6-8 wks. (NHS /PHOF -U18 conception indicator? (PHOF) -Maternity 5YFV (Better births indicators)		Project team identified. Scoping work to begin asap. Joint submission on analysis of prevention strategy and impact with Prevention WS to go to system PIC (April 2018).
Deliver improvements in maternity and perinatal care for City of London women Deliverables: Clarify pathways for women following birth and discharge Improve access to support for breastfeeding Work to ensure parity of provision for those with access issues due to resident / registered discrepancy	As above	-Maternity 5YFV (Better births indicators) -Choice in maternity services (IAF) -Women's experience of maternity services (IAF) -Breastfeeding initiation (NHS /PHOF) -Breastfeeding 6-8 wks (NHS /PHOF	To be discussed.	Scoping work to begin asap for all. Delivery from April 2018.

Cross Workstream and Enabler work

There are a number of areas where work is being developed together with agendas delivered across other work streams. These are:

- Strengthening links between Primary Care and Community health services for children and maternity. The neighbourhood model (Unplanned Care and whole system) provides a good opportunity to deliver this.
- Work with Planned Care around continuing health care budgets, agreeing a joint approach across the pathway for children and adults, focussing on areas of transition.
- Work with Prevention around aligning our approach to under 18 conception prevention (to PHE framework), and on scoping models for delivery of a whole life course tier 3 weight management intervention.
- A submission for support with workforce and OD is being taken through governance routes in March 2018 (CPEN and ICT enablers). We are working with the Engagement enabler to secure a second public representative (interviews Feb 18), and to scope current children and young people's engagement mechanisms across the system to develop the engagement strategy for the workstream.

2.0 Virtual Teams

Ask: Priority Area	Deliverable	Lead and Virtual Team	Update Status 02.18
General: Strategic Leadership, oversight, and Implementation			
		Angela Scattergood SRO Sarah Wright (Vice chair WS) Amy Wilkinson WD Director Olivia Katis WS Support 2x additional support posts to be recruited	Team In place Likely early / mid 2018
General: Business Functions: Commissioning and Contracting, HR, Finance and Performance Management			
	Children and Maternity Children and Maternity Children and Early Years Children and Young People CQUINS and quality Performance and quality Management of clinical lead support Commissioning & Procurement Finance HR CoL	Pauline Frost CCG Programme Board Director Sarah Darcy CCG CYP PB Manager Jairzina Weir CCG Mat PB Manager Theresa Shortland CoL Kate Heneghan LBH Lucy Vanes LBH Jenny Singleton CCG Anna Garner System Curtis Whyte CCG Zainab Jalil & Team LBH Mizanur Rahman & Lee Walker CCG & LBH Annabel Scarf & Lorraine Robinson CCG & LBH Ellie Lorna Corbin CoL	Interim to 07/18. Post re-worked to support WS from 08/18 Both seconded to LBH in re-worked posts 04/18 LBH PH Strategists Virtual cross - system support team
Overarching Workstream Deliverables			
	Governance review, recommendations and implementation	Amy Wilkinson Olivia Katis, Deborah Ennis (LBH CYPS) Tamara Al'Naama (HLT) Kate Heneghan (LBH PH) Pauline Frost & Team (CCG) Ellie Ward (CoL) Dermot Ryall (ELFT) Laura Smith (LBH CYPS)	Review Complete. Initial proposal and recommendations presented to WS Feb 18. Paper returning to WS March 18. Needs to align with wider IC programme review. 2 CCG PBs end 03/18.
	Contract and budgets review and recommendations	Amy Wilkinson Olivia Katis Jackie Moylan and team (LBH) Lee Walker and team (CCG) Frank O'Donoghue (HLT), Ellie Ward (CoL) System budget holders.	Proposed process agreed WS Feb 18. Work progressing.
	Development and delivery of service user engagement strategy (Children, Young People and Families)	Amy Wilkinson Olivia Katis Kristine Wellington (HCVS), Pauline Adams, Nadia Sica (LBH YH & PH) Anne Marie Dawkins and WS Reps	In progress.

		Theresa Shortland (CoL) Emily Tullock (Healthwatch)	
	Improving Business as usual, to improve health outcomes for children, young people and their families	Amy Wilkinson Pauline Frost, Sarah Darcy, Jairzina Weir (CCG) Kate Heneghan, Lucy Vanes (LBH) Greg Condon (CCG) Lorna Corbin (CoL) Anna Garner and procurement colleagues as appropriate	Business Performance and Oversight Group (Commissioners) set up to jointly manage performance with a view to looking across the system and improving alignment
Priority 1: Improving Children and Young People's Emotional Health and Wellbeing			
	See deliverables in Table 1	Amy Wilkinson Rhiannon England (Clinical Ld) Greg Condon (CCG) Laura Smith (Clinical Ld) Sharon Davies (ELFT) Sophie McElroy (HLT) Nicole Klynman (LBH PH) Theresa Shortland (CoL) Ellie Ward (CoL)	Wider advisory team: Service Users: CYP and parents Teachers Youth and CAMHS Workers (including psychology / psychiatry) VCS Providers GPs
Priority 2: Strengthening the Health and Wellbeing offer for Vulnerable groups to reduce health inequalities and adverse childhood events			
	See deliverables in Table 1	Amy Wilkinson Sarah Darcy (CCG) Mary Lee (SG Ld CCG) Nick Corker (HLT VS) Theresa Shortland (CoL) Sarah Wright (LBH CYPS) Nadia Sica (LBH PH) Angela Scattergood (HLT) Toni Dawodu (HLT) Andrew Lee (HLT) Donna Thomas (HLT) Damani Goldstein (LBH PH) Kate Heneghan (LBH PH) Jairzina Weir (CCG) Jayne Taylor (LBH PH) Sarah Webb (HUFT) Laura Smith (Clinical Ld) Paediatric input Shirley Peterson (HUFT)	Wider advisory team: Service Users: CYP and parents Teachers Youth and CAMHS Workers VCS Providers HCVS Paediatricians: Community and Acute Community and school nurses GP and practice managers David Keene (GP Confed) Donna Thomas (HLT)
Priority 3: Improving the offer of care across maternity and early years			
	See deliverables in Table 1	Amy Wilkinson Jairzina Weir (CCG) Shirley Peterson (HUFT) Pauline Frost (CCG) Balvinder Duggal (Clinical Ld) Miranda Eeles (LBH PH) Jairzina Weir (CCG) Theresa Shortland (CoL) Kate Heneghan (LBH PH) Helen Brock (LBH PH) Nicole Klynman (LBH PH) Rhiannon England (Clinical Ld) Donna Thomas (HLT) Ed Dorman (HUFT) Paediatric input	Wider advisory team: Service Users: CYP and parents VCS Providers Paediatricians: Community and Acute Midwives: Community and Ward Children's Centre staff Health visitors Family Nurses GPs and practice managers

3.0 Provider Collaboration

The Children, Young People and Maternity Workstream has strong involvement by both statutory and voluntary / community sector providers. The Workstream is representative of the range of professions across the wider system. It is chaired by senior leadership from Hackney Learning Trust, with clinical leadership from 3 clinical leads (2x GPs – 1 for children, 1 for maternity, and 1 Psychologist. There are also a number of clinicians that sit as members of the workstream), 2 Head teachers (1x Primary – Simon Marks School, 1x Secondary – Clapton Girls School), 2 VCS representatives and 2 service user representatives (1x parent and 1x young parent). This will be supported through a robust engagement strategy for involving children and young people in the workstream and in the production of deliverables (Engagement strategy currently being developed).

Provider membership of the workstream includes:

- Homerton University Hospital Foundation Trust (Children and midwifery representatives)
- East London Foundation Trust
- Schools
- London Borough of Hackney provider services (Clinical service and Young Hackney)
- The GP Confederation
- Children's centre representation
- Voluntary Sector Provider representation (currently being recruited)

Throughout ongoing delivery of our 'Asks' and priority deliverables, we will be engaging and collaborating with providers across the breadth of our work, including in the design and delivery of new services. This builds on a strong history of co-production and collaboration using design lab principles by commissioners across the system. There are also a large number of smaller VCS providers who are currently commissioned to deliver on our CYPM contracts across City and Hackney. We hope they will feed into this work through our VCS provider representatives on the workstream, and through their organisational relationships with their commissioners.

4.0 Workstream Contracting and Commissioning

See attached list of contracts within the direct scope of the CYPM workstream currently (Appendix 2). These contracts explicitly deliver on Children, Young People's and Maternity health and wellbeing across the system. Briefly these include:

- £44,898,033 of CCG funded budget lines. All CCG budget lines are proposed for pooling – subject to approval of the business case.
- £9,998,112 of LBH public health budgets (relevant to CYP) are in scope to propose for either aligning or pooling, subject to agreement.
- Some of these areas are services that also deliver for the City of London
- Some pilot areas of LBH CYPS delivery (incorporating Children's Social Care and Hackney Learning Trust) could be proposed for alignment in the short term, and reviewed with the potential to pool, along with any other contracts identified as in scope for 2019/20. This is circa. £5,301,199 initially.
- £2,111,000 has been identified by the City of London in terms of contracts that are relevant and maybe in scope for aligning or pooling.
- By the end of 2019/20 a number of key contracts across Children and Young People's services will be ending, opening up the opportunity to

design and commission an integrated 0-19yr. old or 0-25 yr. old service. Planning for this would need to start imminently. This also has the potential to deliver a significant level of 'efficiencies'.

The Workstream has begun a mapping exercise (using the same process implemented for scoping and development of new governance, and development of the engagement strategy) to identify and articulate all CYPM contracts relevant (using a definition of 'wider wellbeing') across the system. This is a significant piece of work, and the workstream agreed the process at the February meeting. It will:

- Be led and delivered by the Workstream leadership and delivery team
- Use a virtual group (representing each organisation) to map all relevant contracts across the system
- Map contracts, including commissioners, commissioning process, start, end date and length of contracts, providers, statutory deliverables or otherwise, performance and value.
- The virtual group will work closely with finance colleagues to sense check and quality assure the information
- Small workshops will be held to analyse the contracts for views on what is in and out of scope for further alignment and pooling, specifically with an eye on potential duplication or efficiencies.
- A master contract directory will be developed, alongside a proposal for further pooling to come through Integrated Commissioning governance later in 2018/19.

The workstream has agreed the following key principles to guide the work:

- The work is delivered efficiently and effectively
- The work is delivered in a way that observes confidentiality where appropriate, and declares any conflicts of interest
- The process for the work is clear and transparent

See appendix 2 for full list of contracts in scope of CYPM workstream, going into 2018/19. This is subject to confirmation and recommendations coming out of the above mapping exercise.

5.0 Financial Balance

There are no significant risks for financial delivery of contracts and services for 2017/18, related to the Asks, big ticket items or business as usual. Indicative QIPP targets are currently specified as £586,000 for 2018/19, although are likely to increase to £1,361,348. We are working with partners to identify these. See appendix 3 for month 10 position (CCG only). Public Health predict a break even position on their contracts.

6.0 Management of Risk

See risk register in Appendix 3.

7.0 Clarity about delegation of statutory responsibilities within asks

There are a number of statutory responsibilities delivered that sit within the Asks of the Work stream. These include:

- Delivery of the statutory functions of Designated Nurse for LAC and Designated Nurse for Safeguarding
- Delivery of services to improve Looked After Children's health and support whole system Safeguarding
- Delivery of the National Child Measurement Programme
- Delivery of the Healthy Child Programme for 0-5 year olds and 5-19 year olds
- Ensuring delivery of Young Peoples sexual health services
- Antenatal and new-born screening
- Aspects of delivery of midwifery services
- Aspects of delivery of services to support the health of disabled children and those with Long term conditions and those with Special Educational needs.
- Elements of support to improve and address child and adolescent mental health

8.0 List of Appendices

Appendix 1: Asks of the Children, Young People and Maternity Workstream (Agreed at Assurance Review Point 1 December 2017)

Ask of the Children, Young People and Maternity work stream

The Children Young People and Maternity (CYPM) Care Work stream is asked to establish an accountable care system for the delivery of Children's, Young People and Maternity services for the people of Hackney and the City within the overall strategic framework. The CYPM Care work stream will need to work closely with the other three care work streams in order to ensure a system-wide approach is taken across the work streams:

- Oversee the Children, Young People and Maternity care delivery system
- Ensure a health and social care system wide approach to the delivery of initiatives
- Establish a robust governance arrangement to support collective delivery
- Manage service delivery within the defined CYPM budgets
    - Redirect funding within the work stream that either improves service delivery or reduces cost (or both)
    - Develop service delivery proposals across work streams that reduce overall system costs
    - Ensure most effective use of existing resources including CCG and local authority staff including support teams, clinical input and existing clinical leads to support the work programme of the work stream
- Make suggestions to the statutory commissioners on changes to current contractual arrangements which would improve service delivery and secure performance and value for money
- Ensure the achievement of all performance standards and key performance indicators (KPIs) within existing contracts
- Deliver improvements in outcomes (both nationally mandated outcomes and additional locally relevant outcomes)
- Engage in organizational development offer to develop system leadership
- Ensure that prevention and early help principles are applied across the work of the CYPM work stream and support from the Prevention work stream and early help partners is sought out to enable this

This will involve:

Furthering integration across health and social care provision in the City and Hackney

- Establish a strong collective delivery arrangement across the providers which fully integrates service provision, including mental health (Emotional health and wellbeing and Child and Adolescent Mental Health Services), and minimises duplication and overlap
- Ensure that the delivery arrangement works for both the Hackney Children's health and social care system and City of London health and social care system
- Ensure that the children's health and social care system achieves high quality, patient led services which also secure best practice, reduce unwarranted variations and demonstrates value for money

- Demonstrate the local contribution to the delivery of the North East London STP plans and delivery of the NHS Five Year Forward View (FYFV)

Objectives for 2017/18 (these include essential requirements from the local commissioning organisations but are not an exhaustive list and workstreams can do whatever additional work required to achieve the above system change):

Plan and deliver improvements and efficiencies in year (2017/18):

- Ensure delivery of the Child and Adolescent Mental Health Services Transformation Plans, as agreed by NHS England including delivery of transformation of the full range of service, working toward an more integrated system and delivering improvement models for:
    - strengthening prevention in schools
    - the offer at transition (from young people to adult services)
    - support for parenting
    - ensuring young people get access to support quickly and where it is needed

- Building on the 'strengthening prevention' work as part of the CAMHS Transformation Plans (above), ensure development of a clear prevention offer for children and young people where they are at, including community settings and alternative provision.

- Conduct analysis of increasing presentations of self-harm and suicide in children and young people, leading to the development of an improvement and delivery plan (for delivery in 2018/19)

- Strengthen and target the way we improve health outcomes and reduce health inequalities for our more vulnerable children and young people through:

    - Improving the offer and subsequently the health outcomes of City and Hackney Looked After children. We will:
        - Re-design and re-commission the Health of LAC service, continuing with an integrated partnership model
        - Further integrate LAC pathways with health pathways, particularly for those CYP with complex health needs, mental health needs and challenging behaviour needs

    - 'Make every contact count' for children and young people, through delivery of the vulnerable children's primary care contract which will identify children more effectively in primary care, work closely with our new area model for health visiting and school nursing and review the take up of support for children identifying as young carers. This may link with our work to explore piloting delivery of children's community health services through the new 'neighbourhoods' model, and will build on the 'MECC' work developing through the Prevention workstream.

- Develop improvement plans for management of children and young people with SEND. To be aligned to recommendations arising out of the Ofsted / CQC SEND inspection (November 2017), and including:

    - Ensuring clear and effective pathways for SEND children, and improving these specifically for under 5's

    - Developing and implementing a clear offer of support at key transition points between services

    - Developing a robust mechanism for ensuring our universal Children and Young People's health services are key partners in the development of EHCPs, in line with recent Ofsted / CQC recommendations

    - Responding to the recommendations of the Children's Disability Needs Assessment, improving how we record and share information about local needs, health service activity and compliance with statutory timeframes for Education Health and Care Plans (EHCPs)

- Quality assessing EHCPs and support plans for children with SEND to determine whether health needs are appropriately identified in plans
- Working to support the reduction in exclusions for our SEND children, linked to our ask around ensuring there is a clear prevention offer around emotional health and wellbeing, and appropriate support through CAMHS
- Continuing our joint work with the Orthodox Jewish community regarding equity of service provision for children in independent schools

- Develop work to improve the identification and management of children with long term conditions, including:
  - Localised delivery of the STP integrated asthma provision
  - Delivery of the Primary Care Vulnerable Children's contract (as above), and continued delivery of support in primary care to children and young people with asthma, diabetes, epilepsy and sickle cell
  - Strengthen transition between children and adult's services, and continue to improve the quality of personalized care planning to encourage self-management with less need for emergency care
- Scope the potential for development of a joint pathway across the system to increase preventative support, for those at risk of Child Sexual Exploitation, and provide efficient and effective physical and emotional support and treatment where appropriate for those at risk of and experiencing Harmful Sexual Behaviours and Child Sexual Abuse, in line with the STP. This includes:
  - Working with the NEL STP to deliver an appropriate NEL CSA Hub , incorporating principles behind the 'Child House' model
- Continue to work with the Young Black Men's work programme in order to reduce disparities in health outcomes for this group. This will involve:
  - Exploring the use of technology as a medium for communicating health messages and increasing access to services
  - Working with HCVS to support further work on early years and early intervention
  - Explore the impacts of poor mental health and emotional health and wellbeing and the links to exclusions
- Work across the system in order to improve the offer of care at maternity in City and Hackney, specifically:
  - In line with commitments in our Sustainability and Transformation Partnership (STP), reduce the rate of infant deaths and stillbirths in line with national expectations (20% by 2020). In order to achieve this we will:
    - Manage the HUFT maternity contract to improve performance, and provide assurance that care is safe, effective and responsive
    - Continue to work to increase the number of pregnant women making their initial booking 'early'
    - Develop a shared local plan in line with 'Better Births' (the 5YF national maternity review) to support personalized, continuous and choice of care, improved postnatal care and perinatal mental health support, and easier access to services
    - Review data and recent audit around maternal re-admissions (including guideline introduction on post-natal care), and support implementation of recommendations and a follow up audit / evaluation
    - Work closely with the Prevention workstream on reducing rates of smoking in pregnancy, through embedding the HUFT maternal smoking pathway, and looking at developing a UCL maternal smoking pathway for CoL and Hackney residents. We want to further reduce the rate of women who are known smokers at time of delivery.

- Maximise the impact of delivery of the GP Contract elements on pre-conception care, linked to better outcomes in maternity, and to the development of a clear maternal pre-conception and pregnancy healthy weight pathway.
- Improve rates of antenatal flu and pertussis vaccine

- Work across the system in order to improve the offer of care at Early Years in City and Hackney, specifically:
  - Support work on reducing childhood obesity (linked to priorities of the Prevention workstream), through development of a pre-conception and maternal obesity pathway
  - Improve rates of childhood immunisations at 1 and 2 years, working toward achieving 'herd immunity' for these indicators. We will explore options for devolved commissioning in order to support this, alongside locally resourced interventions, such as additional nurse funding in primary care.
  - Explore options for developing a 'supporting parents' pathway, linked to substance misuse and additional vulnerabilities, and also aiming to reduce 'adverse childhood events'
  - Scope an effective intervention in order to reduce rates of A&E admissions in children under 5, linked to work through the Unplanned Care workstream
  - Continue to push closer working between our community health services, primary care and education professionals, maximizing our leverage through the Health Visiting and Family Nurse Partnership services

- The current NHS and Social Care metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories for 2017/18. Expectations for delivery by the system will be confirmed shortly
- Deliver national CQUIN measures and targets as appropriate
- Work with partners to support relevant actions within City of London Health and Wellbeing Strategy for children, young people and their families

<u>Review all current services and plan improvements in outcomes from 2018/19 onwards:</u>

- Manage the CYPM care budget and agree remedial action to be implemented on 1 April 2018 to bring the budget back into balance should PbR spend increase during 17/18
- Review the current contract portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, reduce avoidable unplanned care spend, maximize quality and efficiency from services and improve value
- Agree system action plans to take forward the local 'big ticket items' linked to this workstream:
  - Improvement of children and young people's emotional wellbeing and mental health
  - Improvements in health outcomes for vulnerable groups
  - Improved performance across the system as relates to maternity and early years
  -
- Agree system action plans to take forward local transformation initiatives:
  - CAMHS Transformation plans, particularly links with schools
  - Re-design and procurement of health services for Looked After Children
  - Improved quality of provision for those with SEND

- Improvements in the quality of maternity care, in line with STP and FYFV expectations
- Continued integration of Early Years provision, maximizing positive outcomes for children

- Linked with the above service delivery changes and/or transformation initiatives, model and agree improvement trajectories for mandated NHS and Social Care outcomes along with agreement on any additional decided local population health outcomes and trajectories attached for 2018/19 onwards

Objectives for 2018/19:

- Deliver system action plans agreed above, alongside improvement in outcomes as per agreed trajectories. This will include:

  - Continuing to ensure delivery of the Child and Adolescent Mental Health Services Transformation Plans, as agreed by NHS England including delivery of transformation of the full range of service, working toward an more integrated system and delivering improvement models for strengthening prevention in schools, the offer at transition (from young people to adult services), support for parenting and ensuring young people get access to support quickly and where it is needed
  - Increased support for children and young people around their mental and emotional health and wellbeing, and reduced demand on higher tier services, therefore reducing costs
  - Continue to embed 'Making every contact count' for children and young people, through delivery of the vulnerable children's primary care contract which will identify children more effectively in primary care, work closely with our new area model for health visiting and school nursing and review the take up of support for children identifying as young carers.
  - Consolidate community service arrangements into delivery through the neighbourhoods model as appropriate.

- Continue to implement improvement plans for management of children and young people with SEND. including:

  - Embedding clear and effective pathways for SEND children, and improving these specifically for under 5's and Implementing a clear offer of support at key transition points between services
  - Continuing to respond to the recommendations of the Children's Disability Needs Assessment, and the SEND inspection (2017) improving how we record and share information about local needs, health service activity and compliance with statutory timeframes for Education Health and Care Plans (EHCPs) and Quality assessing EHCPs and support plans
  - Continuing our joint work with the Orthodox Jewish community regarding equity of service provision for children in independent schools

- Continue to embed an effective CSE, HSB and CSA pathway for City and Hackney children, and delivery of provision in line with NEL plans
- Delivery of an agreed model to improve health messaging and ultimately access to health services by Young Black men.
- Continue to oversee and performance manage maternity contracts in order to move toward a safer, more effective and responsive maternity system
- Continue to further integrate delivery of health and wider services across Early Years, including implementation of the new pre-conception and maternal obesity pathway, implementation of an intervention to reduce admissions in under 5s and support increases in rates of immunisations.

- Evidence impact of new delivery models implemented in 2017/18 on agreed metrics. This will include:

  - Improved health outcomes for Looked After Children, as a result of bedding in new arrangements
  - Changes in flows of Children and Young people through CAMHs

- Increases in satisfaction by users of SEND services, and improvements in timeliness and quality of care planning for this group
- Continuing to improve health outcomes for children with long term conditions (Indicators TBA)
- Improvements in maternity care (as reported in satisfaction surveys and local and national indicators), reductions in smoking at delivery and reductions in maternal re-admissions
- Improvements in health outcomes for children in early years, including more integrated health checks delivered, less A&E admissions for under 5's and increased levels of immunisation

- Manage the CYPM care budget within plan
- Agree remedial action if any deviation from plans
- QIPP (ask TBC)
- Achieve nationally mandated CQUINs for 2018/19

Appendix 2: List of CYPM Contracts and Commissions

Aligned budgets for Children, Young People and Maternity Workstream: Draft end 2017/18

Organisation	Workstream	Pooled or Aligned	Contract/Service Description	Annual Budget	Contract Lead
City and Hackney CCG	**CYP**	Aligned. In scope for pooling.	CHC - Assessment, Reviews and Training services HUHFT	820,903	Sarah Darcy (CCG)
City and Hackney CCG	**CYP**		Early Years Contract: Vulnerable Children PIC Approved in line with Activity	34,000	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Children's Specialist Nursing	263,688	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Children's transition service (Hackney Ark)	282,310	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Community Paediatrics	1,994,492	Sarah Darcy
City and Hackney CCG	**CYP**		CHC - Spot Purchase Complex Care Packages	541,794	Sarah Darcy
City and Hackney CCG	**CYP**		CHC Children's Equipment	41,042	Sarah Darcy
City and Hackney CCG	**CYP**		Childhood Immunisation	220,000	Sarah Darcy
City and Hackney CCG	**CYP**		CHS - Community Services Short Breaks Kids Sunday Club	39,000	Sarah Darcy
City and Hackney CCG	**CYP**		CHS - Huddleston Access Service (Short Breaks)	24,000	Sarah Darcy
City and Hackney CCG	**CYP**		CHS - Looked after children - contribution toward designated nurse role	57,381	Sarah Darcy
City and Hackney CCG	**CYP**		Early Years - Maternity service (Antenatal and Postnatal Care)	260,000	Pauline Frost (CCG)
City and Hackney CCG	**CYP**		Early Years Contract: Vulnerable Children - Non Recurrent (Agreed to continue 18/19)	272,000	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Audiology	645,022	Pauline Frost
City and Hackney CCG	**CYP**		Homerton CHS - CAMHS	459,854	Greg Condon (CCG)
City and Hackney CCG	**CYP**		Homerton CHS - Child Incontinence	141,062	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Children's Community Nursing Team (Incl HV)	706,230	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Children's Complex Care Team	120,384	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Disabled Children's Reg	43,146	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Hackney Ark Children's Service	620,512	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Key Working Children's disabilities	285,874	Sarah Darcy

City and Hackney CCG	**CYP**		Homerton CHS - MARAC Primary care liaison	55,140	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Physiotherapy	776,204	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Safeguarding	345,088	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Short Breaks	90,870	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS - Speech and Language Therapy	1,352,412	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton CHS -Occupational Therapy	640,118	Sarah Darcy
City and Hackney CCG	**CYP**		Huddleston Centre - Children's Disability Forum [Carers Peer Support / Family Social Events]	28,350	Sarah Darcy
City and Hackney CCG	**CYP**		Integrated Epilepsy service	55,000	Sarah Darcy
City and Hackney CCG	**CYP**		LTC elements of Vulnerable Children's contract (In 2016/17 within Adult LTC contract)	100,000	Sarah Darcy
City and Hackney CCG	**CYP**		Richard House Children's Hospice	103,502	Sarah Darcy
City and Hackney CCG	**CYP**		Safeguarding - contribution to adult safeguarding board	11,750	Pauline Frost
City and Hackney CCG	**CYP**		Safeguarding - contribution to children's safeguarding board	23,747	Pauline Frost
City and Hackney CCG	**CYP**		Bump Buddies (managed by LBH: match fund)	80,000	Jairzina Weir (CCG) & Donna Lee (LBH)
City and Hackney CCG	**CYP**		Homerton CHS - Breastfeeding peer support (NR)	40,000	Jairzina Weir
City and Hackney CCG	**CYP**		Targeted antenatal classes	7,500	Jairzina Weir
City and Hackney CCG	**CYP**		Targeted antenatal classes	7,500	Jairzina Weir
City and Hackney CCG	**CYP**		Targeted antenatal classes	7,500	Jairzina Weir
City and Hackney CCG	**CYP**		CAMHS Service	3,697,694	Greg Condon
City and Hackney CCG	**CYP**		CAMHS Transformation Fund	376,397	Greg Condon
City and Hackney CCG	**CYP**		Child Bereavement	25,000	Sarah Darcy
City and Hackney CCG	**CYP**		Children's ASD	46,175	Sarah Darcy
City and Hackney CCG	**CYP**	Aligned. In scope for pooling.	Eating Disorder Service - (NEW INVESTMENT)	135,000	Greg Condon
City and Hackney CCG	**CYP**		Homerton CHS - Children's Autism Spectrum Disorder (ASD)	46,817	Greg Condon

City and Hackney CCG	**CYP**		Homerton CHS - First Steps	1,085,970	Greg Condon
City and Hackney CCG	**CYP**		Non ELFT Eating Disorders - NEW	15,000	Greg Condon
City and Hackney CCG	**CYP**		Perinatal Mild - Moderate IAPT - (NEW INVESTMENT)	75,000	Jairzina Weir
City and Hackney CCG	**CYP**		Perinatal Service	285,589	Jairzina Weir
City and Hackney CCG	**CYP**		Barts Health Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	1,863,187	Sarah Darcy
City and Hackney CCG	**CYP**		GUYS & ST THMAS Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	302,766	Sarah Darcy
City and Hackney CCG	**CYP**		Homerton University Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	18,892,322	Sarah Darcy
City and Hackney CCG	**CYP**		IMP COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	100,119	Sarah Darcy
City and Hackney CCG	**CYP**		KINGS COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	49,454	Sarah Darcy
City and Hackney CCG	**CYP**		ROYAL FREE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	270,787	Sarah Darcy
City and Hackney CCG	**CYP**		NORTH MID Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	311,234	Sarah Darcy
City and Hackney CCG	**CYP**		Whittington Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	952,520	Sarah Darcy
City and Hackney CCG	**CYP**		UCLH Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	4,190,177	Sarah Darcy
City and Hackney CCG	**CYP**		Great Ormond Street Hospital (GOSH) Acute Contract	554,450	Sarah Darcy
City and Hackney CCG	**CYP**		Tongue Tie (final year 2017/18: not funded 18/19)	25,000	Jairzina Weir
CCG TOTAL				**44,898,033**	
LBH Public Health	**CYP**	Proposed for pooling as part of Prev WS BC	Independent National Child Measurement Programme : HUFT / VCS contracts	80,000	Samina Tarafder (LBH PH)
LBH Public Health & CoL	**CYP**	Proposed for pooling as part of Prev WS BC	Children 0-5 Healthy Child programme (FNP: Whittington Health and Health Visiting: HUFT)	6,546,000 425,112	Kate Heneghan (LBH PH)
LBH Public Health & CoL	**CYP**	Proposed for pooling as part of	Children 5-19 Healthy Child programme (School based and community health services: WH & HUFT)	1,290,000	Lucy Vanes (LBH PH)

		Prev WS BC			
LBH Public Health & CoL	**CYP**	Proposed for pooling as part of Prev WS BC	Young Peoples 5-19 Services: Wellbeing and Sexual health (Young Hackney and CHYPS plus HUFT)	656,000 275,000	Lucy Vanes
LBH Public Health	**CYP**	Proposed for pooling as part of Prev WS BC	Oral Public Health (Kent Community NHS Trust)	250,000	Samina Tarafder
LBH Public Health	**Prevention**	Proposed for pooling as part of Prev WS BC	Childhood obesity / healthy weight	346,973	Kate Heneghan
LBH Public Health	**Prevention**	Proposed for pooling as part of Prev WS BC	Childhood physical activity	202,638	Kate Heneghan
LBH Public Health	**CYP**	Proposed for pooling as part of Prev WS BC	Young People's substance misuse (Young Hackney)	386,000	Lucy Vanes
LBH Public Health / HLT	**CYP**	Proposed for pooling as part of Prev WS BC	Children's Centre Nutrition: Eat Better Start Better	90,000	Kate Heneghan
LBH PH TOTAL				**9,998,112 (CYP)** **549,611 (Prev)**	
LBH CYPS	**CYP**	In scope to propose for aligning, and pooling 19/20	Clinical Service	1,603,539	Sarah Wright (LBH CYPS)
LBH CYPS	**CYP**	In scope to propose for	Services for children with SEND	3,697,660	TBC

		aligning, and pooling 19/20			
LBH CYPS TOTAL				**5,301,199**	
CoL CYPS	**CYP**	TBC. Relevant budgets identified for pooling or aligning.		**2,111,000**	Lorna Corbin (CoL)
TOTAL ALL				**53,308,344**	**Potential available for aligning and / or pooling 2018/19, subject to full scoping exercise.**

Appendix 3: CYPM Workstream Month 10 Position and Forecast (CCG Only)

Programme Board	Service Line	Annual Budget £'000	YTD Budget £'000	YTD Actual £'000	YTD (Under)/ Overspend £'000	Forecast Actual £'000	Forecast (Under)/ Overspend £'000	Improvement / Deterioration vs M9	Improvement / Deterioration vs M9 £'000
Childrens	CHC - Childrens Equipment	41	34	0	-34	0	-41		0
	CHC - Complex Care Spot Purchase (Assesment, Reviews and Training services)	821	684	507	-177	609	-212		52
	CHC - Spot Purchase Complex Care Packages	542	451	456	5	643	101		0
	Childhood Immunisation	220	183	183	0	220	0		0
	Clinical&Medical-Serv Recd-CCGs	0	0	-11	-11	0	0		0
	Community Services Short Breaks Kids Sunday Club	39	33	39	6	39	0		0
	Great Ormond Street Hospital (GOSH) Acute Contract	554	462	462	0	554	0		0
	Homerton University Hospital NHS Foundation Trust (CHS)	7,908	6,590	6,590	0	7,908	0		0
	Huddleston Access Service (Short Breaks)	24	20	24	4	24	0		0
	Huddleston Centre - Children's Disability Forum [Carers Peer Support / Family Social Events]	28	24	53	29	28	0		0
	Looked after children - contribuition toward designated nurse role	57	48	48	0	57	0		0
	LTC elements of Vulnerable Children's contract (In 2016/17 within Adult LTC contract)	100	83	83	0	100	0		0
	Richard House Children's Hospice	104	86	50	-37	104	0		0
	Safeguarding - contribution to children's safeguarding board	24	20	23	3	24	0		0
Childrens Total		**10,462**	**8,719**	**8,508**	**-211**	**10,310**	**-152**		52
Childrens / Mental Health	Homerton University Hospital NHS Foundation Trust (CHS)	460	383	383	0	460	0		0
Childrens / Mental Health Total		**460**	**383**	**383**	**0**	**460**	**0**		0
Corporate	Safeguarding - contribution to adult safegurading board	12	10	11	2	12	0		0
Corporate Total		**12**	**10**	**11**	**2**	**12**	**0**		0
Maternity	Bump Buddies	50	42	42	0	50	0		0
	Early Years - Maternity service (Antenatal and Postnatal Care)	260	217	217	0	260	0		0
	Early Years Contract: Vulnerable Children - Non Recurrent	272	227	227	0	272	0		0
	Early Years Contract: Vulnerable Children PIC Approved in line with Activity	34	28	28	0	34	0		0
	Homerton University Hospital NHS Foundation Trust (CHS)	40	33	33	0	40	0		0
	Targeted antenatal classes	30	25	25	0	30	0		0
	Targeted Antenatal Clinics	0	0	-8	-8	0	0		0
	Tongue Tie	25	21	21	0	25	0		0
Maternity Total		**711**	**592**	**585**	**-8**	**711**	**0**		0
Mental Health	CAMHS Transformation Fund	376	314	314	0	376	0		0
	Child Bereavement	25	21	21	0	25	0		0
	Childrens ASD	46	38	38	0	46	0		0
	East London NHS Foundation Trust	4,193	3,494	3,494	0	4,193	0		0
	Homerton University Hospital NHS Foundation Trust (CHS)	1,133	944	944	0	1,133	0		0
	Online Counselling Support (Eating Disorders)	15	12	12	0	15	0		0
Mental Health Total		**5,789**	**4,824**	**4,824**	**0**	**5,789**	**0**		0
Planned Care	Barts Health Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	1,863	1,553	1,553	0	1,863	0		0
	Barts Health Hospital NHS FT Children & YP over / under performance	0	0	-208	-208	-249	-249		0
	Great Ormond Street Hospital (GOSH) Acute Contract over / under performance	0	0	-94	-94	-113	-113		(12)
	GUYS & ST THMAS Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	303	252	252	0	303	0		0
	GUYS & ST THMAS Hospital NHS FT Children & YP over / under performance	0	0	6	6	7	7		3
	Homerton University Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	18,892	15,744	15,744	0	18,892	0		0
	IMP COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	100	83	83	0	100	0		0
	IMP COLLEGE Hospital NHS FT Children & YP over / under performance	0	0	15	15	18	18		(0)
	KINGS COLLEGE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	49	41	41	0	49	0		0
	KINGS COLLEGE Hospital NHS FT Children & YP over / under performance	0	0	-2	-2	-2	-2		(0)
	NORTH MID Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	311	259	259	0	311	0		0
	NORTH MID Hospital NHS Children & YP over / under performance	0	0	105	105	126	126		4
	ROYAL FREE Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	271	226	226	0	271	0		0
	ROYAL FREE Hospital NHS FT Children & YP over / under performance	0	0	-3	-3	-4	-4		(32)
	UCLH Hospital NHS FT Children & YP (Paed A&E + Paed % EL Acute activity)	4,190	3,492	3,492	0	4,190	0		0
	UCLH Hospital NHS FT Children & YP over / under performance	0	0	260	260	312	312		0
	Whittington Hospital NHS Children & YP (Paed A&E + Paed % EL Acute activity)	953	794	794	0	953	0		0
	Whittington Hospital NHS Children & YP over / under performance	0	0	387	387	465	465		322
Planned Care Total		**26,933**	**22,444**	**22,910**	**466**	**27,492**	**560**		285
PPI	CHS - Older Peoples Reference Group (OPRG) - Age UK	28	23	20	-3	28	0		0
PPI Total		**28**	**23**	**20**	**-3**	**28**	**0**		0
Aligned Children/Young people Total		**44,394**	**36,995**	**37,241**	**247**	**44,802**	**408**		337

Appendix 4: Risk Register

Risk / Event Details					Inherent Scores [pre mitigation]			Mitigation Plan	Action Taken	Residual Scores [post mitigation]				Risk Direction since last report
Reference Number	Workstream / Project	Lead Officer	Risk Description	Likelihood	Severity	Inherent Risk Score		**Scoped programme of work to mitigate this risk** [bullet action plan including timescales and performance metrics where available & appropriate]	**Monthly update on actions taken to mitigate risk and impact of actions**	Likelihood	Significance	Inherent Risk		**Decision suggested by Olivia / Pauline / Amy Friday 16th Feb**
Page 92	CYPM	WS Dir / Clinical Lead	**Immunisations for pregnant women.** There is very low uptake of flu and pertussis immunisations to pregnant women in City and Hackney. The CCG does not commission this service from GPs nor from Maternity services as it is within NHS England's commissioning remit. Currently commissioning is focused on GPs providing the service but it is midwives who see women antenatal and have the opportunity to offer on the spot immunisations. As the CCG neither pays for or commissions the service there appears to be little the CCG can do to influence this situation and drive up uptake. The effect of low uptake can result in maternal and infant mortality and morbidity.	**2**	**5**	**10**		1. Maternity PB working with NHSE, GPs and Homerton to develop a pragmatic approach to try to overcome some of these barriers. 2. A bid to provide community outreach and education to raise women's awareness and pursuit of these immunisations was submitted to PIC. This was not successful as the CCG did not feel immunisations were our responsibility. 3. HUH and NHSE have agreed an SLA for maternity service to deliver imms following women's 20w scans. 2 nurses were recruited and the service started in January 2017. Successful bid by HUHT for NHSE funding for 1.5wte nursing resource to support vaccination of pregnant women. Nurses recruited and in post. Delivery commenced January 2017. Progress being monitored by MPB and NHSE but there is some difficulty getting accurate and timely data. Further opportunities to directly commission and fund immunisations may be available via devolution and co-commissioning of primary care.	There is still a risk that uptake may not improve and that serious morbidity or mortality occurs due to a women not being immunised. September 2017 update: Letter from PHE regarding Seasonal 'flu and Pertussis vaccination offer in maternity units to pregnant women in London 2017/18.	**1**	**4**	**4**	N / A	Keep risk as uptake of Imms across Hackney is still not as high as it should be. Consider a review of update of imms, specifically midwifes scanning when women are 20 weeks and re-assess risk content and mitigations
	CYPM	WS Dir / Clinical Lead	**HUH Maternity staffing levels and skill mix.** There were two closures to HUH maternity unit in July & Aug 2016 due to lack of registrar cover. Acuity of women has potentially increased, reflected by an increase in deliveries with comorbities / complexities (from June 15, rising from 35% to 50%). This increase could require higher staffing levels (midwifery and medical) and a different skill mix. The Oct 16 Homerton SI thematic report flags up workload/capacity as a key theme (5/12 cases).	**3**	**4**	**12**		1. HUH have put in place a system to bring in the on-call consultant when a registrar is unavailable. Another consultant will take over the on-call duty. This should help prevent further closures but if they do occur HUH has agreed to notify CCG immediately by email. 2. 50 cases of deliveries will be audited as part of the Information Governance (IG) audit. This should show up any coding issues i.e. if acuity in deliveries is being accurately coded. 3. Following this audit a staffing review will take	It was agreed at CQRM Feb 17 to deliver a further audit focusing on delivery coding. This is ongoing. HUH will be utilising Birth-rate+ for their midwifery staffing review. This is due to report June 2017. HUH is reviewing Obstetric staffing and changes made to the model should be available Oct 17.	**3**	**4**	**12**	N / A	Keep risk but make it more general, reflecting challenges recruiting and retaining staff acute care settings across C&H for services for Children and Young People and their families.

							place to review capacity and skill mix. HUH receive additional funding for higher acuity cases and it isn't clear whether staffing has increased to reflect this. Midwifery: birth ratio at 1:29 Sep 16. The IG toolkit audit identified high levels of coding accuracy in Obstetrics but did not specifically looking at the coding of delivery.	September 2017 update: The CCG are still awaiting this information. Escalated to the CQRM meeting for discussion Sept 2017. See action plan above regarding staffing. Have had their staffing review .					Include: as delivery rates are dropping, surplus of midwifes in HUH, three consultant paeds and some nursing vacancies in Paeds.
		WS Dir	If professionals recommend individual packages of care outside of the agreed pathways and governance arrangements this may lead to inflated, unnecessary costs which could mean that the programme goes over budget. Sarah Darcy	**3**	**4**	**12**	1. SEN (Designated Med Officer) to liaise with secondary and tertiary care 2. Iterative local offer websites detail provision and assessment pathways 4. CSU monitor & manage monthly CHC and PHB budgets	1. Pt consent to share information to be included in LTC contract 2017/18 2. SEND joint commissioning process for funding packages is required - on the work plan of the Hackney Integrated Commissioning task group 3. CCG and HLT drafting partnership EHCP dashboard.	**2**	**4**	**8**	N / A	Keep risk, Olivia to work with Sarah to update
	CYPM	WS Dir	As a result of the unpredictable nature of continuing health care budgets there may be an overspend which could adversely affect the overall CCG budget	**3**	**4**	**12**	1. CSU to monitor and manage the budget 2. Monthly review meetings with CSU		**3**	**4**	**12**	N / A	Keep risk but modify to reflect changing landscape of CHC portfolio, reviewing working with planned care workstream
	CYPM	WS Dir	Risk of failing to offer and deliver Personal Health Budgets to CYP with continuing care and those eligible for EHCPs. Failure could result in lack of personalisation for families, and legal proceedings could be instigated against the CCG.	**3**	**3**	**9**	1. PHB MOU in place with CSU 2. Monthly CSU reporting against PHB target of 12 in 16/17 3. Feedback from families via reviews and engagement events 4. MDT working and feedback via Joint Complex Care Panel 5. CCG offer published 01/04/2016	1. Closer integration of PHB and EHCP pathway to enable offer of PHB to eligible CYP 2. 2017/18 management service to be commissioned to achieve 25 PHBs by end of March 2018 3. MOU signed October 2016 for 2016/17 included scoping of opportunities to integrate offer with EHCPs 4. Target of 12 achieved by end of March 2016/17	**2**	**3**	**6**	N / A	Keep risk - Sarah to update re delivery time take (should be on track for delivery March 2018)

	CYPM	WS Dir	Collaboration across wider system is slow and challenging due to large number of partners and potential differing agendas. Possibility of subsequent minimised impact by Workstream.	**3**	**2**	**6**	1. Set up being done jointly across a range of partners. Robust programme of stakeholder engagement planned and being implemented.	1. Possible risk to be revisited in March / April after 6 months	**2**	**2**	**4**	N / A	Monitor closely
	CYPM	WS Dir	Silo working and gaps in commissioned pathways as priority areas sit across the remit of a number of organisations.	**3**	**2**	**6**	1. Formal joint team meetings have been set up 2. Business and Performance Oversight Group set up and functioning 3. Robust integration programme underway.	1. Joint team meetings underway 2. Strong communication across organisations between commissioners 3.Joint approach to CCG PIC process an upcoming system PICC	**2**	**2**	**4**	N / A	
	CYPM	WS Dir	Failure to have formal quality assurance processes for services commissioned by NHS England (include GP practices, opticians, pharmacy, dentistry, SARC, tier 4 CAMHS and Primary Care). This could result in: C&H CCG not being able to fully fulfil its statutory duty to promote the wellbeing and safety of children and may result in reputational damage.	3	4	**12**	The CCG continues to engage in meetings with NHSE and discussions are in place in relation to options for co-commissioning	NHSE membership of the CPB from June 2016. Training programme in place since May 2015. 28/12/2017: Since April 2017 C&H CCG commissions primary care with NHSE. Programme of SG children training offered to all primary care services in City & Hackney.	2	4	8	N / A	Review governance arrangements with NHSE re quarterly reporting for the services listed and take a view as to whether this risk remains valid - if so, Olivia to work with team to create new risk to reflect
	CYPM	WS Dir	Failure of NHS England and LETB to agree on the arrangements for the provision of safeguarding children training for independent contractors. This may result in staff lacking confidence, knowledge and skills to identify and act on concerns to safeguarding children	3	4	**12**	Designated nurse and named GP deliver safeguarding training to primary care clinicians	Designated network collectively raising with NHSE regarding assurance. We still do not have assurance regarding this. Letter sent out to private providers. 28/12/2017: Letter sent out jointly in February 2017 by C&H CCG and the CHSGCB sign posting the training on offer.	2	4	8	N / A	Adapt risk to reflect safeguarding risks associated with system working and the CYPM WS - including identifying areas across the system where Safeguarding awareness is low and actions to implement - map with Olivia / Mary re Safeguarding in the new system will be carried out in this next phase of the governance review

	CYPM	WS Dir	Joint procurement with LbH of CHC care hours providers. Insufficient providers / unintended impact of transfer on families	3	4	**12**	Formal procurement process in place with CCG Board oversight	1. Need to agree a transition plan in event that all on caseload need to transfer provider. 2. Plan delayed, awaiting legal advice. TUPE eligibility confirmed November 2016 3. Final decision from 'new' providers whether to proceed with contract due March 2017 4. Ongoing dialogue regarding TUPE risk Update: October 2017. There are small number of families who have children who need to transfer from the HUHFT. The HUHFT have a number of band 4 CCNT staff who have jobs at risk due the change in the re-commissioning arrangements in 2015. There may be TUPE/or redundancy costs which the CCG are seeking further advice from corporate solicitors. 28/12/2017: A plan has been drawn up and agreed with NELCSU regarding the notification and transfer of care from the HUH CCNT. The HUH have indicated that the ability to spot purchase from this service will cease from 1st April 2018. Families will be informed via a formal on 2nd January 2018.	2	4	8	N / A	Keep risk for the time being, Sarah to manage. Work should be completed from 1 April 2018, where risk can be removed (completion depending)
	CYPM	WS Dir	Changes to commissioning responsibilities has led to fragmented provision. Herd immunisation is not achieved			**0**	1. The CPB escalated risk to NHS England and is involved in review meetings. 2. Partnership monitoring of commissioning arrangements through Immunisation Steering Committee	1. WS submitted further investment bid to CCG PIC in January 2018. 2. NR funding secured for 2018/19' pending contracts committee approval 3. 18/19 specification to be signed and reporting agreed 6. Quarterly partnership Immunisation meeting ongoing with PH, CCG and NHSE.	3	4	12	N / A	Keep risk - services are part of early years contract with GPC to continue in 18/19. Sarah to update risk.
	CYPM	WS Dir	The Paediatric Audiology Service contracted by HUHFT as part of a block contract was served notice of the intention to divest itself of the historical SLA for Bart's Audiology that provides support to the second and third tier Audiology Service in	5	3	**15**	The service will require at least 0.5 PA's from an AVC in order to ensure the Tier 3 children are seen and reviewed in a timely manner.	11/05/2017: The CHCCG have asked the Bart's Health Audiology Service to contact the private provider they currently use to support similar services they	2	3	6	N / A	Risk to be updated to reflect the following: Tier 2 service has been commissioned and

			September 2016. The rationale for this decision was that HUHFT acted as a sub-commissioner and this was not felt to be an appropriate arrangement. The audio vestibular consultant (AVC) input to the service for the Tier 3 service was provided by UCLH who were also served notice. The CHCCG has been in negotiation with the providers to commission a new service from the 1st June 2017. On 11.05.2017 the UCLH AVC team manager confirmed to DS that they were no longer in a position to provide the medical input into the Tier 3 service. There will be a risk to children who require a Tier 3 AVC consultation of their hearing loss diagnosis being delayed if an AVC service is not provided from the 1st June 2017. Approximately 50% of the Tier 3 service is for children from THCCG.					provide for other CCGs. This may result in a higher cost for the AVC service. CHCCG have also contacted Guys service to identify if they have capacity to support the AVC requirements for this service. The risk will be elevated to the corporate risk register. 18/05/2017: CHCCG have been in contact with the AVC service managers at UCLH and GSTT who have offered to support the service going through the commissioning transition. The OACCG contact lead will identify a tariff for the proposed AVC service pathway. Meetings with THCCG will take place on the 18th May 2017 to go through proposed pathways for Tier 3 children and set a tariff for the activity. BH Audiology team have challenged the length of time the contract renewal - 10 months. This point will also be discussed with THCCG. 05/07/2017: The Audiology contract has been agreed by all parties and the service specification will be completed by 14/07/2017. The AVC provision will be provided by Headline for the next 10 months with the intention for the BH audiology service to appoint a consultant to cover this role as UCLH do not have the capacity. There has been no break in service and the back log 40 of children have now been followed up. This service is now fully up and running. The CCG is in the final stages of signing off contracts and MOU with BH and HUH respectively. 28/12/2017: Tier 3 contract signed and in place. Tier 2 MOU agreed final service specification to be agreed for Tier 2 service and contract signed. The structure of the Tier 2 service after April 2018 to be determined				is running (via HUH) Community Consultant Peed and Audiology led service), Tier 2 contract needs to be written - risks associated with this. Tier 3 service is also up and running, provided by Barts - Tier 3 contract is under review by the CCG, financial risk associate with this Tier 3 contract...

								with HUH Community Paediatric team and BARTS Health Audiology team.						
	CYPM	WS Dir	The implementation of the new Child Health Information System (CHIS) by PH England. Concerns about the robustness of the record transfer service (transferring records in and out). Provider trusts report they have not received transfer notifications. This is currently putting babies, children and young people at risk therefore they may not have not have their health needs addressed. Risk of sending late birth notifications which means health visitors are not able to do the new birth visit within 14 days. There is also a potential in missing results for new-born blood spot screening. Providers are responsible for following up abnormal results and this is putting this group of children at risk.	3	5	**15**	Update required from Health Care partners. 99% of City & Hackney GP practices now linked to QMS.	The CHSGB Chairman will issue a letter of concern to NHSE PH commissioner in June 2017 raising this as a concern. Partnership to monitor via the 0-5 years Oversight Group. 13/09/2017: Assurance received from NHSE via the designated professional network. The robustness of this assurance against the data set has been challenged by the provider therefor escalated to the CGCB. 20/09/2017: The CHSCB received a report from Kenny Gibson where a number of actions were agreed with the provider. **28/12/2017:** Mary Lee emailed Sarah Webb the Deputy Chief Nurse asking if there was still an ongoing issue. Pauline Frost emailed Shona Ash Commissioning Manager Antenatal & New-born Screening at NHSE for an update. To date C&H CCG have not been notified of any significant concerns.	2	4	8	N/A	Risk to be updated to reflect the following: CHIS is up and running across the system, a piece of work to review the CHIS and assure that it is functioning appropriately across the system to be carried out. Post review, a view to be taken on whether this risk should remain on the register.
	CYPM	WS Dir	Recognition of a gap in joint processes around EHCP arrangements for children and young people with complex health needs who do not have an identified learning need. Health support at school is identified outside of the EHCP framework and agreed on a case by case basis with no QA across the range of involved health services currently	5	3	**15**	Governance process proposal to go to the SEND partnership board in December 2017 and the CYPMS work stream. A budget line will need to be secured in order to progress this.	29/11/2017: SD met with home tuition service coordinator and DMO to identify relevant cases. 28/12/2017: This has been taken to the CYPM work steam and the CCG CPB as there is a financial implication to fund these children appropriately in order to meet their educational needs.	5	3	15	N/A	Keep risk, Sarah responsible for updating

Assurance Review Point 3: Planned Care (PC) Workstream

Assurance of 18/19 workplans and financial plans.

Review Date:
March 2018

ICSG: 2 March 2018

TB: 9 March 2018

ICB: 21 March 2018

Planning and delivery

1. Describe the key plans and outcomes for 18/19 and your proposed improvement trajectories for these outcomes. How do these align with the wider ECHLP plans?

The Planned Care Workstream plans for 18/19 will focus on a consolidation and implementation of three major transformation projects developed in 17/18.

1.1 Outpatients Transformation (appendix A):

This project proposes a structured approach to service transformation applying the following principles across outpatient care at the Homerton Hospital:

- Increase opportunities for self-management/care
- Specialist support to the generalist including mental health support in managing patients
- Reducing unnecessary or process driven steps in care pathway
- Ensuring community services are fully integrated into care pathways
- Using technology and innovation

The Key transformation areas are:

- Preventing unwarranted first attendance/referral;
- Reducing unnecessary routine face to face follow ups;
- Optimising what should be done in secondary care and by whom;
- Maximising the utilisation of community service resources.

Commitments to patients include:

- Patients will receive timely access to advice, treatment and support;
- Patients will not incur unnecessary inconvenience when accessing outpatient services;
- Patients will gain access to outpatient services when it is clinically appropriate.

The Outpatient plan has been discussed at Transformation Board (TB) and is on March agenda for Integrated Commissioning Board (ICB). Outline timescales have been revised following feedback at TB and the issue of resources to implement this project remains outstanding.

This work is very much aligned to the ELHCP approach to outpatient transformation and delivers City and Hackney's continued successful approach to demand management via use of shared care pathways at speciality level between primary and secondary care.

1.2 Learning Disability Transformation(appendix B):

This is a major piece of transformation work which has been recently agreed by the ICB and involves system partners is a service redesign of the Integrated Learning Disability Service (ILDS). The PC workstream will support this development by agreeing a comprehensive set of health and social care outcomes, service objectives and specifications to deliver the agreed outcomes. There will be an increased focus on genuine integration and increased multidisciplinary working within the service along with better transition planning and proactive support to service users and families in crisis and who are receiving long term care.

A fortnightly implementation group will oversee the service redesign and report progress to the PC Core Leadership Group (CLG). The priorities for the project are set out below and there is an ambition to deliver the service redesign by June 2018.

The PC workstream and LD commissioners are linked with the Transforming Care Programme for ELHCP. There may be strategic opportunities at this level particularly regarding acute assessment unit provision which is currently being explored.

1.3 Pooled Budgets for Continuing Healthcare and Adult Social Care(appendix C):

Proposals from the PC workstream to extend existing joint funding arrangements and pooled budgets between City and Hackney Clinical Commissioning Group (CHCCG), the London Borough of Hackney (LBH) and City of London (CoL) have been recently agreed by the ICB. In line with our ambition to increase the scope and scale of our integration, pooling proposals from the PC workstream for care home, nursing home placements, Continuing Healthcare (CHC) and care packages in the home into a section 75 arrangement have been delegated to finance leads to finalise for 2018/19 which will be subject to sign off in the normal way.

All partners have experienced significant financial pressures in the budgets for these services. It is anticipated that a single approach will enable better cost control, and eliminate the potential for ‘cost shunting’, which can be detrimental to patient experience. Creating the budget will be supported by a programme of work led by the PC workstream to create a single system approach and this has also been agreed at the ICB

This will be a system that provides:

- Better patient experience through a single consistent commissioning/funding process
- Joint funding of care packages - initially beginning with Learning Disability care packages although these are already within the existing section 75 pool in Hackney currently under review
- Joint/single brokerage function (brokerage is the process of identifying an appropriate provider to meet the care and support needs of an individual and then negotiating and agreeing the cost of the care)
- Joint/single commissioning function
- Greater efficiency and better utilisation of resources with increased flexibility to share funding of care packages across care groups particularly to prevent an escalation of care needs
- Greater market influence, control and development opportunities
- Improved planning and commissioning of care

The final business case will be submitted to NHS England to enable the arrangements to come on line in April 2018.

This further pooling will enable a particular focus to be put on progressing joint funding arrangements and it is expected that joint funding of care packages will start for Integrated Learning Disability Services client group first. These arrangements will then be developed for other client groups. The existing joint funding arrangements in place between in relation to funding Learning Disabilities Services are historic and limited in their scope, having changed little since the CCG was formed. As part of a wider CHC review in 2017 it was identified that

there are a lack of joint funding mechanisms in City and Hackney, especially in comparison to neighbouring boroughs. Furthermore since the integrated service was setup the growing complexity of health and social care needs has meant that there is a clear rationale and need for these arrangements to be implemented.

A number of next steps have been identified to support progress in this area which include:

- Establishing a joint brokerage function - this will enable joined up negotiation with providers and consequently an expected lower cost for health and social care funded packages of support including CHC
- Establishing a joint funding protocol - In line with Department of Health guidance a joint funding protocol should be developed for dealing with jointly funded packages and placements including local dispute resolution processes which should cover both disputes over joint funding as well as NHS CHC eligibility.
- Putting in place an effective Discharge to assess and Placement without Prejudice model - this would allow people to be discharged and assessed in the community and the funding mechanism to be agreed following assessment and backdated to point of discharge. Currently CCG targets to assess 85% of people for CHC in the community are not being met and in some cases delays related to CHC assessments are delaying discharge.

1.4 Continuing Healthcare and the Commissioning Support Unit (CSU)

The current commissioning arrangements for CHC are fragmented across two providers – the Homerton and the Commissioning Support Unit and an external review has confirmed that this is not an optimum model for delivery of this function. The workstream has delivered an action plan of improvements across the CHC function and plans to change these commissioning arrangements are the next step. As in City and Hackney, there is an increased move towards borough based solutions for CHC across all of ELHCP and thus the CSU service will be decommissioned from June 2018. The workstream is out to recruit a project manager for six months to manage this transition. We hope to increase the capacity of the service by resource transfer from the CSU contract though the transfer of all end to end functions for CHC delivery will need to be carefully mapped and managed.

1.5 Cancer

Our focus on improvement of the 62 day cancer constitution standard will increase as there has not been sustained delivery of this target. We are involved with ELCHP plans regarding shared IT systems which would make a significant impact on the transfer of referrals on inter trust transfers. However, the PC cancer project group will be working with the Homerton to improve the management of referrals in line with the 38 day standard as this is a major contributing factor to under delivery of the target. Additional actions will include real time escalation of problems on patient pathways and ensuring enablers such as the service level agreement for PET scans are in place between key providers.

We are working with the GP confederation on their cancer contract with a view to improving the bowel screening uptake. A review of this will also be aligned to ELHCP and Cancer Vanguard plans as well as those of NHSE screening commissioners to ensure we are not duplicating efforts. This may also provide opportunity to further implement the recovery agenda for cancer patients in primary care which is a welcomed intervention as well as support stratified follow up for stable prostate cancer patients.

1.6 Mental health

The proposals for Cedar ward will be included in the workstream plans for 18/19 and aligned to the improvements in the delivery of CHC.

New plans for truly integrating mental health expertise with general medicine will be considered by the workstream during 18/19 and will possibly align to the mental health model for Long term conditions and will especially provide an offer to cancer patients. The workstream presents an opportunity to rethink care pathways from an acute medicine perspective.

1.7 Out of Area Providers

Plans for working with out of area providers will be developed by the workstream during 18/19

1.8 Prescribing

Recent requests for a lead from the prescribing board to join the CLG will create an opportunity for further engagement with the prescribing board plans for 18/19 in addition to the implementation of the Anti-coagulation service in 17/18

2. Describe progress with the big ticket items and plans for transformation in these areas moving towards a more preventative/early intervention approach. Please also outline where and how you intend to use co-production.

2.1 Housing (appendix D):

The workstream was tasked by the TB to 'develop a system action plan to take forward the 'big ticket' item relating to housing'. The Housing Project Group established with membership from health and both LAs, has engaged with Housing Strategy and Housing Needs and has identified the following areas of focus:

- Better use of Disabled Facilities Grant

Adaptations to the home play an important role in helping people maintain independence in their own homes or enable timely discharge from hospital. Local authorities receive Government grants to provide Disabled Facilities Grants (DFGs) which are provided to private sector, owner occupied and housing association households (adaptations to local authority homes are funded through the Housing Revenue Account) that have a disability to assist them to live independently and remain within their home. There is a mandatory requirement for authorities to provide funding to eligible households, traditionally the processes is reactive with a needs assessment and financial means testing completed following an application.

The government is increasing the amount given to Local Authorities for Disabled Facilities Grants significantly in the coming years. The expectation is that local authorities will be allowed greater flexibility in how the money is spent. The DFG monies are now contained within the Better Care Fund (BCF) and that health priorities are important in the way DFG is spent. Delayed transfers of care and readmission to hospital, which are key health priorities, could be supported using some of the DFG finance. Housing options advice and support with moving is another important issue that could potentially be funded.

The workstream plans to review the use of DFGs in Hackney and the City of London in order to identify improvements to the existing processes, increase take-up amongst eligible residents, proactive and planned use of DFGs and, where possible, increase the focus on preventative approaches. This will include an investigation of the role of the Home Improvement Agencies commissioned in Hackney and the City to support DFG applicants through the process as well as the role relevant local authority services.

- Stronger collaborative commissioning in partnership with Housing

Discussions with commissioners has confirmed a desire to improve the way in which health and housing services support each other and the potential for integrated commissioning to facilitate this. This could include joint processes to remove duplication and overlap, improved communication at the strategic and individual case level, rationalised approaches to brokerage, better market intelligence sharing and market building, and improved information sharing to inform needs analysis and future commissioning decisions.

The existing organisational arrangements mean that commissioners are often working in isolation and opportunities for collaboration are missed. Decisions which result in changes to existing provision are often made without considering the opportunity to use resources together. For example, to maintain schemes that support clients to continue to live independently rather than relying on higher cost supported housing accommodation. The fragmentation of approach and market intelligence can lead to partners commissioning the same provision at different cost.

Positive links made with Housing at LBH and workstream leads will be attending a joint

workshop regarding health and housing on 14/03/2018. There are unprecedented demands on housing locally and considerable numbers of vulnerable people are living in temporary accommodation. We are keen to explore with housing locally how we can think about more innovative and responsive ways to support people in temporary accommodation in particular.

2.2 Prevention

Plans for Outpatients will have an embedded approach to self-management and 'Make Every Contact Count' MECC. Outpatients Transformation will standardise an early intervention and prevention based approach to all care pathway developments and this has been included in the role descriptions for current clinical leads.

Cancer – our plans will link with the Prevention workstream to utilise MECC opportunities in the fast track referral pathway. Opportunities for services to support the health and well - being of cancer survivors as advised by cancer clinical lead and Macmillan in particular

Services for People with Learning Disabilities – we need to ensure the opportunities for service users to gain independence are maximised across all preventative, universal and mainstream services including employment opportunities. This should include an offer from the statutory partners especially regarding employment opportunities.

2.3 Co-production

- Patient/resident representatives are working well as part of the CLG and advising on plans for co-production within our agreed priorities.
- The Engagement Enabler Group is supporting us in producing an engagement plan for co-production within Outpatient Transformation.
- A reference group will be established for the further pooling proposals for CHC and ASC
- Service user engagement plans are in place for the service redesign of learning disability services
- Involving cancer survivors and residents in the importance of cancer screening

3. What support does your workstream need from other parts of the system in order to deliver the required transformation?

Outpatient Transformation	Alignment of resources within PC commissioning and clinical leads and relevant functions in Homerton. Additional project management capacity is required to implement the project and has been requested via IT enabler group (not agreed). Potential additional IT costs might be accepted though the need to agree funding to start this project remains urgent. See section on finances.
CHC and ACS further pooling budgets	This is a complex and wide ranging project which will be managed by the workstream and requires the cooperation and alignment of finance, commissioning and contract and brokerage staff within all the partner organisations to the workstream. A project board will be established to oversee all the project components and coordination and implementation requires additional managerial capacity for the workstream.
CHC delivery of National Quality Premium target for assessments in community setting	Successful implementation of this requires a contextual shift across providers in discharge to assess and placement without prejudice which is being driven by Unplanned Care and seems to have been slow to implement
Neighbourhoods and Intermediate Care	Plans developed by the Unplanned Care workstream need to refer to Planned Care especially regarding BCF metrics and any increase on commissioning budgets for residential / continuing care Neighbourhoods - can support delivery model for Outpatients

4. Financial planning

4.1 Outline your financial plans for 2018/19 including any QIPP and local authority savings and any further pooling plans.

The overall savings target for the workstream in 18/19 is £4,921m. Current savings plans have been developed within existing commissioning organisations and are explained in appendix E. Most of these schemes are rated green or amber as an indication of the likelihood of delivery. Any additional stretch would be challenging for the workstream to manage. This is particularly important in the context of creating the pooled budget, managing joint funding and increasing demand and the underlying deficit within the learning disability service.

The TB and ICB are asked to note that the QIPP plans for Advice and Guidance and Follow up Transformation are dependent on the agreement of short term additional resources to manage the project for Outpatient Transformation. This is also important as delivery of these schemes maintains the baseline agreed as part of the 18/19 Homerton contract refresh and must be implemented to reduce future financial risk to the CCG.

Further savings will be considered as pipeline plans for the workstream. Integration of mental health in acute medicine may provide opportunities for savings by a simplification of pathways and creation of a single system.

5. Managing risk

5.1 Outline the key workstream risks and the mitigation and management plans in place.

(See Appendices F and G :)

Key risks for the workstream are:

- CHC Quality premium (appendix H): this risk which will shortly be added to the workstream risk register. Delays in implementing Discharge to assess (D2A) and Placement without prejudice are impacting on our ability to deliver the CHC target of assessments being undertaken in the community. Currently most CHC assessments are still undertaken in a hospital setting. We have agreed with Unplanned Care to increase CHC nursing to focus on D2A for CHC patients and aim to see this impact on our performance before March 2018. This also needs to be supported by commissioner relationships with care homes and nursing homes to accept patients in advance of the full assessment.

- IAPT In October 2017 there were two data reporting issues neither of which affected the actual service received by patients. However it did affect how City and Hackney's performance was recorded by NHS Digital and NHSE. The impact of these changes shows in the Q3 2017-18 reported data, which shows City and Hackney as being red on two targets:
  Access rate - 44% against the target of 4.2%
  Recovery rate – 42.25 % against the target of 50%

- As these issues relate to data reporting and not the actual service delivery, it is anticipated that reported KPIs for recovery and access will be green in Q4. This is based on the fact that the service has been consistently achieving its targets. If the problems in recording data cannot be rectified by NHS Digital then there will be an impact on the annual access rate.

- Cancer (appendix I): IAF rating is likely to remain as 'greatest need of improvement'. Despite improved survival rates and proposals to improve Homerton performance it is anticipated that these actions will not impact in 18/19

6. Contracting and commissioning

6.1 What are your commissioning intentions for 18/19 and how have you/will you consult on these? If relevant, please include notice that will need to be served in terms of contractual arrangements?

We anticipate that there will be an increase to joint commissioning intentions for 18/19 arising from the priority projects agreed in the workstream. However, some specifics that can be identified over and above these priorities include:

- Teledermatology - the teledermatology pilot was completed successfully and we are now pursuing how a service can be implemented building on key lessons learnt which may require more resources allocated to provide neighbourhood hubs. We have a specification drafted and are about to start consultation regarding possible provider models. We aim to deliver the new model through service redesign though this may not be possible and we may need to consider procurement for the new service in September for 2019/20.

- Diabetes - we are about to begin a needs assessment and service review and expect this will lead to new commissioning intentions in September for 2019/20.

- Obesity – we are auditing services at dietetics and bariatrics at the Homerton with a view to new commissioning intentions in September for 2019/20.

- Prescribing – Access to Minor Ailments scheme following NHSE recommendations to decommission Pharmacy first. This may be an additional cost to the Prescribing Board if we agree to fund this. This may have additional impact on local residents due to the National consultation on reducing primary care prescriptions for minor ailments.

- Discharge to pharmacy – formalising communication of discharge information to community pharmacists which will improve the pharmaceutical care of patients and seamless transfer of care for vulnerable patients.

SH – 6 March 2018

Assurance Review Point 3, February 2018

This paper, along with appendices A, B and C presents the review point three submission for the unplanned care workstream.

1. *Describe the key plans and outcomes for 18/19 and your proposed improvement trajectories for these outcomes. How do these align with the wider ECHLP plans?*

Please also outline where and how you intend to use co-production.

One of the key successes of 2017/18 is that the unplanned care work-stream programme board have agreed the three main areas of transformation that will deliver our asks and our strategic aims. These are: **neighbourhoods, urgent care** and **discharge.** We have just started working with an OD consultant to help us clarify our strategic aims, and how we need to work together to achieve them. This could result in some changes to the ambitions described below.

The following provides further detail on the ambitions as they are currently defined, and the current position in relation to each of the transformation areas:

Neighbourhoods

What is the vision?
The neighbourhood will build on existing communities to create a geographical health community around GP practice populations of 30,000-50,000 residents. We will develop 8 neighbourhoods across City and Hackney. The neighbourhood will addresses the wider determinants of health, including psychological and social issues.

The neighbourhood model will organise our health and care services around the patient, rather than the hospital. This approach should lead to real and meaningful integration of health and social care. It builds on the concept of mutual patient support and peer learning to empower patients to better manage their health and their lives within the context of their conditions. This model can be used equally successfully for physical and psychologcial issues. Patients will be supported to use existing services in the form of informed navigation and a structure that makes sense to them and is accessible.

This is a major transformation which requires health and social care to work very differently and to be successful must utilises patient input and the voluntary sector in a major way.

Where are we now?
We have gained agreement from the City and Hackney Integrated Commissioning Board to progress neighbourhood development as a key strategic priority for all partners in the borough. We have also secured some non-recurrent funding to support the transformation required through implementation. We have set up the project structure to implement neighbourhoods and are working to the time-line that the first neighbourhood areas are ready to go live by summer 2018.

Further detail on the contracting arrangements for neighbourhoods is in section 6 of this template, 'contracting and commissioning'

What outcomes are expected?
We are still in the design phase of neighbourhoods so the outcome metrics are not yet fully defined or quantified, however, we would expect to see improvement on the following areas:

- Reduction in duplication of effort/resources/time
- Reducing emergency attendances and admissions through appropriate evidenced based interventions focusing in particular on clinical pathways
- Focus on safeguarding: reducing risk of patients "falling between teams" or red flags not being picked up
- Reduction in waiting and wasted time
- Improved patient reported measures
- Improvement in recruitment and retention figures across key staff groups
- Improvement in staff survey results

Urgent Care

What is the ambition?

This work aims to deliver an urgent care system in City and Hackney which best meets patients' urgent needs at all times and joins up the range of different services on offer, including services based at the Homerton such as A&E, the primary urgent care centre (PUCC) and the City and Hackney Urgent Health Social Enterprise (CHUHSE); GP practice out of hours hubs, ambulance services, the 111 telephone line, mental health crisis response and services such as Paradoc. The objective is to ensure that patients can access the right services, quickly, first time.

A key objective is to improve working between primary and secondary care, which includes reviewing how GP led services fit within the wider urgent care model, and also introducing a model of re-directing patients that present in ED that can be safely and appropriately managed in primary care back to their GPs with a booked appointment.

Where are we now?

Key developments in 2017/18 include implementation of two primary care out of hours hubs in the borough for evening appointments; a new ambulatory care service at the Homerton to provide an alternative to admission for certain pathways and a review of our PUCC service to ensure that it continues to deliver value for money.

There are a number of drivers that are external to City and Hackney within this area of transformation. Nationally, all systems must provide an Urgent Treatment Centre which meets a set of defined standards. This is also being driven through the ELHCP. The PUCC is now close to meeting these standards. In 2017/18 there was also a NEL wide 111 procurement; this goes live in August 2018. Through 2018/19 CHUHSE will continue to provide a stand-alone face to face service, but from 2019 onwards we will need to have put in place a new, sustainable model of urgent care that delivers our aim of integrating the current range of services. We are working to have designed the new models of care by August 2018, with implementation happening thereafter.

What outcomes are expected?

- Sustain 95% delivery of the 4 hour wait target
- Reduce % of LAS calls resulting in a conveyance to the acute trust
- Improve % A&E attendances diverted into PUCC
- First episode of psychosis has package of care within two weeks
- Reduce overall costs to the system from falls

Discharge

What is the ambition?

Delays to discharges can lead to adverse outcomes to patients who can lose mobility and

the ability to do everyday tasks, it is also important that patients that require any rehabilitation following their hospital stay can access it as quickly as possible. The workstream is pulling together health and social care services to improve how we discharge people from hospital by ensuring that they have the right services in place at the point of discharge, and that that they do not sit in acute or mental health trusts for longer than is medically required. Nationally, a High Impact Change Model has been published which provides a framework for supporting improved discharge. Delivery of this framework is a priority for the ELHCP and we are progressing implementation of this framework trough this workstream.

Where are we now?

In May 2017/18, disappointingly, there was an increase in the number of City and Hackney patients reported as delayed transfers of care (DToC) from both acute and mental health trusts. We have worked hard to address this through improved daily communication, commissioning additional continuing healthcare assessments and introducing a weekly director led escalation meeting. We have also implemented hospital and social care discharge services over seven days so that patients can access the same range of services at weekends. Positively, the number of DToCs has reduced steadily since this point, and we are close to achieving our initial trajectory set at the start of the year.

In December 2017 we gained agreement from the City and Hackney Integrated Commissioning Board to pilot a new model of care known as discharge to assess, where patients receive assessments for their ongoing health and social care needs post-discharge rather than from a hospital bed. We have now started to discharge patients on this pathway and will conduct a full evaluation over the 12 month pilot. We have started to scope the feasibility of commissioning bed-based intermediate care services in the borough, as currently we utilise beds at St Pancras Hospital in Camden. We will look to build a case for this by May 2018. More recently, we have started to work with our local City and Hackney care homes to review the primary care services available to those residents and to improve training to care home staff.

What outcomes are expected?

- Reduction of DToCs down to below BCF target level for NHS and social care
- Reduction in excess bed days
- Discharge to assess implemented for all eligible patients
- Increase proportion of people still at home 90 days after discharge into re-ablement services

Patient Involvement across the work-stream

We have spent time as a board considering how to best involve patients in our decision making and service re-design. Patients are represented at board level, and on each of the reference/steering groups directly below the board. We have also taken our plans to various patient groups including the Older Peoples' Reference Group, the CCG Patient and Public Involvement Forum, the CCG Patient User Experience Group and the Health in Hackney Overview and Scrutiny Committee. Given the breadth of transformation required to deliver the neighbourhood model we have convened a patient panel to help us to communicate what we are doing with patients and to hold us to account to involving patients as the work progresses.

Whilst patients are already represented on the formal board structures, the challenge that we will try to deliver on is ensuring that the right patients are involved in detailed service re-design processes. We will utilise our existing patient and clinical networks to try identify patients with the relevant experience to do this. Some of the activities that we have planned within each transformation area include:

Integrated urgent care:
- holding a workshop with a range of patient representatives to better understand what drives people's behavior when they are in crisis or have an urgent health or care need
- patient representatives to undertake surveys in ED to understand why people are attending

Neighbourhoods
- We are holding a mental health workshop which will include patients with experience of mental health services.
- Involve expert patients in the clinical pathway re-design stage

Discharge
- Getting detailed feedback from patients discharged on discharge to assess pathways to inform improvements as the mode of care is expanded

2. *Describe progress with the big ticket items and plans for transformation in these areas moving towards a more preventative/early intervention approach.*

The work-stream has 2 further big ticket items, End of life care and Dementia. Rather than treat these as stand-alone items, these areas are being delivered through the three transformation areas described above. The following provides further detail on each area:

End of life care:
Key areas of work which are being delivered through the three transformation objectives described above include improved care planning and pathways for patients at end of life within primary care (this falls within neighbourhoods); implementing a pilot 'hospice at home' service, which would provide an urgent response to patients in the last year of life where a traditional hospital admission may not be best for that patient (this links well to our integrated urgent care transformation); and improving training for nursing home staff on end of life care (this falls within discharge).

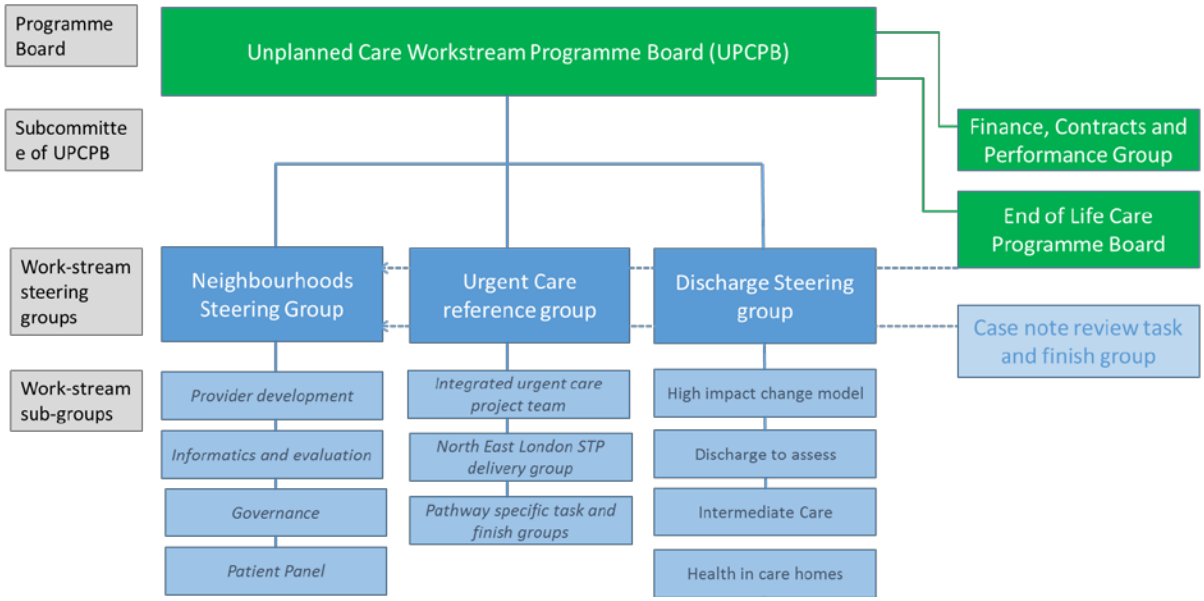
We will continue to hold a quarterly end of life care board which will feed into and oversee the delivery of end of life care objectives in each of the other three transformation areas.

Dementia
Further work is required by the workstream to develop a strategic vision for dementia**.** Care for patients with dementia is a core element of the discharge workstream, given that a high proportion of complex discharges are patients with dementia. The group is ensuring that the range of discharge and step-down services provide for patients with dementia and we are reviewing health care support to care homes for patients with dementia. The neighbourhoods programme will review MDT and care planning for patients with dementia, including exploring how specialist psychiatry services can better support primary care. The urgent care work-stream have identified a potential gap in urgent crisis response services for patients with dementia. We will work with the CCG mental health commissioning team and ELFT to address this.

Colleagues from East London Foundation Trust are well represented at the workstream programme board and in each of the three transformation sub-groups. We will also work with the City and Hackney mental health
co-ordinating committee who will provide an expert steer on issues relating to dementia.

2a: Governance to ensure delivery

The workstream has now established a clear governance structure to oversee delivery of the ambitions described above. This is shown in the following diagram:



We are heavily clinically led, with both senior managerial and clinical representation from the Homerton, East London Foundation Trust, City and Hackney GP Confederation and City and Hackney CCG. We have also recently recruited three clinical/practitioner leads across the workstream, one for each transformation area. These posts will be key to leading and engaging wider system partners in our transformation.

We have started working with an organizational development consultant to support the board to work most effectively to define and deliver their strategic goals.

We have defined a broad set of process and outcome indicators that will indicate how we are doing against both our transformation objectives and our more business as usual deliverables. These are being developed into a workstream scorecard report, a prototype of this is shown in appendix A

3. What support does your work-stream need from other parts of the system in order to deliver the required transformation?

Support is needed from the rest of the system on 3 main areas: Reporting, ICT, Workforce development and Technical Skills:

Reporting: In order to discharge the duties of the workstream it is absolutely vital that we have good management information. As a minimum, this means the we need the following:
-Monthly workstream level dashboard reporting from the CCG and LBH informatics teams to monitor how we are doing on operational and outcome metrics (the prototype dashboard in appendix A has been agreed but we will need this to be reported monthly to the board).
-Regular finance and activity reporting from the CCG integrated commissioning team. This is not yet in place.
Without these we cannot deliver our workstream objectives.

Integrated systems: The IT enabler group have overseen a programme of work to integrate patient records from a range of different systems into the Health Information Exchange (HIE). This will support all of our transformation objectives where we require different health and social care partners to work more closely together. We will also be submitting a further bid to the IT enabler group with more specific system requirements to deliver the neighbourhoods and integrated urgent care transformation areas.

Workforce development and support: The current work within CEPN to develop a practice based nursing pilot will influence the nursing model that we develop for neighborhoods.
We have also asked for support from the CEPN on the following areas:
-Development of a transformation board-wide approach to QI
-Support to develop training in health coaching for existing workforce
-Consideration for the challenge of recruiting GPs that support urgent care pathways (as a distinct skill set from practice based primary care)
As the neighbourhood and integrated urgent care workstreams develop we will be asking the CEPN to support role specific workforce development.

Technical expertise: We do not hold specific technical skills within the workstream team around communication, analytics and financial management. We will need input from these professional groups from partners across City and Hackney. In practice this means we will need the following:
-Support from LBH and CCG communications teams to support public and staff engagement for neighbourhoods
-Support from CCG and LBH informatics teams to develop the analytics to support neighbourhoods
-Support from the CCG and LBH finance teams to undertake financial modelling associated with any transformations or system savings initiatives.

Financial planning,
4. Outline your financial plans for 2018/19 including any QIPP and local authority savings and any further pooling plans.

In 2018/19 we have a total budget of £134.9m. and a target to deliver £1.6m of savings to the system (which may increase).

We have identified savings of £1.3m to date. In all cases the saving is a reduction in health commissioner expenditure (CCG spend) delivered through a reduction in demand for acute or mental health services that we expect to see from improvements to other health and social care services. The main areas of savings are as follows:

- Improvement of the falls pathway to reduce the number of avoidable falls. This is reflected in the Homerton contract.
- Introduction of a pro-active care service to improve how GPs care for frail, elderly patients on their registers which is being funded through primary care PMS monies. This should reduce non-elective admissions into hospital for this patient group. We will need to understand and manage any risks in relation to potential increasing demand on social care. This is not reflected in the Homerton contract.
- Providing Increasing Access to Psychological Therapies (IAPT) services to patients with long term conditions, there is evidence that providing psychological therapies to this patient cohort will improve symptom management and therefore reduce hospital attendances and admissions. This is reflected in the Homerton

contract.

- Ceasing expenditure on a winter escalation ward at HUH. This is a transactional QIPP so will be delivered.
- Introduction of a hospice at home service to care for patients with urgent health needs in their last year of life. This should avoid hospital admissions. This requires some investment to be approved by PIC, and so is not yet reflected in contracts.
- Reducing the use of out of area mental health placements. This is a transactional QIPP so will be delivered.
- Work with Barts Health and University College London Hospitals to understand why there has been a recent increase in non-elective admissions and ensuring that City and Hackney patients that go to these A&Es can access the same range of admission avoidance services. These are being negotiated with providers.

There are risks attached to delivery of some of these schemes, though these have been identified and are being actively managed.

In order to identify the remaining savings we are scoping the following areas which should deliver further savings:

- Reducing the number of patients experiencing delayed transfers of care in acute and mental health settings and therefore reducing spend on hospital bed days.
- Improving how we care for patients that attend A&E repeatedly by working with substance misuse and mental health services based in the Homerton A&E.

Appendix B shows a more detailed description of each area of saving with current progress against delivery.

The work-stream is committed to delivering a balanced budget. We do not currently have a regular finance report, which would be required to manage the budget on an ongoing basis. We are working with the integrated commissioning team to develop this, and we will need their support to produce this each month. Without this visibility we will not be able to discharge our duties in relation to financial management.

Managing risk

5. Outline the key workstream risks and the mitigation and management plans in place.

The programme risk register is in Appendix C

This is reviewed monthly at the unplanned care workstream programme board.

Contracting and commissioning

6. What are your commissioning intentions for 18/19 and how have you/will you consult on these? If relevant, please include notice that will need to be served in terms of contractual arrangements?

Our commissioning intentions are centred around the three main areas of transformation described above.
2018/19 is very much a stepping stone towards more ambitious contractual changes in 2019/20 and beyond. Therefore, whilst we have adjusted some 2018/19 contracts to better support delivery of our intended outcomes, in all cases the contract form is still a traditional commissioner to single provider agreement. In the longer term we will implement contract

models that support wider system accountability across a range of partners.

The following describes the contracting intentions around each of the three transformation areas:

Neighbourhoods:
In 2018/19 we will have agreed contracts with each of the main partners to deliver the design, planning and implementation phase of neighbourhoods. These contract values total £816k and are primarily for partners to release staff to support neighbourhood implementation and they include a specification with clear outputs and outcomes related to delivery of the programme. Initially, we expect neighbourhoods to be vehicles for service delivery, however, part of the design phase of neighbourhoods will be to agree what governance and contractual frameworks are required to support neighbourhood delivery. We are likely, in the first instance, to set up MOUs between providers as a written commitment to neighbourhood working and provision of neighbourhood services. In time, we see neighbourhoods as being vehicles for partnership contracts across a range of providers for delivery of local services.

Other Primary care
We are implementing a new Proactive care service within primary care. This is an expansion of the current frail home visiting service to include frail, but not house-bound patients. This requires creation of a register and delivery of two proactive visits for patients on the register. We expect this to reduce emergency admissions amongst this patient population. This will form part of the GP confederation contract from April 2018.

Urgent Care
In 2018/19 we have adjusted the PUCC contract to incorporate both PUCC and enhanced PUCC into one contract and to try to drive better value through the contract by introducing a cap and collar to penalise low activity levels and to incentivise higher activity levels (and therefore divert more patients from ED).
The current Homerton and CHUHSE contracts end at the end of March 2019, and by this stage we hope to be in position to put in place a new contract for integrated urgent care services at the front door, which link to the new 111 service, and best meet patients' urgent needs. We intend for this be an alliance agreement between a range of existing primary and secondary care partners.

Paradoc:
In 2018/19 we are adjusting the Paradoc contract to improve productivity from it. Using the same overall financial envelope we will deliver the following improvements:
-increased skill mix, by utilising paramedics working alongside GPs, instead of HCAs in order to further reduce the number of hospital conveyances.
-Expanded opening hours, moving from 1200 (mid-day) – 1200 (midnight) to 0800 – 1200 (midnight)
-Use of an IIT therapist at certain times of day to better integrate with other admission avoidance schemes and to reduce reliance on GPs within the service, given they are a scarce resource.

Discharge
The Integrated Independence Team contract has been expanded in order to deliver discharge to assess in 2018/19. This is on a pilot basis in order to gather evidence for this service. We will use the pilot to build a case for the service and then a new contracting model will be developed with clear outcomes around expedited discharge.
We are also building a case for an intermediate care unit in the borough. This case will be based upon admission avoidance and increased hospital discharges.

Prevention: Assurance Review Point Three

Assurance of 18/19 work plans and financial plans.

Review Date:	March 2018
Integrated Commissioning Steering Group:	2 March 2018
Transformation Board:	9 March 2018
Integrated Commissioning Board:	21 March 2018

Planning and delivery

1. Describe the key plans and outcomes for 18/19 and your proposed improvement trajectories for these outcomes. How do these align with the wider ELHCP plans?

Overview of plans
(Please see attached workstream 'highlights report' for further information)

Whole system transformation plans to address the main preventable risk factors for poor health and premature death:

- Obesity - this work is being led by the Hackney Obesity Strategic Partnership (OSP), with learning being shared with City of London. The OSP is focused on addressing all aspects of the local 'obesity system', including upstream approaches to creating health promoting environments and easier/cheaper access to healthy food, as well as targeted support for people at risk of obesity and related harms.
- (Also relevant is the multi-million pound Sport England Local Delivery Pilot funding that is coming into Hackney over the next 3 years - a placed-based approach focused on the Clapton Park and Kingsmead estates in the south east of the borough)
- Tobacco Control - Hackney Health and Wellbeing Board provides strategic oversight as the de facto Tobacco Control Alliance for the borough; in the City, oversight is provided via the Healthy Behaviours Steering Group. Local plans align with ELHCP plans for smoking cessation/tobacco control (which are being led by Jayne Taylor).
- Alcohol and substance misuse - this is led in Hackney by the Alcohol and Substance Misuse Oversight Group, which City representatives also attend. The Group coordinates activity related to the Alcohol Strategy, gives direction on substance misuse services, provides clarity on referral and care pathways, identifies areas for improvement, and identifies gaps and solutions.

Long-term conditions - early intervention/secondary prevention (governance is currently via the Long Term Conditions Programme Board and clinical sub-boards):

- NHS Health Check contract in both the City and in Hackney is performing well, both in historical terms and compared with other areas

- Long Term Conditions contract - this is moving towards an outcomes-based approach as part of the CCG's Primary Care at Scale contract
- Right Care - respiratory and stroke reviews complete and recommendations for new/enhanced services being taken forward via the system prioritisation process
- Collaborative work with Planned Care workstream on outpatients transformation (e.g. adult type 2 diabetes needs assessment)
- City and Hackney was a first wave site for National Diabetes Prevention Programme (along with Tower Hamlets, Newham and Waltham Forest) and is part of an ELHCP bid for roll-out of the programme across North East London.

Mental health: Governance of all mental health-related asks is via the Mental Health Coordinating committee. In addition there is a Steering Group to direct the Five-to-Thrive campaign, which is led by staff at the CCG but receives input from all partners. There is also a mental health action plan steering group to take-forward the LB Hackney commitments to be delivered as part of the Local Government Mental Health Challenge.

In 2018/19 the City and Hackney Wellbeing Network will enter into the first of two possible added years for its contract and so the process of re-commissioning this service will commence this year, as part of a fully co-produced exercise.

Vulnerable groups: The Prevention ask includes reference to a number of specific groups who are at increased risk of a range of multiple long-term conditions and poor mental wellbeing - including people who are recently bereaved, carers, people who are socially isolated and rough sleepers (see highlights report). These (and other vulnerable) groups will be considered in all plans to improve identification and early intervention.

Workplace health:

- Homerton, City of London Corporation, LB Hackney and City & Hackney CCG have all gained London Healthy Workplace Charter status, demonstrating their commitment to investing in staff health and wellbeing. This aligns with the ambitions set out in the ELHCP Prevention workstream plans for workplace health.
- Hackney staff health and wellbeing partnership (LB Hackney, Homerton, CCG) meets on a regular basis to share good practice and deliver joint activity where appropriate/relevant (e.g. LB Hackney staff health and wellbeing champions invited to attend NHS Healthy Ambassadors training) - plans to widen membership to City of London corporation.
- Highly successful Business Healthy network supports City employers in improving the health and wellbeing of their staff.

Sexual health:

- Plans to prevent STIs and improve the sexual health of local people being led by City and Hackney Sexual Health Forum (chaired by Homerton clinical lead).
- GUM service recommissioned in 2017/18 on basis of London integrated tariff

(releasing significant savings from previous trajectory).

- GP based sexual health service being developed in partnership with the GP Confederation to improve access in the community.

Key outcomes, current performance and trajectories (statutory/mandated functions)

	Latest performance	**2018/19 plans**
Uptake of NHS Health Check (PHOF 2.22V)	**LB Hackney** Outturn of 48.9% of eligible population receiving NHS Health Check (2013/14-2016/17) **City of London** Outturn of 44.2% These figures compare to a London average of 40.9%	City of London and LB Hackney contracts will continue to include incentives to maximise uptake and reduce variation in performance across GP practices
Sexual health - chlamydia detection rate age 16-24 (PHOF 3.02)	**LB Hackney** 4,428 per 100,000 pop **City of London** 1,843 per 100,000 pop These figures compare to a London average of 2,309 per 100,000 pop. *NB: Figures for the City are based on very small numbers.*	2017/18 and 2018/19 service re-commissioning supports continued high performance on these metrics
Alcohol and Substance Misuse	**LB Hackney** Successful treatment completions for alcohol (only) users are now above the national average and significantly higher than in previous years. Likewise successful treatment completions for opiate users are in top quartile performance. Specific figures cannot be share due to NDTMS	2018/19 service re-commissioning will support continued improvement on these metrics

	confidentiality. **City of London** 2016/17 outturn of 0% due to exceptionally low numbers	
People with a LTC feeling supported to manage their condition (NHSOF 2.1)	60% (July 2016) - slightly below England average of 63%	Various prevention initiatives to improve support for patients to self-care (see attached 'highlights report'). Other relevant services covered by Planned Care (e.g. rehabilitation programmes, embedded psychologists in diabetes and COPD community services, new IAPT offer for people with LTCs from 2018/19).
Diabetes IAF metrics	Triple target* - 37% achievement in 2015/16, compared to an England average of 39% Structured education - 11.5% newly diagnosed attending in 2014, compared to an England average of 7.5% **% patients in whom NICE recommended treatment targets are met for HbA1c, cholesterol, blood pressure*	Proposal is to continue to use contractual levers to increase performance on both of these metrics (LTC contract with the GP Confederation and diabetes community nursing contract with Homerton) Successfully applied (via ELHCP) for 2017/18 NHSE transformation funding to improve uptake of structured education. Underspend will be carried forward to continue with implementation of improvement plans in 2018/19.
The proportion of adults with a learning disability in paid employment (ASCOF 1E)	**LB Hackney** 2016/17 outturn of 4.2% against England average of 5.7% and London average of 7.2%	The LB Hackney target for 2017/18 is 5.5%. A new in-house service has been commissioned for LBH

	City of London 2016/17 outturn of 0% due to exceptionally low numbers.	via Hackney Works with targets that would bring Hackney in line with the London average
Proportion of working age adults (18-69) who are receiving secondary mental health services and who are on the Care Programme Approach at the end of the month who are recorded as being employed (ASCOF 1F)	**LB Hackney** 2016/17 outturn of 2% against England average of 7% and London average of 6% **City of London** 2016/17 outturn of 0% due to exceptionally low numbers.	A new in-house service has been commissioned for LBH via Hackney Works with targets that would bring Hackney in line with the London average

Supporting other workstreams to embed prevention principles in their plans

A number of opportunities have been identified for collaboration with other workstreams to improve the prevention focus of their plans. We will be working with other WDs to develop priority plans during 2018/19. Examples of areas identified during initial discussions are listed below.

CYPM	**Planned Care**	**Unplanned Care**
● Teenage pregnancy self-assessment (using PHE TP framework) ● Options appraisal of suitable service models for treatment of obesity in children and adults with complex needs (including family-based approaches)	● Outpatient transformation - self-management, MECC ● Cancer - prevention (e.g. MECC opportunities in 2ww pathway), services to support health and wellbeing of survivors ● Rehab and physical activity integrated pathways ● Access to preventative/ self-management support for people with LD	● Falls prevention pathway ● Neighbourhoods ● Link between End of Life Care and bereavement ● Alcohol and substance misuse frequent attenders

Commissioning approach

The Prevention workstream has an additional, generic ask to "review the current contract

portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, maximize quality and efficiency from services and improve value." This is being delivered as part of the strategic commissioning approach adopted by local statutory partners.

For example, at LB Hackney contract registers are managed as per standing orders with performance and spend monitored through quarterly review meetings with all providers. Where performance falls short of requirements before contract expiry this is addressed through intervention measures or termination as a last resort. However termination is rare and the majority of contracts are managed through to completion with a recommissioning exercise initiated well in advance to learn from experience, hear additional user experience, apply sector best practice, test the market for value and innovation, and deliver savings where required. Examples that illustrate this cycle in process are reflected in our response to Question 6 below..

2. Describe progress with the big ticket items and plans for transformation in these areas moving towards a more preventative/early intervention approach. Please also outline where and how you intend to use co-production.

(Please see attached workstream 'highlights report' for further information)

We have made good progress on our big ticket items over the past 11 months, but some are further developed than others.

- Supported employment - provider led programme network established and progressing four key projects (employer engagement, individual placement support accreditation, supported employment passport, communication).
- Making every contact count (MECC) - currently developing a business case (more detail below).
- Support for self-management/self-care - various services, projects and partnerships delivering on this agenda, but work to develop a coordinated whole system approach has not yet started; this is a cross-workstream priority.

We are working with our workstream resident reps and Healthwatch to determine where and how we can most usefully apply a co-production approach in progressing our 'big ticket items' and other transformation projects. Our resident reps are bringing a discussion paper on co-production to our next core leadership meeting on 6 March.

As an illustration of our commitment to work in a truly collaborative way to bring about system transformation, our approach to our MECC ask has been one of co-production from the start.

1. A MECC scoping workshop was held on 8 December 2017, attended by a very broad spectrum of partners (including GPs, Homerton, ELFT, VCS, adult social care,

workforce leads/CEPN, pharmacy, Hackney's community library service, representatives from other workstreams, public health, commissioners, HLP, etc.).

2. Workshop attendees (and other partners) were then invited to join a planning group to develop a business case to design and implement a MECC programme for City and Hackney - this group met for the first time on 21 February 2018, attended by over 20 partners.
3. The next step is to work with Healthwatch to consult with patients and the public to get their feedback and views about MECC. The planning group will then reconvene at the end of March to agree the outline business case, which will be taken forward by the Prevention workstream.
4. All planning group members have been invited to join a steering group to guide the implementation of the programme, subject to approval of the business case. Co-design will be a guiding principle of our local MECC programme.

Other activity which supports delivery of our 'big ticket' items are being led by the VCS through a collaborative partnership approach:

- the supported employment network is chaired by the Prevention workstream's VCS Associate Member
- a joint working group of VCS partners and Prevention workstream members, led by HCVS, is working to improve integration of various local services and programmes which support self-care - with a particular focus on reaching into harder to engage/socially isolated communities (currently this includes Social Prescribing, Health Coaches and Connect Hackney).

3. What support does your workstream need from other parts of the system in order to deliver the required transformation?

Making Every Contact Count (MECC)

Programme support is currently being provided by an officer in the Public Health team. A business case is being developed for a dedicated programme management resource to lead the design and implementation of this transformation programme during 2018/19. Support required from other parts of the system includes:

- transformation funding for year 1/2 programme management resource
- continued support of MECC 'champions' emerging from the workshop/planning group
- senior and visible leadership across partner organisations
- ongoing support from engagement enabler group to facilitate public and patient involvement in design/testing/implementation
- enabling support from CEPN/workforce enabler group to embed MECC training across provider organisations
- developmental input from ICT enabler group as part of programme team - to identify/develop ICT solutions to test to support effective MECC delivery

- funding to develop and test approaches to MECC training - e.g. CEPN, ICT enabler funding.

Personal resilience and self-care

There is a significant amount of activity under the scope of this 'big ticket' item, both within the Prevention workstream (e.g. Social Prescribing, Health Coaches, peer support, LTC contract extended consultations, care planning) and within the priorities and plans being led by other workstreams (e.g. Planned Care - outpatient transformation; Unplanned Care - Neighbourhoods; CYPM - ELHCP programme to improve self-management of asthma). Cross-workstream collaboration will be key to ensure that these various plans and programmes are progressed in an integrated way across the system. This requires a programme management approach and resources will need to be identified during early 2018/19 to support this.

Supported employment

Programme support is being provided by an officer in the Public Health team. Leadership comes from the provider sector and members of the wider Supported Employment Network, which includes local and regional statutory partners.

Projects within the network are developing their plans which are likely to require the following resources at a minimum.

- ICT advice and resources for the creation or extension of a 'work passport' to minimise assessment duplication for residents who make use of multiple services.
- Funds to complete a network-wide fidelity review for supported employment.
- Introduction of a scheme to educate and support local employers on creating posts, recruiting and retaining staff with learning disability and/or mental health needs.
- Communications and marketing materials.

Financial planning

4. Outline your financial plans for 2018/19 including any QIPP and local authority savings and any further pooling plans.

The 2018/19 QIPP and Local Authority savings target for the Prevention workstream is £1.02m. This comprises £51k QIPP savings (minimum) and £969k Local Authority savings from London Borough of Hackney. There are no specified savings requirements from City of London. These savings are within the context of a total workstream allocation of £39.9m.

It should be noted that the workstream allocations are not static and will change throughout the year. Any proposals for transfers between workstreams will need to

include associated savings that are planned for those portions of the budget. For example, a significant proportion of the workstream allocation for Prevention comes from the LB Hackney Public Health budget but we know that a number of services funded from that budget (with savings attached) will transfer to the Children, Young People and Maternity workstream. Therefore, when delivery of savings is monitored and accounted for during the year, these changes will need to be taken into account.

LB Hackney savings for 2018/19 totalling £969k are due to come from re-commissioning of existing services, much of which is already in process for being delivered.

QIPP savings will be delivered from the Time to Talk element of the Long-Term Conditions contract with GP Confed.

Further system savings to be confirmed.

Managing risk

5. Outline the key workstream risks and the mitigation and management plans in place.

The Prevention workstream risk register is attached separately.

System risk - Personal Health Budgets

An additional system risk that has been identified is progress on performance towards target on the number of people with a Personal Health Budget. The NHSE target (based on population size) is for 56 PHBs to be in place by the end of 2017/18 (Q3 performance was 33) and 114 by the end of 2018/19. The focus so far has been on CHC patients (adults and children), and there is also an offer (but no take up so far) for children with complex health needs on the Education Health and Care Plan pathway. The CSU manages the process for CHC patients.

Officers from Planned Care, CYPM, Mental Health and Prevention have meet on a number of occasions in the past few months to explore options for identifying additional PHB cohorts. We have also participated in the NHSE mentoring scheme and gathered intelligence from other 'high performing' CCGs to inform our local approach. However, as there is no allocated system resource to lead on PHBs, we have not been able to progress any further than this. There are no levers within Prevention in relation to any of the potential cohorts identified so far. This risk needs to be owned at a system level.

On behalf of the Prevention, Planned care and CYPM workstreams, we are therefore putting forward a cross-workstream proposal for a dedicated resource to (a) lead a detailed scoping exercise to agree our local ambitions for PHBs, and (b) provide support in designing a model for implementation. We are seeking advice from system leaders as to where this resource might come from.

Contracting and commissioning

6. What are your commissioning intentions for 18/19 and how have you/will you consult on these? If relevant, please include notice that will need to be served in terms of contractual arrangements?

We will continue to develop our commissioning plans during the early part of 2018/19. Any commissioning intentions that emerge will be consulted on with system partners, including providers and the public. The particular form that this consultation will take is yet to be determined, but will align with the emerging service redesign and clinical leadership framework that is currently in development, while also conforming with statutory organisation governance requirements. It is anticipated that a 6 month notice period will be required for all current contracts affected.

Long-term conditions - early intervention/secondary prevention

During 2018/19, further progress will be made on moving towards an outcomes-based Primary Care at Scale contract with the GP Confederation. At this stage, we anticipate that for the LTC element of the contract, a similar approach will be taken to negotiating targets as in previous years, via collaboration between the GP Confederation, commissioners, clinical lead and the Clinical Executive Group (to provide local intelligence to guide target setting).

The planned diabetes needs assessment may also throw up recommendations for the commissioning plans of both the Prevention and Planned Care workstreams, but these will not be known until September 2018.

LB Hackney alcohol and substance misuse service

The LB Hackney Cabinet Procurement Committee has agreed to issue a new contract for the Hackney Recovery Service for one-plus-one years to cover the period up until 30 September 2020. The contract will be award to the current provider on the basis set out in a report to the committee, available here.

We will start a full re-commissioning process in June 2018 in order for a new service to start in April 2020. The work will be led by a Strategist within the LBH Public Health team. This period has been set aside to provide stability for the service and service users and to allow sufficient time for full engagement and participation of partners across the integrated commissioning system to participate.

Regarding consultation, the intention is to work within the principles of co-production as far as possible, given that all service users will be clients of the incumbent provider.

It is likely that savings will need to be identified as part of this re-commissioning project.

City and Hackney Wellbeing Network

All funding for the City and Hackney Wellbeing Network is provided by LB Hackney. The contract for this service has two options for 12 month extensions from 31 March 2018.

A full re-commissioning project will be conducted in 2018/19 for this service. As well as operating within the principles of our co-production charter, this re-commissioning project will need to be carried out with support from the Mental Health Coordinating Committee. Options will also be explored for closer alignment with the Psychological Therapies Alliance and the Hackney Recovery Service (above).

It is likely that savings will need to be identified as part of this re-commissioning project.

Early Intervention and Ongoing Support services for adults in the City

Work has commenced to review current service provision that offers early intervention and ongoing support (including assistive technology and equipment) to adults in their homes and in the wider community. These services also contribute to reduced hospital admissions and timely hospital discharge.

A number of these services are delivered by provider organisations, working alongside the Corporation's internal services such as Reablement and Tenancy Support. Many of the externally provided services have historically been procured in isolation, without a wider regard to a 'service system' approach. Furthermore, many of the contracts for these services expire within the next 12 months.

The proposed approach is to undertake a full commissioning review of Early Intervention and Ongoing Support services for adults with a view to an outcome-based procurement process in 2018 and new service provision from April 2019.

This work is being led by commissioning in the Corporation, with input from *all Workstream directors* and liaison with LB Hackney where a complementary offer appears viable.

It is anticipated that savings will be identified as part of this re-commissioning project.

Physical activity re-commissioning for adults and children in Hackney

As part of the Public Health re-commissioning pipeline, work has already begun to review physical activity services across the borough. The review includes services for both adults and children, with a view to improving access to evidence-based family approaches and meeting gaps in existing provision. Re-commissioning of these services will be completed during 2018/19, and will involve full collaboration with the CYPM workstream.

This re-commissioning exercise is being informed by a mapping of all related service provision across the council (including that provided/commissioned by the Leisure team and Young Hackney). Service recommissioning plans are being developed with these wider partners, to make the most of opportunities to align with current provision and ensure that a targeted approach is taken to support the least active people (where the marginal health gains are greatest). Pathways into community provision to support sustainable behaviour change will be a key focus of the new service(s).

It is anticipated that savings will be identified as part of this re-commissioning project.

Other plans TBC

Two further areas where new commissioning intentions relevant to Homerton contracts are likely to emerge during 2018/19 are as follows:

- treatment of tobacco dependency embedded within specialist care pathways - this is in line with the London Clinical Senate's *Helping smokers quit* recommendations, as endorsed by the ICBs in May 2017
- recommendations emerging from the adult complex obesity audit, and proposed options appraisal for adult and children's complex obesity services (see response to Question 1).

Ask of the Children, Young People and Maternity work stream

The Children Young People and Maternity (CYPM) Care Work stream is asked to establish an accountable care system for the delivery of Children's, Young People and Maternity services for the people of Hackney and the City within the overall strategic framework. The CYPM Care work stream will need to work closely with the other three care work streams in order to ensure a system-wide approach is taken across the work streams:

- Oversee the Children, Young People and Maternity care delivery system
- Ensure a health and social care system wide approach to the delivery of initiatives
- Establish a robust governance arrangement to support collective delivery and engage with processes for scrutiny of finance and performance information
- Manage service delivery within the defined CYPM budgets
    - Redirect funding within the work stream that either improves service delivery or reduces cost (or both)
    - Develop service delivery proposals across work streams that reduce overall system costs
    - Ensure most effective use of existing resources including CCG and local authority staff including support teams, clinical input and existing clinical leads to support the work programme of the work stream
- Make suggestions to the statutory commissioners on changes to current contractual arrangements which would improve service delivery and secure performance and value for money
- Ensure the achievement of all performance standards and key performance indicators (KPIs) within existing contracts
- Deliver improvements in outcomes (both nationally mandated outcomes and additional locally relevant outcomes)
- Engage in organizational development offer to develop system leadership
- Ensure that prevention and early help principles are applied across the work of the CYPM work stream and support from the Prevention work stream and early help partners is sought out to enable this

This will involve:

Furthering integration across health and social care provision in the City and Hackney

- Establish a strong collective delivery arrangement across the providers which fully integrates service provision, including mental health (Emotional health and wellbeing and Child and Adolescent Mental Health Services), and minimises duplication and overlap
- Ensure that the delivery arrangement works for both the Hackney Children's health and social care system and City of London health and social care system
- Ensure that the children's health and social care system achieves high quality, patient led services which also secure best practice, reduce unwarranted variations and demonstrates value for money
- Demonstrate the local contribution to the delivery of the North East London STP plans and delivery of the NHS Five Year Forward View (FYFV)

Objectives for 2018/19 (these include essential requirements from the local commissioning organisations but are not an exhaustive list and workstreams can do whatever additional work required to achieve the above system change):

- The current NHS and Social Care metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories, with particular focus on:
    - Improved health outcomes for Looked After Children, as a result of bedding in new arrangements
    - Changes in flows of Children and Young people through CAMHs
    - Increases in satisfaction by users of SEND services, and improvements in timeliness and quality of care planning for this group
    - Continuing to improve health outcomes for children with long term conditions (Indicators TBA)
    - Improvements in maternity care (as reported in satisfaction surveys and local and national indicators), reductions in smoking at delivery and reductions in maternal re-admissions

- Improvements in health outcomes for children in early years, including more integrated health checks delivered, less A&E admissions for under 5's and increased levels of immunisation

- Agree system action plans to take forward the local 'big ticket items' linked to this workstream:
  - Improvement of children and young people's emotional wellbeing and mental health
  - Improvements in health outcomes for vulnerable groups
  - Improved performance across the system as relates to maternity and early years

- Strengthen and target the way we improve health outcomes and reduce health inequalities for our more vulnerable children and young people through:
  - Improving the offer and subsequently the health outcomes of City and Hackney Looked After children. We will:
    - Re-design and re-commission the Health of LAC service, continuing with an integrated partnership model
    - Further integrate LAC pathways with health pathways, particularly for those CYP with complex health needs, mental health needs and challenging behavior needs
  - 'Make every contact count' for children and young people, through delivery of the vulnerable children's primary care contract which will identify children more effectively in primary care, work closely with our new area model for health visiting and school nursing and review the take up of support for children identifying as young carers. This may link with our work to explore piloting delivery of children's community health services through the new 'neighbourhoods' model, and will build on the 'MECC' work developing through the Prevention workstream.

- Manage the CYPM care budget and agree remedial action to be implemented to bring the budget back into balance should PbR spend increase

- Deliver QIPP savings of a minimum of £586K

- Review the current contract portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, reduce avoidable unplanned care spend, maximize quality and efficiency from services and improve value

- Ensure delivery of the Child and Adolescent Mental Health Services Transformation Plans, as agreed by NHS England including delivery of transformation of the full range of service, working toward an more integrated system and delivering improvement models for:
  - strengthening prevention in schools

- the offer at transition (from young people to adult services)
- support for parenting
- ensuring young people get access to support quickly and where it is needed

- Delivery of the CAMHS CQUIN

- Building on the ‘strengthening prevention’ work as part of the CAMHS Transformation Plans (above), ensure development of a clear prevention offer for children and young people where they are at, including community settings and alternative provision.

- Conduct analysis of increasing presentations of self-harm and suicide in children and young people, leading to the development of an improvement and delivery plan

- Build on existing wellbeing network/’5 to Thrive’ work to improve Mental Wellbeing
- Develop improvement plans for management of children and young people with SEND. To be aligned to recommendations arising out of the Ofsted / CQC SEND inspection (November 2017), and including:
    - Ensuring clear and effective pathways for SEND children, and improving these specifically for under 5’s
    - Developing and implementing a clear offer of support at key transition points between services
    - Developing a robust mechanism for ensuring our universal Children and Young People’s health services are key partners in the development of EHCPs, in line with recent Ofsted / CQC recommendations
    - Responding to the recommendations of the Children’s Disability Needs Assessment, improving how we record and share information about local needs, health service activity and compliance with statutory timeframes for Education Health and Care Plans (EHCPs)
    - Quality assessing EHCPs and support plans for children with SEND to determine whether health needs are appropriately identified in plans
    - Working to support the reduction in exclusions for our SEND children, linked to our ask around ensuring there is a clear prevention offer around emotional health and wellbeing, and appropriate support through CAMHS

- Continuing our joint work with the Orthodox Jewish community regarding equity of service provision for children in independent schools

- Develop work to improve the identification and management of children with long term conditions, including:
    - Localised delivery of the STP integrated asthma provision
    - Delivery of the Primary Care Vulnerable Children's contract (as above), and continued delivery of support in primary care to children and young people with asthma, diabetes, epilepsy and sickle cell
    - Strengthen transition between children and adult's services, and continue to improve the quality of personalized care planning to encourage self-management with less need for emergency care

- Scope the potential for development of a joint pathway across the system to increase preventative support, for those at risk of Child Sexual Exploitation, and provide efficient and effective physical and emotional support and treatment where appropriate for those at risk of and experiencing Harmful Sexual Behaviours and Child Sexual Abuse, in line with the STP. This includes:
    - Working with the NEL STP to deliver an appropriate NEL CSA Hub, incorporating principles behind the 'Child House' model

- Work with the Young Black Men's work programme in order to reduce disparities in health outcomes for this group. This will involve:
    - Exploring the use of technology as a medium for communicating health messages and increasing access to services
    - Working with HCVS to support further work on early years and early intervention
    - Explore the impacts of poor mental health and emotional health and wellbeing and the links to exclusions

- Work across the system in order to improve the offer of care at maternity in City and Hackney, in line with commitments in our Sustainability and Transformation Partnership (STP), and reduce the rate of infant deaths and stillbirths in line with national expectations (20% by 2020). In order to achieve this we will:
    - Manage the HUFT maternity contract to improve performance, and provide assurance that care is safe, effective and responsive
    - Continue to work to increase the number of pregnant women making their initial booking 'early'
    - Develop a shared local plan in line with 'Better Births' (the 5YF national maternity review) to support personalized, continuous and choice of care, improved postnatal care and perinatal mental health support, and easier access to services

- Review data and recent audit around maternal re-admissions (including guideline introduction on post-natal care), and support implementation of recommendations and a follow up audit / evaluation
- Work closely with the Prevention workstream on reducing rates of smoking in pregnancy, through embedding the HUFT maternal smoking pathway, and looking at developing a UCL maternal smoking pathway for CoL and Hackney residents. We want to further reduce the rate of women who are known smokers at time of delivery.
- Maximise the impact of delivery of the GP Contract elements on pre-conception care, linked to better outcomes in maternity, and to the development of a clear maternal pre-conception and pregnancy healthy weight pathway.
- Improve rates of antenatal flu and pertussis vaccine

- Work across the system in order to improve the offer of care at Early Years in City and Hackney, specifically:

  - Support work on reducing childhood obesity (linked to priorities of the Prevention workstream), through development of a pre-conception and maternal obesity pathway
  - Improve rates of childhood immunisations at 1 and 2 years, working toward achieving 'herd immunity' for these indicators. We will explore options for devolved commissioning in order to support this, alongside locally resourced interventions, such as additional nurse funding in primary care.
  - Explore options for developing a 'supporting parents' pathway, linked to substance misuse and additional vulnerabilities, and also aiming to reduce 'adverse childhood events'
  - Scope an effective intervention in order to reduce rates of A&E admissions in children under 5, linked to work through the Unplanned Care workstream
  - Continue to push closer working between our community health services, primary care and education professionals, maximizing our leverage through the Health Visiting and Family Nurse Partnership services

- Work with partners to support relevant actions within City of London Health and Wellbeing Strategy for children, young people and their families

Ask of the Planned Care workstream

The Planned Care Workstream is asked to establish an accountable care system approach to planned care for the people of Hackney and the City within the overall strategic framework. The Planned Care workstream will need to work closely with the other three care workstreams in order to ensure a system-wide approach is taken across the workstreams:

- Establish a robust governance arrangement to support collective delivery and engage with processes for scrutiny of finance and performance information
- Manage service delivery within the planned care budget:
    - Redirect funding within the workstream that either improves service delivery or reduces cost (or both)
    - Develop service delivery proposals across workstreams that reduce overall system costs
    - Ensure most effective use of existing resources including CCG and local authority staff including support teams, clinical input and existing clinical leads to support the work programme of the workstream
- Ensure a health and social care system wide approach to the delivery of initiatives
- Make suggestions to the statutory commissioners on changes to current contractual arrangements which would improve service delivery and secure performance and value for money
- Ensure the achievement of all performance standards and key performance indicators (KPIs) with existing contracts
- Deliver improvements in outcomes (both nationally mandated outcomes and additional locally relevant outcomes)
- Engage in organisational development offer to develop system leadership
- Ensure that prevention principles are applied across the work of the Planned Care workstream and support from the Prevention workstream is sought out to enable this

This will involve:

Furthering integration across health and social care provision in the City and Hackney

- Establish a strong collective delivery arrangement across the providers which fully integrates service provision, including mental health, and minimises duplication and overlap
- Ensure that the delivery arrangement works for both the Hackney health and social care system and City of London health and social care system
- Ensure that the health and social care system achieves high quality, patient led services which also secure best practice, reduce unwarranted variations and demonstrates value for money
- Demonstrate the local contribution to the delivery of the North East London STP plans and delivery of the NHS Five Year Forward View

Most efficient use of resources across the system

Objectives for 2018/19 (these include essential requirements from the local commissioning organisations but are not an exhaustive list and workstreams can do whatever additional work required to achieve the above system change):

- The current NHS, Social Care and Public Health metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories for 2018/19 onwards. In particular system will be expected to:
    - Maintain or improve admissions to residential and nursing care homes
    - Maintain or improve user satisfaction with social care services
    - Model and agree improvement trajectories for mandated NHS and Social Care outcomes along with agreement on any additional decided local population health outcomes and trajectories attached for 2018/19 onwards
- Review the current contract portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, reduce avoidable unplanned care spend, maximize quality and efficiency from services and improve value

- Manage the planned care budget and agree remedial action to be implemented to bring the budget back into balance should PbR spend increase
- Deliver QIPP savings of a minimum of £2.68M
- Implement the Cancer Plan improvements, with a focus on achievement of:
    - Waiting times standards, particularly improving 62 day standard at the Homerton
    - Earlier diagnosis (including delivery of the Quality Premium target for early diagnosis)
    - Improved survival from cancer
    - Improvements in outcomes for cancer survivors (survivorship)
- Develop a plan for future management of medicines management support and delivery of medicines management/optimization plans and associated QIPP
- Develop a new cost effective operating model for Continuing Healthcare which delivers 17/18 QIPP and achieves national plan to deliver 85% of CHC assessments in the community (in line with national guidance in relation to Fast Track Continuing HealthCare and as per Quality Premium target)
- Deliver national CQUIN measures and targets on:
    - Antibiotic prescribing (in addition to Quality Premium targets on antibiotic prescribing)
    - Advice and guidance services to GPs
    - Improving assessment of wounds
- Plan and deliver the Outpatients Transformation programme, including
    - Review all current outpatient pathways and ensure that mental health is on each pathway
    - Reducing outpatient follow ups (including actively managing medically unexplained symptoms)
    - Use of technology
    - Increase in e-referrals

    - Self care

- Initiate a programme to increase use of diagnostics to support primary care based management and reduce duplication of unnecessary diagnostics
- Deliver mandated targets on IAPT (access, recovery, 6wk and 18wk waiting times, Quality Premium target on improving recovery for BAME groups and access for over 65s), QIPP targets and deliver maintenance of waiting list backlog at zero and first appointment to second appointment waiting times, along with initiatives on employment advisor workstream with DWP, IAPT provision for pts with LTC, new service for mild to moderate perinatal patients, interface with psychosexual Health Service, e-CBT
- Improve the Community Health Services (including children's and maternity services) offer to City resident/registered populations (referral routes/pathways appropriate and accessible for CoL population, including working with Unplanned Care workstream on integration of different services e.g. CHS and Integrated Independence team and Paradoc)
- The workstream will need to develop a system action plan to take forward the 'big ticket' item relating to housing
- Review current initiatives and recommend changes needed to secure a system wide approach to improving the management of long term conditions (LTCs; CVD/AF, Diabetes, COPD/asthma, hypertension, renal) including potential to apply the renal model to other LTC (shared priority with Prevention)
- Deliver the Right Care programmes to support improvement in outcomes and value in Circulation (CVD) and Respiratory focus areas (shared priority with Prevention)
- Support STP plans around improving elective surgical outcomes and North East London model
- Develop a plan to address clinical practice variation across primary and secondary care
- Review the support offer to local care and nursing homes (working with the Unplanned Care workstream)
- Build on existing wellbeing network/'5 to Thrive' work to improve Mental Wellbeing
- Improve care for those Learning Disabilities (improved screening uptake including cancer screening, increase employment and training opportunities, improve mental wellbeing, increase uptake of annual health reviews and health action plans, plan to address any areas of poor performance/gaps identified in latest SAF, deliver Transforming Care Partnership's local objectives to better support local people with challenging behaviour, input to strategic review of the current integrated Learning Disabilities service)

Ask of the Unplanned Care workstream

The Unplanned Care Workstream is asked to establish an accountable care system for the delivery of unplanned care services for the people of Hackney and the City within the overall strategic framework. The Unplanned Care workstream will need to work closely with the other three care workstreams in order to ensure a system-wide approach is taken across the workstreams:

- Oversee the unplanned care delivery system
- Ensure a health and social care system wide approach to the delivery of initiatives
- Establish a robust governance arrangement to support collective delivery and engage with processes for scrutiny of finance and performance information
- Manage service delivery within the unplanned care budget
    - Redirect funding within the workstream that either improves service delivery or reduces cost (or both)
    - Develop service delivery proposals across workstreams that reduce overall system costs
    - Ensure most effective use of existing resources including CCG and local authority staff including support teams, clinical input and existing clinical leads to support the work programme of the workstream
- Make suggestions to the statutory commissioners on changes to current contractual arrangements which would improve service delivery and secure performance and value for money
- Ensure the achievement of all performance standards and key performance indicators (KPIs) within existing contracts
- Deliver improvements in outcomes (both nationally mandated outcomes and additional locally relevant outcomes)
- Engage in organisational development offer to develop system leadership
- Ensure that prevention principles are applied across the work of the Unplanned Care workstream and support from the Prevention workstream is sought out to enable this

This will involve:

Furthering integration across health and social care provision in the City and Hackney

- Establish a strong collective delivery arrangement across the providers which fully integrates service provision, including mental health, and minimises duplication and overlap
- Ensure that the delivery arrangement works for both the Hackney health and social care system and City of London health and social care system
- Ensure that the health and social care system achieves high quality, patient led services which also secure best practice, reduce unwarranted variations and demonstrates value for money
- Demonstrate the local contribution to the delivery of the North East London STP plans and delivery of the NHS Five Year Forward View (FYFV)

Objectives for 2018/19 (these include essential requirements from the local commissioning organisations but are not an exhaustive list and workstreams can do whatever additional work required to achieve the above system change):

- Manage the unplanned care budget and agree remedial action to be implemented to bring the budget back into balance should PbR spend increase
- Deliver a minimum of £1.68M QIPP savings
- Review the current contract portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, reduce avoidable unplanned care spend, maximize quality and efficiency from services and improve value
- The current NHS and Social Care metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories. In particular the system will be expected to:
    - Maintain or reduce the emergency admission rate for the 19-59 year old group (ensuring activity levels stay within activity trajectory for total non-elective admissions submitted to NHS England)
    - Reduce levels of Delayed Transfers of Care

    - Maintain or reduce in the A&E attendance rate and in particular “minor” cases presenting to A&E (ensuring activity levels stay within trajectory for total A&E attendances submitted to NHS England)
    - Achieve the Better Care Fund metric targets
    - Model and agree improvement trajectories for mandated NHS and Social Care outcomes along with agreement on any additional decided local population health outcomes and trajectories attached for 2018/19 onwards

- Agree system action plans to take forward the local ‘big ticket items’ linked to this workstream:
    - End of life care (including improving access and provision of individualised care, quality and coordination of care, improvement in management of symptoms/pain, reducing unnecessary hospital admissions, increasing the number of people who die in their preferred place and support to care homes and care workers)
    - Dementia (continue to delivery diagnosis standards and robust care planning support)

- Plan and implement a local model for management and delivery of care via Neighbourhoods, based on 30-50,000 population localities, within existing financial envelope (and expecting efficiencies from these new ways of working)

- Plan and implement improved discharge from hospital model, delivering national FYFV expectations

- Ensure compliance with East London Health and Care Partnership Urgent and Emergency Care plan
    - Implementation of high impact changes
    - Achievement of 4hr target as per ELHCP trajectory
    - Implementation of other services/targets outlined in UEC plan

- Develop a proposition for the local face to face/home visiting service to complement the 111 clinical assessment service and local primary care, consult on this and prepare for mobilization once agreed by the Integrated Commissioning Boards

- Implement the local ambulatory care model to achieve an increase in ambulatory care admissions with a corresponding reduction in emergency/non-elective admissions, reduction in length of stay and develop an integrated delivery model with primary and community services

- Develop the systems to identify and support frequent systems users: focusing on unrecognised and unmet mental health needs

- Develop plans to improve management of Mental Health patients:
    - Management of mental health beds (management of mental health needs to include appropriate levels of bed occupancy and efficient use of inpatient beds and support the review of Continuing Care beds)
    - Review the plans to ensure adequate Mental Health care in A&E (ensure that liaison services are ‘core 24’ compliant and delivery of national CQUIN)
    - Deliver local measures and targets for CQUIN for ELFT on reducing use of Mental Health Act for BAME communities
    - Work with ELFT on having 24/7 community-based mental health crisis response
    - Ensure continued achievement of psychosis waiting times target
    - Elimination of out of area placements
- Build on existing wellbeing network/’5 to Thrive’ work to improve Mental Wellbeing
- Develop and deliver a series of proposals that maximise the use of primary care to reduce any unnecessary A&E attendances, including strengthening the duty doctor model and ensuring consistent delivery.
- Deliver national CQUIN measures and targets on:
    - Proactive discharge
    - Sepsis screening
    - Improving services for people with mental health needs who present to A&E
- Implement the RightCare programme relating to Falls, to reduce admissions from falls in the over 65s
- Work with partners to support relevant actions within City of London Health and Wellbeing Strategy (on mental health and effective health and social care integration)

Ask of the Prevention workstream

The Prevention Workstream is asked to establish an accountable care system approach to prevention for the people of Hackney and the City within the overall strategic framework. The Prevention workstream will need to work closely with the other three care workstreams in order to ensure a system-wide approach to prevention and early intervention is taken across the workstreams:

- Establish a robust governance arrangement to support collective delivery and engage with processes for scrutiny of finance and performance information
- Ensure a system wide approach to the delivery of prevention initiatives
- Provide support (as needed and agreed) to the other three workstreams to help embed prevention principles in their plans
- Manage service delivery within the prevention budget
    - Redirect funding within the workstream that either improves service delivery or reduces cost (or both)
    - Develop service delivery proposals across workstreams that reduce overall system costs
    - Ensure most effective use of existing resources including CCG and local authority staff including support teams, clinical input and existing clinical leads to support the work programme of the workstream
- Make suggestions to the statutory commissioners on changes to current contractual arrangements which would improve service delivery and secure performance and value for money
- Ensure the achievement of all performance standards and key performance indicators (KPIs) within existing contracts
- Deliver improvements in outcomes (both nationally mandated outcomes and additional locally relevant outcomes)
- Engage in organisational development offer to develop system leadership

This will involve:

Furthering integration across health and care service provision in the City and Hackney

- Establish a strong collective delivery arrangement across the providers which fully integrates service provision, including mental health, and minimises duplication and overlap
- Ensure that the delivery arrangement works for both the Hackney health and care system and City of London health and care system
- Ensure that the health and care system achieves high quality, resident led services which also secure best practice, reduce unwarranted variations and demonstrates value for money
- Demonstrate the local contribution to the delivery of the East London Health and Care Partnership (North East London STP) plans and delivery of the NHS Five Year Forward View

Working with wider services across the two local authorities and beyond to influence the social and economic determinants of health and wellbeing (including housing, planning, transport, regulatory services, employment, education, etc)

- Advocating for health and wellbeing to influence relevant local policies and plans
- Working in partnership with relevant service leads on joint projects of relevance to the health and wellbeing of local residents and workers

Objectives for 2018/19 (these include essential requirements from the local commissioning organisations but are not an exhaustive list and workstreams can do whatever additional work is required to achieve the above system change):

- The current NHS, Social Care and Public Health metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories. In particular the system will be expected to:
    - Model and agree improvement trajectories for mandated NHS, Social Care and Public Health outcomes along with agreement on any additional decided local population health outcomes and trajectories attached for 2018/19 onwards:

- Review the current contract portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, maximize quality and efficiency from services and improve value
- Deliver a minimum of £51K QIPP savings
- Develop system wide plans to reduce smoking prevalence and inequalities in smoking prevalence across the local population (and worker populations), including
    - Delivery of Quality Premium target on smoking quitters
    - Ensure progress towards making Homerton and ELFT smoke free
- Develop system wide plans to reduce obesity in the local population
- In addition to the above, review current services and develop integrated plans to drive primary and secondary prevention (including risk factor management and early detection) of long term conditions in the local population
- Review current initiatives and recommend changes needed to secure a system wide approach to improving the management of long term conditions (LTCs; CVD/AF, Diabetes, COPD/asthma, hypertension, renal) including potential to apply the renal model to other LTC (shared priority with Planned Care)
- Deliver the Right Care programmes to support improvement in outcomes and value in Circulation (CVD) and Respiratory focus areas (shared priority with Planned Care)
- Ensure an integrated approach to national plans to increase NHS Health Checks
- The workstream will need to develop a plan to take forward the ‘big ticket’ items relating to:
    - Employment (working with the Central London Forward Work and Health Programme) and specifically improving employment rates for those with Learning Disabilities and Mental Health problems
    - Self-care, including access to advice and social prescribing: develop plans to increase self-management, access to self-care/advice and link social prescribing to other community based prevention initiatives to support primary prevention initiatives and those with LTC to manage their own health care and wellbeing
    - Making every contact count

- Work with Planned Care workstream to make recommendations about how improve uptake of all screening programmes and adult immunisations
- Develop system wide plans for health and social care organisations to work in a more integrated way to identify and support carers
- Build on existing wellbeing network/'5 to Thrive' work and suicide prevention plans to improve Mental Wellbeing and reduce rates of suicide
- Review available capacity and service model for bereavement support services most appropriate to meet need of local population
- Work across organisations, including voluntary sector, to reduce social isolation and the impact of this on health and wellbeing
- Improve the accommodation pathway/care provided to rough sleepers
- Agree, and develop recommendations to implement, the local strategy for a whole systems approach to tackle alcohol-related harm.
- Ensure the substance misuse shared care model with primary care continues to deliver positive outcomes, and improve the support available for young drug and alcohol users to quit by strengthening links with the criminal justice system and mental health services.
- Implement required improvements to the support available to substance misusers with complex needs, informed by the results of an evaluation of the Multiple Needs Service.
- Develop and implement system wide plans to reduce STI prevalence and improve the sexual health of the local population, including in high risk groups
- Implementation of new sexual health service models (including GUM integrated tariff, London STI testing e-service)
- Work with providers to ensure that plans are implemented to secure delivery of national CQUIN measures and targets on:
    - Screening, brief advice and referral for people who smoke and/or have high alcohol consumption (in ELFT and Homerton)
    - Personalised care and support planning
    - Staff flu immunisations
- Support the local delivery of STP ambitions relating to workplace health (London Healthy Workplace Charter accreditation; alongside delivering national CQUIN on staff health and wellbeing – for both ELFT and Homerton), smoking and diabetes

Title:	Proposal for the award of a single outcomes-based contract for clinical Locally Enhanced Services service to the GP Confederation
Date:	Wednesday 21st March 2018
Lead Officer:	David Maher, Acting Managing Director, City & Hackney CCG
Author:	Lee Walker, Senior Contracts Manager, City & Hackney CCG
Committee(s):	CCG Clinical Executive Committee – for review and endorsement – 13 December 2017 CCG Finance & Performance Committee - for review endorsement - 19 December 2017 CCG Audit Committee – for review and to make recommendation on audit and performance reporting requirements – 11 January 2018 Local GP Provider Contracts Committee – for review – 26 January 2018 Transformation Board - for review and comment - 9 February 2018 Local GP Provider Contracts Committee – for approval – 23 February 2018 Informal Workstream Directors Group – for review – 8 March 2018 Integrated Commissioning Board - for review and to endorse – 21 March 2018 CCG Governing Body - for approval - 23 March 2018
Public / Non-public	Public

Executive Summary:

The CCG process for awarding contracts to primary care providers is that the contract award decision is made at the Local GP Provider Contracts Committee (LGPPCC) by CCG Lay Members, the Board Nurse and the Board Consultant. No GPs or GP Board members are present at those meetings to remove conflicts of interest. The decision is then passed from the LGPPCC to the Governing Body as a contract award recommendation for approval.

This paper summarises the contract award recommendation that was made by LGPPCC on 26th February to award a single 7 year contract to the GP Confederation for all of the clinical services currently commissioned by the CCG. It asks the Integrated Care Board to review and endorse that recommendation before it is presented to the CCG Governing Body for approval on 23rd March.

As a result of discussions with at the Transformation Board, the workstreams were made more prominent in the design of the contract. In future years of the contract we will ensure that workstreams are proactively engaged in the design and redesign to ensure that workstream needs are met.

The sources of funding that are behind the services in this proposal are a mixture of aligned and ring fenced primary care funding which is not pooled. It is therefore not appropriate for the proposal to be approved by the ICB at this time but it is consistent with the ethos of integrated commissioning for the ICB review this proposal before it is approved.

Recommendations:

The City Integrated Commissioning Board is asked to:

- **REVIEW AND ENDORSE** the recommendation from the Local GP Provider Contracts Committee to award the single contract to the GP Confederation.

The Hackney Integrated Commissioning Board is asked to:

- **REVIEW AND ENDORSE** the recommendation from the Local GP Provider Contracts Committee to award the single contract to the GP Confederation.

Links to Key Priorities:

This proposal links to the following strategies:

- The GP Five Year Forward

  The GP Five Year Forward View recommendation is for CCGs to use GP Federations to maximise opportunities for greater collaboration between practices that can drive economies of scale and quality improvement.

- The Five Year Forward and NEL STP

  The Five Year Forward View and the NEL STP has identified that successful implementation of ACSs require new payment approaches that provide financial sustainability as well as incentives to integrate care.

- Hackney and City Health and Wellbeing Strategy

  The Hackney Health and Wellbeing Strategy states a clear commitment to a shared vision for integrated care and support in Hackney. The single contract provides a contractual platform that will allow the GP Confederation to more easily deliver services on a neighbourhood level providing clearer systems for delivering services in a way that is integrated locally between general practices and community pharmacists.

- Hackney and City Devolution Plans

  The Hackney and City Devolution plans talks about "…coordinating community based services around GP practices…". At the heart of the neighbourhood model are clusters of GP practices who in the first phase of the neighbourhood programme will work together on understanding how these clusters of practices will work more closely together to deliver better outcomes for their local population.

- North East London Sustainability and Transformation Plan

  The NEL STP talks about the need "to develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care".

  While the single contract is not a proposal for a new model of care itself; by moving away from payment by item of service to block and outcomes based payment the single contract can be used to incentivise the GP Confederation to develop and implement new models of care to deliver better outcomes for the whole population.

Specific implications for City of London

There are no specific implications for the City of London.

Specific implications for Hackney

There are no specific implications for Hackney.

Patient and Public Involvement and Impact:

Patient and public engagement is undertaken whenever a new primary care Locally Enhanced Services is commissioned or modified significantly. As all of the services except Proactive Care: Practice Based are existing services that are current commissioned from/delivered by the GP Confederation there has not been additional engagement on this proposal.

Feedback was sought from the PPI Committee in August 2017 on the Proactive Care: Practice Based service proposal.

It is unlikely that the content of this paper will impact on the public and patient perception of the service provider. LES services are delivered through the patient's own practice or a neighbouring practice; this is not a proposal to alter that configuration of clinical services.

Clinical/practitioner input and engagement:

The Clinical Executive Committee of the CCG was the first committee to be consulted about this proposal.

Feedback was also sought from the Clinical Commissioning Forum on the Proactive Care: Practice Based service proposal in October 2017.

Impact on / Overlap with Existing Services:

There is no specific impact on existing services from this proposal.

Sign-off:

City & Hackney CCG – David Maher, Acting Managing Director

Main Report

1. CCG process for awarding contracts to Primary Care Providers and Conflicts of Interest

The current CCG process is that primary care provider contract award decisions are made at the Local GP Provider Contracts Committee and then the decision is passed to the Governing Body as a recommendation for approval.

This paper asks the Integrated Care Board to review and endorse the LGPPCC recommendation before it is presented to the CCG Governing Body for approval on 23rd March.

The CCG process is for only basic information to be given to the Governing Body such as the contract start date, end date, contract value and service description to be reported to the Governing Body to ensure that the contract award decision is not influenced by conflicts of interest.

As the ICB is neither the committee approving the recommendation or making the recommendation there should be no conflict of interest issues and so the content of paper can be discussed by all ICB members.

2. Introduction and Background

The CCG began commissioning services from the GP Confederation in 2015 and since that time the number and value of the contracts has increased. At the end of 2017/18 there will be 11 separate service contracts with an estimated combined annual contract value of £8.9m.

Most of the individual contracts are paid on an item of service / fee for activity basis which is a bureaucratic payment system to manage. It was felt that overseeing this payment system diverts committee time (in particular the Local GP Confederation Contracts Committee and GP Confederation Oversight Group) and management time away from discussing service performance, quality and innovation which could lead to reorganisation and improvement of services.

The Commissioning Intentions Letter sent to the GP Confederation in September started a process to integrate the existing clinical service contracts into a single outcomes based contract with the GP Confederation. The proposal has been developing since that time with other CCG committees, the Transformation Board and ICB all having been involved in and fed into the proposal. A list of the key committee meetings is listed in the Appendix to this paper.

The recommendation to award a single contract to the GP Confederation (GPC) is not a

proposal to commission different services from the GPC but it is a recommendation to change the way that the CCG pays the GP Confederation for those services over a longer period of time.

It is hoped that the single contract will be a contractual framework that will enable GPC service improvement over the April 2018 to March 2025 period.

3. Integrated Commissioning Governance Issues

- While sharing this proposal with the Transformation Board concern was expressed that the proposal had been developed by the CCG in isolation and was not a proposal created by workstreams.

- It was felt that the length of the contract and the significant contract value being awarded at a time when the context of local commissioning is in flux may not have been consistent with the principles of integrated commissioning. It was considered important that the 7 year contract must not restrict the workstreams from implementing future commissioning plans before those plans have been developed.

- The Transformation Board recommended that further engagement was undertaken with workstreams to ensure that the contract would not prevent workstreams from being able to implement plans and that these concerns should be addressed before the proposal was considered by the ICB. The detail of this engagement is included in the Appendix.

- Following the Transformation Board paper on the GP Confederation was deferred from the ICB on 28 February to the 21 March meeting to allow some more time for engagement. This activity resulted in the agreement that the changes below would be made to contract to give workstreams more flexibility:

  <u>Unplanned Care workstream</u>
  - Service specifications for Duty Doctor and Proactive Care: Home Visiting are to include outcomes for only 2018/19 so that these can be revised by the workstream in 2019/20. There is a plan to roll out common outcomes for the whole of the unplanned care system next year.
  - The service specification for Proactive Care: Practice Based will make clear that the service funding is non-recurrent and is part of the single contract for 2018/19 only. This funding is ring fenced for primary care as it is being funded by the PMS premium.

  <u>Planned Care workstream</u>
  - Community Anticoagulation pricing model will continue to be activity based in 2018/19 with a plan for this to be reviewed and potentially made into a block and outcomes priced service in 2019/20.
  - Phlebotomy and Wound Care contract values can be increased in 2019/20 if services are successful in diverting more activity away from secondary care.

- A long stop date of 30th June 2018 (contract break clause) will be added to the Cancer Time to Talk Service (part of LTC) to allow the outcome of a prostate cancer pathway review to be reflected in the service specification.

Children, Young People and Maternity workstream

- The contract will be clear that the Childhood Immunisation service and part of the Early Year service funding is non-recurrent and is therefore part of the single contract for 2018/19 only.

Primary Care enabler group

- The contract will be clear that Enhanced Access funding is non-recurrent and is subject to NHS England agreeing to a continuation of the funding.

The discussion at the Transformation Board has helpfully highlighted the issue that proposals that come to the ICB need to have been shared with other workstreams so that they can give input to the proposal before it comes to the ICB for approval because those proposals may have an impact on services beyond the work area making the proposal.

With hindsight it may have better to have done the engagement before, rather than at, the Transformation Board and for more time to have been allowed for workstream engagement which has resulted in some important improvements to the draft contract.

4. Other rationale for developing GP Federations and moving away from a fee for activity payment system

- The GP Five Year Forward View recommendation is for CCGs to use GP Federations to maximise opportunities for greater collaboration between practices that can drive economies of scale and quality improvement.

- The Five Year Forward View and the NEL STP has identified that successful implementation of ACSs require new payment approaches that provide financial sustainability as well as incentives to integrate care.

- Outcomes based commissioning has been established as the most effective way to commission whole population based healthcare services. By paying incentives for achieving outcomes alongside a fixed/block amount the provider is encouraged to come up with ideas for reforming services to better meet those outcomes.

5. Overarching Principles to be written into the single Contract

- Services should be delivered as per the practice registered list (e.g. linked to the patient's own GP where possible). Practices should not be unnecessarily destabilised by the implementation of the Neighbourhood model but, in support of the development of the Neighbourhood model and where services are being considered for delivery at Hubs, care closer to home and maintaining continuity for patients

should be considered (and the case for the benefit of this presented)

- Equity of access and outcomes for all residents should be prioritised. Reducing variation in performance between the top and bottom performing practice to be achieved during the duration of the contract. No patients are to be disadvantaged because of practice they are registered with or the neighbourhood in which they live
- The GP Confederation primary care services should work in an integrated way with other healthcare providers and other healthcare professionals (including pharmacists) to improve outcomes for patients
- Patient should be in the centre of the whole contract and therefore deliver a balance of Access, Quality and Value for Money. All of these elements are interconnected and there is a direct relationship between them
- Flexibility of budget should be matched by transparency of expenditure and transparency of financial reporting to the CCG. The CCG would want to see the majority of the budget spent on services delivered at GP Practices and on patient care with the GP Confederation running costs minimised.
- GP Confederation services should allow for clinical training of the future workforce to take place. The staff providing the services should have specific workforce training objectives, including work with the Prevention workstream on the Making Every Contact Count programme (in development)
- GP Confederation should work with the CCG and workstreams to identify most effective way of collecting patient feedback and experience data
- Increase in efficiency: services should aim to save patients' time where possible (where this is a priority)
- The outcomes included within the contract can be influenced by primary care (they will not be completely within the control of primary care and there will be external factors which can also influence the outcome: as is the nature of outcomes). Outcomes may be difficult to measure and there may be a time lag in seeing the impact of GP Confederation interventions (thus KPIs are also included as method of measuring progress/contribution towards an outcome and KPIs may change over time as a result). Evidence base and local data should be used to prioritise outcomes based on highest need.

6. Contract Summary

Commencement Date:	1st April 2018
Expiry Date	31st March 2025
Option to extend:	None
Parties to the Contract:	NHS City and Hackney CCG & The City & Hackney GP Confederation CIC

7. Contract Value and Annual Financial Adjustments

Contract Element 2018/19	Paid	Value	Percentage

Block	Paid monthly on a schedule	£6,069,739	62.3%
Overhead	Paid monthly on a schedule	£425,000	4.4%
Activity Based	Quarterly after the activity has been completed	£2,296,959	23.6%
Outcomes Based Incentive	At the end of each year when performance against outcome has been assessed	£956,086	9.8%
TOTAL		**£9,747,784**	

At the end of each financial year a financial adjustment will be applied to the contract for:

1. The general NHSE uplift for inflation;
2. The NHSE efficiency factor reduction;
3. Demographic growth;
4. Agreed cost pressures;
5. QIPP reduction.

Excluding the effect of non-recurrent services coming to an end and services being decommissioned or added to the contract the annual adjustment should be more than or less than a 5% adjustment to the annual contract value.

When the effect of annual adjustments is considered the total 2018/25 contract value is estimated to be £72.8m.

It is planned that during the 3rd year of the contract there will be a rebasing exercise which will identify other more factors which might suggest a more significant adjustment to the contract value:

- Within the contract financial envelope, any situation where the actual cost of delivering a service is significant different from the original value; or
- When the contract value of one service is subsidising another service, or a workstream budget is subsidising another workstream, the budgets can be transferred; or
- Efficiency, demographic changes, growth in demand that are larger than the contractual cap will allow to be made in Year 2 or Year 3;
- Any other significant financial adjustment.

8. List of the Clinical Services to be incorporated into the contract

Service	Description of the Service	Source of Funding	Workstream
Proactive Care: Home Visiting	GPs visit frail elderly housebound patients and create care plans (on CMC) which can be used by LAS and other providers to avoid unnecessary admission to Hospital.	CCG aligned funding	Unplanned Care Workstream
Proactive Care: Practice Based*	GPs identify ambulatory patients at risk of admission and CMC care plans are created for those patients which can be used by LAS and other providers to avoid unnecessary admission to Hospital.	PMS Premium funding – non-recurrent. Ring fenced for primary care.	Unplanned Care Workstream.
Duty Doctor	A 'Duty Doctor' is available during core in each practice to respond to patients with urgent treatment needs and questions from health care professionals.	CCG aligned funding	Unplanned Care Workstream
End of Life Care	A CMC care plan is created for palliative care patients with the objective that more patients can die in their preferred place of death.	CCG aligned funding	Unplanned Care Workstream
Community Anticoagulation	Undertake more warfarin monitoring and NOAC initiation closer to patients' homes. The service uses hub practices to provide a service to all practices.	CCG aligned funding.	Planned Care Workstream.
Phlebotomy	Take blood test samples in the practice avoiding patients' journeys to Hospital phlebotomy services.	CCG aligned funding.	Planned Care Workstream.

Post-Operative Wound Care	To reduce PUCC attendances, provide post-operative would dressing changes in general practices.	CCG aligned funding.	Planned Care Workstream.
Primary Care Mental Health Alliance including EPC and Depot	A bundle of mental health services to a) provide long term mental health services in the community for patients with psychosis and bipolar disorders, b) review patients with depression and anxiety alongside reviews of physical health and c) provide training to GPs in managing mental health.	CCG aligned funding. Ring fenced for Mental Health because of parity of esteem.	Planned Care Workstream.
Long Term Conditions including Cancer, Time to Talk, Children's LTC	Provide incentives and additional appointments for reviewing and following up patients with long term conditions in primary care.	CCG aligned funding. Combination of Prevention and	Planned Care Workstreams.
Childhood Immunisation	Targeted intervention to boost immunisation amongst hard to reach groups of patients in Hackney.	CCG aligned funding – non-recurrent.	Children, Young People and Maternity Workstream.
Early Years	Provide additional support for expectant mothers with a long term conditions or at higher risk of delivering a low birthweight baby, as well as, providing additional appointments for reviewing children.	CCG aligned funding – mixed non-recurrent and recurrent funding.	Children, Young People and Maternity Workstream.
Enhanced Access	Provide additional routine appointments in practices between 8-8.	NHS England funding – non-recurrent. Ring fenced for primary care because of GP Forward View improving access requirements.	Primary Care Enabler Group

* The proactive care: home based service has not previously been commissioned and is being commissioned for the first time in 2018/19.

9. Summary of the Finances in 2018/19

Service	2018/19 estimated contract value	2018/19 payment based on
Proactive Care: Home Visiting	£1,412,047	90% block, 10% outcomes plus £70K disaggregated overhead
Proactive Care: Practice Based	£274,581	Number of patients on the PC register
Duty Doctor	£1,542,106	90% block, 10% outcomes plus £61K disaggregated overhead
End of Life Care	£194,192	75% block, 25% outcomes plus £32K disaggregated overhead
Community Anticoagulation	£354,987	Payment per patient and per domiciliary visit
Phlebotomy	£290,000	90% block, 10% outcomes
Post-Operative Wound Care	£145,000	90% block, 10% outcomes
Primary Care Mental Health Alliance including EPC and Depot	£805,593	Reviews and Check – block based on population coverage, EPC & Depot – per consultation, Training – amount per practice
Long Term Conditions including Cancer, Time to Talk, Children's LTC	£3,427,604	Core LTC 80% block, 20% outcomes Cancer 75% block, 25% outcomes T2T per consultation Children LTC 90% block, 10% outcomes
Childhood Immunisation	£25,000	100% block
Early Years	£598,306	90% block, 10% outcomes plus £66K disaggregated overhead
Enhanced Access	£678,367	Payment per appointment
TOTAL	**£9,747,784**	

Appendix 1: Approval and consultation process leading to the recommendation being presented to the GB

CCG Clinical Executive Committee 13 December 2017	The proposal to combine the contracts and reform the payment system was endorsed. Specific questions were raised about what would happen if there was a dispute with the GP Confederation and whether there was a potential for financial destabilisation of practices particularly around the hub model
GP Confederation Oversight Group (Informal) 15 December 2017	This was a non-quorate meeting and was therefore informal. The proposal was discussed with the GP Confederation and it was clarified that all clinical services that the CCG commissions with the GP Confederation if they were already commissioned as a block/outcome based they would be left as they are. There was general discussion about contractual flexibility that exists to change specifications during the term of the contract and the scrutiny and oversight role of the GP COG once the contract has been awarded.
Finance and Performance Committee 19 December 2017	The financial envelope for the block contract should be kept the same as the current payment level so that CCG headroom is not lost. The existing percentages linked to outcomes should be adjusted to get this to fit. The outcomes should be suitably stretching so that they additional payments cannot be achieved too easily. Other financial principles were agreed such as demographic and non-demographic annual adjustments, a planned rebasing at year 3 and a limit on annual adjustments of +/- 5%.
Local GP Provider Contracts Committee 22 December 2017	The draft outcomes were reviewed by the committee. There was a request for draft outcomes to have thresholds, targets of financial incentive values developed before the committee can approve these specifications. Permission was granted for a OJEU Prior Information Notice of planned direct award of contract to be published.

28 December 2017	OJEU PIN published http://ted.europa.eu/udl?uri=TED:NOTICE:524153-2017:TEXT:EN:HTML&src=0
GP Confederation Oversight Group 5 January 2018	There was a detailed discussion about each of the proposed outcomes and KPIs with a recommendation that where outcomes were not measurable then the existing KPIs or activity measures could be used to measure whether the service had been delivered in the first year. Outcomes should be ambitious and aspirational but this was a practical way to assess performance when a way to measure the achievement of the outcome had not yet been delivered.
CCG Audit Committee 11 January 2018	The audit committee considered whether additional audit and financial monitoring arrangements should be put in place to monitor the single contract. Following a CCG audit chair to Confederation audit chair meeting it was recommended that monitoring could be done effectively by the GP COG provided that the terms of reference were updated and that there was transparent financial and performance reporting provided to this meeting.
Local GP Provider Contracts Committee Friday 26th January 2018	The nil response from the Prior Information Notice was received. There was brief review of the draft service specifications which was continued outside the meeting.

Transformation Board Friday 9th February 2018	The proposal was discussed without GPs in attendance because of potential conflicts of interest. Concern was raised that the proposal had not been developed by workstreams and that such a long contract with a significant value was being awarded at a time when the context of local commissioning is in flux. It was important that the 7 year contract must not restrict the workstreams from implementing future plans. The meeting recommended that further engagement was undertaken with workstreams to ensure that the contract would not prevent workstreams from being able to implement plans and that these concerns should be addressed before the proposal was considered by the ICB. This would primary be through the Workstream Directors Group. Following this meeting a paper was withdrawn from the ICB 28 February meeting and deferred to the 21 March meeting to allow more time for engagement.

Local GP Provider Contracts Committee Friday 23rd February 2018	The Local GP Provider Contracts Committee continued the review of the draft service specifications and it was agreed that a recommendation to award the single contract could be made to the GB. The LGPPCC requested that before the contract is signed that: - Patient Surveys are a GP Confederation responsibly and a plan for further development during the term of the contract must be written into the contract. - Further work should be done on the Duty Doctor and Proactive Care: Home Visiting outcomes to simply these and define what 'maintaining' performance means in practice. - GP COG should not be the single point of performance but can become the single point of accountability for performance management. - The GP COG should be a support for the Workstreams and they should be allowed to attend GP COG and be able to escalate performance problems to GP COG. - Flexibility should be written into the agreement where workstreams request flexibility. - The EoLC target for % of people dying at home should be made more stretching and be benchmarked against other CCGs. - LTC was approved but the committee wants the KPIs to come back to the LGPPCC in June for approval following an assessment of year end practice performance.

Informal Workstream Directors Group Thursday 8th March 2018	The workstream directors expressed concern that the single contract, which was mostly a block contract, required the GP Confederation to change its behaviour and adopt the ethos of the single contract - this had not yet happened. Some specific examples of behaviours that would need to change were: - when a service over performs the GPC would need to develop a plan for containing activity within the funding envelope and not simply ask commissioners for more funding to pay for the over performance; - where a service under performs at an individual practice the GPC will need to develop a plan for delivering that activity at neighbouring practice; - when commissioning priorities have changed and additional funding is not available, the GPC will need to make decisions about which services should be stopped to release funding for new services to be commissioned; - decisions about the amounts that practices are to be paid from the block are for the GPC to decide, this is not a CCG decision. This meeting was preceded by informal discussions between workstream directors and the Senior Contracts Manager to ensure that individual workstream concerns were being captured and, where flexibility was required, this was being written into the draft contract. These flexibilities included: Unplanned Care workstream - Service specifications for Duty Doctor and Proactive Care: Home Visiting are to include outcomes for only 2018/19 so that these can be revised by the workstream in 2019/20. There is a plan to roll out common outcomes for the whole of the unplanned care system next year. - The service specification for Proactive Care: Practice Based will make clear that the service funding is non-recurrent and is part of the single contract for 2018/19 only. This funding is ring fenced for primary care as it is being funded by the PMS premium. Planned Care workstream - Community Anticoagulation pricing model will continue to be activity based in 2018/19 with a plan for this to be reviewed and potentially made into a block and outcomes priced service in 2019/20. - Phlebotomy and Wound Care contract values can be increased in 2019/20 if services are successful in diverting more activity away from secondary care. - A long stop date of 30th June 2018 will be added to the Cancer Time to Talk Service (part of LTC) to allow

	outcome of a prostate cancer pathway review to be reflected in the service specification. Children, Young People and Maternity workstream - The contract will be clear that the Childhood Immunisation service and part of the Early Year service funding is non-recurrent and is part of the single contract for 2018/19 only. Primary Care enabler group - The contract will be clear that Enhanced Access funding is non-recurrent and is subject to NHS England agreeing to a continuation of the funding. The formal Workstream Directors Group had been cancelled the week earlier because of snow.
Integrated Commissioning Board Wednesday 21st March	

Title:	IT Enabler support for VCS – including scoping for Social Prescribing software
Date:	21 March 2018
Lead Officer:	Jackie Brett
Author:	Mohammed Mansour
Committee(s):	IT Enablers workstream – January 2018 – proposal approved Transformation Board – February 2018 – proposal approved Integrated Commissioning Board - March 2018 – for decision
Public / Non-public	Public

Executive Summary:

This proposal, approved by the IT Enabler Board and Transformation Board , is to scope out the best platform to underpin Social Prescribing in Hackney and City of London which will allow us to achieve a transformative cross-sector collaboration. The scoping phase will consist of stakeholders' engagement exercises to identify the requirements of the platform and establish a clear agreement on how it will be applied in practice. This will help achieve the aims of this proposal and identify the most practical ways for implementation across stakeholder groups.

Once the platform is identified and the procurement process finalised, the project officer will continue to engage the stakeholders to facilitate the implementation of the digital platform and working closely with our partners for continual service improvement and shaping an agreed common outcomes framework.

Recommendations:

The City Integrated Commissioning Board is asked:

- to **APPROVE** funding of £55,800 for a Professional Level 3 post for 18 months, part time @ 0.8 wte; and
- to **NOTE** that a further request for funding in the region of £75,000 for the platform will be submitted after the scoping exercise.
    a. Licensing, training and support costs for Social Prescribing platform 2 years - £ 57,900 Exc. VAT (EMIS connection fees £200 per practice for 1 year)
    b. Staff training, venue hire, and management costs - £15,000

The Hackney Integrated Commissioning Board is asked:

- to **APPROVE** funding of £55,800 for a Professional Level 3 post for 18 months, part time @ 0.8 wte; and
- to **NOTE** that a further request for funding in the region of £75,000 for the platform will be submitted after the scoping exercise.
    c. Licensing, training and support costs for Social Prescribing platform 2 years - £ 57,900 Exc. VAT (EMIS connection fees £200 per practice for 1 year)
    d. Staff training, venue hire, and management costs - £15,000

Links to Key Priorities:

Prevention workstream priorities:

'Develop plans to increase self-management, access to self-care/advice and link social prescribing to other community based prevention initiatives to support primary prevention initiatives and those with LTC to manage their own health care and wellbeing.

Specific implications for City

This proposal covers the City. As part of the scoping we will need to ensure that the platform can be linked to any separate City directory of services

Specific implications for Hackney

This proposal covers Hackney and we will work closely with LBH who are reviewing iCare and the potential to develop a shared dataset.

Patient and Public Involvement and Impact:

Service users will be involved in the scoping exercise to decide on the best platform for the project and designing the referral pathway.

Clinical/practitioner input and engagement:

GPs, Social Prescribers, Health Coaches, and the wider VCS providing activities will be involved in scoping out the best platform for social prescribing.

Impact on / Overlap with Existing Services:

This proposal will enable a feedback loop to GPs that will enable us to track outcomes for people who are 'prescribed' activities and support from services in Hackney (statutory and Voluntary & Community Sector) via Social Prescribing and Health coaches. The platform will enable GPs to understand where individual patients they have referred to social prescribing go and what impact this has on their wellbeing.

The platform will also enable us to gather wider evidence of impact of services that provide activities and social support to residents of City & Hackney.

The platform aims to minimise the impact on GPs and health professionals by reducing the amount of work they should do to generate social prescription referrals. For example the platform could prepopulate the contact fields in the referral with the following information from EMIS when the GP clicks on the [Social Prescription] button while in a given patient context:

● Provenance - Clinic Details & Current User (GP)

● Patient - Identifier (NHS Number), Name, DOB, Address, Contact Details (mobile, email, etc)

Clinicians can be notified on the patient's page on EMIS Web that there has been new information relating to social prescription uptake and activity. When this is clicked, the Clinician can be taken to a tab that shows a list of recent updates and corresponding codes. These might include:

● Social Prescription activation, update, and attendance

● BMI score (Initial score at baseline and subsequent measurements thereafter)

● Wellbeing score (Initial score at baseline and subsequent measurements thereafter)

● Any other measurable values.

The Clinicians could select (one of more) so they can be imported into EMIS Web where it could appear in the patient's record along with the corresponding code.

Supporting Papers and Evidence:

Attached:

ICB Social Prescribing IT Enabler Proposal - March 2018

Website links:

https://www.emishealth.com/products/elemental-social-prescription-connector/

Equally well report 2 (1) - Dundee Partnership

Sign-off:

London Borough of Hackney _____Anne Canning, Group Director of Children, Adults & Community Health

City of London Corporation _____Simon Cribbens, Assistant Director or Commissioning & Partnerships

City & Hackney CCG _____ David Maher, Acting Managing Director

Social Prescribing IT Enabler support for VCS

By: Jackie Brett, Mohammed Mansour – Hackney CVS
Supported by: Prevention Workstream – Jayne Taylor, LBH Public Health

1. Proposal:

Hackney CVS have worked with Prevention Work stream directors and the wider social prescribing group on developing the local offer. This has included input and support from Dr Patrick Hutt at clinical lead and Charlotte Painter and Long-Term Conditions Programme Director at the CCG. Our proposal is to invest into an established social prescribing platform that is already accredited by EMIS and provide a tested referral pathway for health professional to refer to voluntary sector services through this platform. The social prescribing platform will be customised to draw on the local directory of services to inform GPs about the local options for their patients. The platform will also serve as common interface for social prescribers, health coaches, and GPs when referring their patients into local community services as well as tracking the progress of their wellbeing against desired outcomes. We will continue to work with the prevention work stream to shape the outcomes framework and define the sets of data required to be reported back.

This proposal, approved by the IT Enabler Board and Transformation Board , is to scope out the best platform to underpin Social Prescribing in Hackney and City of London which will allow us to achieve a transformative cross-sector collaboration. The scoping phase will consist of stakeholders' engagement exercises to identify the requirements of the platform and establish a clear agreement on how it will be applied in practice. This will help achieve the aims of this proposal and identify the most practical ways for implementation across stakeholder groups.

Once the platform is identified and the procurement process finalised, the project officer will continue to engage the stakeholders to facilitate the implementation of the digital platform and working closely with our partners for continual service improvement and shaping the common outcomes framework by:

- Working closely with social prescribing platform developers and EMIS-web and iCare leads, and the wider VCS to implement a solution for inter connectivity with EMIS-web, LBH iCare, and City of London DoS.
- Working closely with Family Action, Shoreditch Trust and GP Confederation to promote the integration of social prescribing into EMIS.
- Liaison with Discovery to establish a pathway for population health analytics on voluntary sector interventions
- Facilitation of education and training for staff to use the social prescribing platform integration module in EMIS.

Hackney

CITY OF LONDON

NHS
City and Hackney
Clinical Commissioning Group

2. Brief Options appraisal

The IT Enablers Board recommended that the first part of the proposal, the 18 months post, should be funded, and that Hackney CVS return to IT Enablers Board with a follow up proposal once the scoping of the platform is agreed with all stakeholders. We are also speaking to NHS England who have recognised the need to provide more guidance to local areas on digital providers, and aim to scope out the options locally working with:

- EMIS
- LBH iCare
- City of London DoS
- The Discovery Project
- Family & Young People's Information Service (City)

consulting with

- GPs
- Social Prescribers
- Health coaches
- Activity and service providers across the VCS and statutory sector

3. Evidence base

Social prescribing has been in place for a good number of years now, albeit on a relatively small scale. Brandling and House (2009) for example, cite the Bromley-By-Bow scheme which was developed in the 1990s.

According to the evaluation report Dundee Equally Well by Lynne Friedli; Social prescribing can help provide psychosocial and practical support for people with a wide range of problems and conditions whose needs are not being met within existing services or who may be using services inappropriately. The overall outcome is to improve the mental wellbeing of patients, through supporting them to access non-clinical sources of support within the community. Individual outcome measures include:

- Enhanced skills and behaviours that improve and protect mental wellbeing.
- Increased social contact, support and networks.
- Increased participation in community activities.
- Increased uptake of local services.
- Improved mental wellbeing – Warwick Edinburgh Mental Wellbeing Scale and Work and Social Adjustment Scale.

Furthermore, digital platforms are now accredited with EMIS Web systems such as

Elemental Social Prescription Connector. It is provided by EMIS partner Social Prescribing People. https://www.emishealth.com/products/elemental-social-prescription-connector/

"Elemental is a great solution, as it enables GPs to find all the support that is available when looking at the best solutions for our patients." Dr Paul Molloy, Clarendon Medical Centre.

4. Anticipated benefits

This would enable GPs and health professionals to send pre-populated referrals directly from EMIS-web to the nearest Social Prescribing Hub. As well as having the functionality to track the social prescribing activities they referred their patients to and see the progress of their patients outside of the clinical atmosphere.

Patient journey; this will allow voluntary and community sector data to be transmitted through EMIS to aid the Discovery project patient explorer utility. Patients' progress reports for those referred to the voluntary and community sector can be tracked through the utility and identify the benefits of the voluntary sector interventions. The social prescribing platform will focus on the patient journey. A total of 6 key touch points are facilitated and recorded within the platform:

- Referral generation
- Assessment arranged
- Baseline metrics obtained
- Social prescription generated/ providers engaged
- Further visits recorded
- Progress reported

5. Project risks

Patient Confidentiality: maintain the appropriate technical and organisational measures to ensure patient confidentiality across the referral pathway.

Social Prescribing Project governance: Ensure quality of service checks are embedded into the social prescribing scheme to moderate the services listed on the directory

Due Diligence: ensuring the services in the voluntary sector meet a set standard compatible with the due diligence requirements by the scheme and Link Workers proactively monitoring the referral pathways.

Information Governance: any platform identified must meet the NHS Information Governance requirements to be accredited to access primary healthcare records of patients.

6. Project timeline

Service users will be involved in the scoping exercise to decide on the best platform for referrals

Scoping phase between April 2018 to September 2018

- Stakeholder Engagement Events (GPs, Social Prescribers, Health Coaches, and VCS providers.
    - 43 GP practices engaged in the scoping phase
    - 50 Social prescription providers engaged
    - GP confederation and local medical council engaged
    - Social Prescribers and Health Coaches engaged
    - GP IT enabler steering grouping engaged
    - iCare, City of London DoS, and NEL MiDoS programme officers engaged
    - Discovery programme managers engaging on data sets requirements.
- Joint-review of the Social Prescribing project governance and data sharing agreement in place to ensure quality of services
- Identify further project risks arising from the scoping phase and agree the adoption of a suitable risk management framework.
- Platforms identification and selection feeding into the most suitable procurement process as would be agreed during the scoping phase.
- Going back to the IT enablers board on 11 or 12 September 2018 with findings from the scoping phase and requesting the remainder of the funds to initiate the procurement process.
- October 2018 to September 2019 procurement and implementation of the agreed digital platform.
- October 2018 to March 2020 evaluation and review of the social prescribing project and presentations to IT Enabler and Transformation boards and discussing plans for sustainability of the project.

7. Resources required and how they will be managed/governed:

The Integrated Commissioning Board is asked to approve funding of £55,800 for a Professional Level 3 post for 18 months, part time @ 0.8 wte

The post will be managed by Hackney CVS and work in partnership with Prevention workstream, GP Confederation, Local medical council, Discovery project, and LBH iCare Team, City of London. The Scoping phase is to identify the common platform and get all stakeholders input on what it should provide.

And to note that a further request for funding for the platform will be submitted after the scoping exercise – sample costs below (*based on Elemental platform*):-

a. Licensing, training and support costs for Social Prescribing platform 2 years - £ 57,900 Exc. VAT (EMIS connection fees £200 per practice for 1 year)
b. Staff training, venue hire, and management costs - £15,000

Title:	Supporting co-production and public involvement in Integrated Commissioning in City and Hackney: the continuation of funding for the Engagement Enabler Group
Date:	21 March 2018
Lead Officer:	Jon Williams – Director, Healthwatch Hackney Catherine Macadam – PPI CCG Lay Lead Co-Chairs of the Engagement Enabler Group
Author:	Jon Williams – Director, Healthwatch Hackney
Committee(s):	City and Hackney Integrated Commissioning Board – for decision
Public / Non-public	Public

Executive Summary:

This proposal seeks to ensure effective public engagement and involvement in the care work streams and associated work continues to be supported beyond March 2018 as part of the Integrated Commissioning Programme in City and Hackney. This includes supporting the public and patient representatives involved in the programme and the care workstream use of co-production to the support development and review of services. This will maintain and strengthen public representatives' ability to:

- co-produce services, leading to improved and more appropriate services;
- Participate meaningfully in workstream, design-lab and other activities
- scrutinise performance; and
- give advice on involving the wider public.

It would also be a practical demonstration of the City and Hackney Integrated Commissioning Boards (ICBs) and Transformation Board (TB)'s commitment to engaging with and empowering communities and patients in new ways, in line with the Five Year Forward View.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **APPROVE** the continuation of the non-recurrent funding of the post of Communications and Engagement Manager - Transformation for 2018-19, with the remit to support, grow and develop public representative and co-production for 2018/19 in line with workstream requirements
- To **APPROVE** this work with identified funding of £45,000 from within existing resources Integrated Commissioning s256 agreement between the CCG and London Borough of Hackney.
- To **NOTE** plans will also be developed during this time period for how the functions of the Engagement Enabler Group can continue in a sustainable way.

The City Integrated Commissioning Board is asked:

- To **ENDORSE** the continuation of the non-recurrent funding of the post of Communications and Engagement Manager - Transformation for 2018-19, with the remit to support, grow and develop public representative and co-production for 2018/19 in line with workstream requirements
- To **ENDORSE** this work with identified funding of £45,000 from within existing resources Integrated Commissioning s256 agreement between the CCG and London Borough of Hackney.
- To **NOTE** plans will also be developed during this time period for how the functions of the Engagement Enabler Group can continue in a sustainable way.

Links to Key Priorities:

Increasing effective public participation in the care workstreams and through co-production increases our ability to involve more people and to help us achieve our joint health and wellbeing aims for communities in the City of London and Hackney.

The programme will support the design and re-design of services within the four key themes of the Integrated Commissioning programme and the care workstreams. This includes the Neighbourhood Care Model.

This programme supports the ambition of the Transformation Board for the public to be equal partners in delivering integrated commissioning with managers and clinicians/practitioners.

Specific implications for City

There are no specific implications for the City as this work is across the City of London and Hackney

Specific implications for Hackney

There are no specific implications for Hackney as this work is across Hackney and the City of London

Patient and Public Involvement and Impact:

This work supports Integrated Commissioning's Engagement and Enabler Group to deliver its works programme of supporting public participation in the work of the Care Workstreams. Specifically the programme (a) supports the public representatives on the Care workstreams and their sub-groups; and (b) embeds co-production in the service design and re-design of the Care Workstreams

Clinical/practitioner input and engagement:

The CCG's Patient and Public Involvement clinical lead, a local GP, will provide direct clinical input into this work. Clinical/practitioner input and engagement also comes through public representatives in care workstreams and their sub-groups working closely with clinicians. This will increase once the programme of co-producing services starts in 2018.

Impact on / Overlap with Existing Services:

The programme will support the monitoring and scrutiny of services by the public representatives. It also supports existing services by involving the public in the design and re-designing of services through the implementation of co-production. The Transformation Board has asked the Engagement Enabler Group to work with existing agencies public involvement teams to assess how better this work can be joined up for the benefit of integrated commissioning and the local populations.

Main Report

Background and Current Position

City and Hackney have a long tradition of public, patient and user involvement in the review and development of health and social care services. With the development of integrated commissioning, local leaders committed themselves to building to a position where the public can be equal partners with managers, clinicians and practitioners.

To achieve this ambition, an Engagement Enabler Group (EEG) is in place to ensure

people are informed of and able to shape integrated commissioning, and any future development such as an accountable care system (ACS). The group also supports public representatives on the Care Workstreams (CWs) and helps embed co-production in their work.

Current funding for the EEG (which began in May 2016 under the Hackney devolution pilot) ends 31 March 2018. The need to support public involvement does not come to an end in March 2018. If anything, it becomes more important, given the health and care challenges in City and Hackney. Without continued funding, it will not be possible to support the public representatives nor the piloting of co-production. This risks public involvement in integrated commissioning becoming piecemeal and tokenistic, undermining the ICBs and TB's ambition of the public as equal partners in the local development of health and care. The ambition of the Engagement Group is to make real the Transformation Board commitment to public involvement in the care workstreams and coproduction. This is a challenging ask; without staff resource it will not happen

The ambition of the TB is that the care workstreams are led by a Senior Responsible Officer, a Director, a clinical lead and a public lead, all working together as equals. However, given the power and resource imbalance, the public leads need support if they are able to effectively fulfil their role.

The public representatives have been in post since around June 2017 (with 1 in place from Dec 2016). While it is still very early days, they have expressed concerns about the challenge of the role and the need for support. It is recognised in the Directors' job description that they need to support the public representatives to be effective in their roles, however they cannot do this alone. The role of the Communications and Engagement Manager - Transformation is essential to support workstream directors and to give the public representatives practical help (i.e. training, 121 support, bringing them together to share experiences and learn from each other) to improve their ability to be effective.

An extension of one year to current funding would allow new ways of working to be properly embedded within workstreams. An assessment can then be carried out to determine future co-production support needs once this work becomes mainstreamed.

Option

Proposed budget

Communications & Engagement Manager - Transformation	F/T for one year from 1/4/18	40,520

Support Costs	Allocation of public representative expenses and venue hire	4,480
Total		**45,000**

One of the Key Performance Indicators for this post is linked to generating engagement activity related to integrated commissioning. The full costs associated with this activity are not yet known, as workstreams are at an early stage of planning their service re-design work. Once a clearer engagement activity plan emerges it will be necessary to establish what additional funding may be needed, and potential sources of this funding. A future report to the ICB will identify these costs and how they can be met and report back on progress with establishing the new ways of working across the workstreams.

Equalities and other Implications:

Continuation of the Engagement manager's role to support the Integrated Commissioning Engagement Enabler group will benefit the TB, ICBs and workstreams by:

- making sure workstreams benefit fully from the input of informed and confident public reps with their unique understanding of health and care services as pathways, rather than distinct services, so that service change and development is co-produced by patients and users of the services under review
- supporting the recruitment and development of new representatives, in particular those from underrepresented groups, i.e. BAMER groups, young and new Hackney, people with sensory impairments, ensuring the widest range of relevant perspectives is available to workstreams
- offering on-going practical support to the CWs as they begin to work on their co-production pilot projects, design-lab activities etc. and to embed new ways of working before work is handed over to engagement teams within partner organisations
- helping the integration partnership to achieve its target of involving all relevant stakeholders (commissioners, providers, the public) in its work to integrate and improve health and care locally, and to continue to be recognised as a centre of excellence in public involvement.
- to provide support for the programme evaluation to ensure public voice is involved this effectively involved in the work

Proposals

Proposed Key Performance Indicators (KPIs)

This role initially involved a significant element on Communications work originally under the devolution pilot and then the Integrated Commissioning Programme. With the splitting of the Communication and Engagement Enabler Group into the Communications Group and the EEG the role focused more on the public and patient involvement, engagement and co-production.

To date the role has delivered:

- Communications for the Devolution Pilot and Integrated Commissioning (Communications & Engagement Strategies, public information including FAQs, internal commissioner staff briefings and FAQs)
- Developed and maintains a Transformation webpage of the Healthwatch Hackney website - http://www.healthwatchhackney.co.uk/city-and-hackney-go-local-community-conversation)
- 4 public meetings on system development of primary care (Quadrant meetings)
- 2 public meetings major developments health and care developments (the Healthwatchs 'What future our NHS?' meetings in March 2017 and March 2018)
- Co-produced a City and Hackney Coproduction Charter at a conference with local residents, endorsed by both the City and Hackney Integrated Commissioning Boards. This is first charter to cross health and social care.
- Developed guidance for Care Workstreams on implementing co-production within their service-design plans
- Recruited and supports the 8 public representatives for the 4 care workstreams. Also recruited and supports public representatives (in Unplanned Care Workstream sub-groups), these are:
    - 3 people to the Neighbourhood Care Model patient panel
    - 1 person to Integrated Discharge Group
    - 1 person to the Urgent Care Group
    - 1 person to Estates Enabler Group
    - 1 person to IT Enabler Group
- Supports the Chairs of the Engagement Enabler Group including running the Group's meetings which bring together engagement, PPI and co-production leads from across health and care organisations in the Hackney and City system to share best practice, develop joint tools and support integration.

In the coming year the role's KPI's are:

- Public representatives on care workstreams and other integrated project

group activities feel supported and able to make an effective contribution.

- Care Workstream SROs and Directors are able to articulate the difference that the public representatives have made and assess their effectiveness
- Care workstreams feel adequately supported to run at least two co-production activities per workstream and to embed co-production practice in their work.
- An outcomes framework to measure integrated commissioning impacts (e.g. using "I…" statements), which aligns with national outcome frameworks, is co-produced with local residents by September 2018.
- Chairs of the Engagement Enabler group are adequately supported to carry out their role effectively and regular (monthly/bi-monthly) meetings are held.
- Public are informed about involvement in integrated commissioning including opportunities to co-produce services through a variety of media platforms including a webpage.
- The Engagement Enabler Group identifies and promotes partner and national best practice (in engagement, involvement and coproduction) to support effective engagement for the care workstreams and across the health and care system in Hackney and City.
- Care workstreams have access to:
    - A pool of strategic patient and service user experts to support their work.
    - Patient and user populations appropriate to effective coproduction.

Conclusion

To ensure services are designed with people as partners requires a demonstrated commitment to effectively resource public involvement. Without this people cannot engage and understand why services need to change. This proposal represents value for money in a context of over £500m spent annually on health and care in Hackney and City. It shows local commissioners are committed to making shared decision-making a reality in the spirit of "nothing about me, without me".

Supporting Papers and Evidence:

N/A

Sign-off:

London Borough of Hackney _____Anne Canning, Group Director of Children, Adults & Community Health

City of London Corporation _____Simon Cribbens, Assistant Director or Commissioning & Partnerships

City & Hackney CCG _____ David Maher, Acting Managing Director

Title:	**Proposal to merge Cedar Lodge with Thames House**
Date:	9th March 2018
Lead Officer:	Dr Rhiannon England (MH Clinical Lead) Dan Burningham (Mental Health Programme Director)
Author(s):	Dan Burningham, Mental Health Programme Director, City and Hackney CCG Dr Waleed Fawzi – Older Adult Consultant Psychiatrist East London NHS Foundation Trust Dean Henderson, Borough *Director C&H, East London NHS* Foundation
Committee(s):	1.The City and Hackney Transformation Board (endorsed 9.3.17) 2. Planned Care Core Leadership Group (endorsed 27.2.18) 3. Patient Public Involvement (consulted 22.2.18) 4. Health in Hackney Overview and Scrutiny Committee (endorsed 14.2.18) 5. City of London Corporation Health and Social Care Scrutiny Committee (endorsed 13.2.18) 6. Older Person's Reference Group (consulted 16.1.18)
Public / Non-public	Public

Executive Summary:

Cedar Lodge and Thames House are long term dementia wards for people with behavioural and psychiatric symptoms. Occupancy across both wards will fall to 32% by April 2018 and Cedar ward is now isolated from other healthcare facilities, creating safety concerns. This paper presents an outline proposal to merge the 13 bed Cedar Lodge with the 18 bed Thames house to create a shared older adult dementia inpatient ward at Thames House. This proposal would:

- Eliminate the current risks related to service isolation of Cedar Ward, namely staff cover and access to rapid response services,
- Enhance the utilisation of Thames House at Mile End Hospital, which is currently operating below capacity,
- Enable investment to enhance the staffing skill mix at Thames House, improving quality of care and helping to optimise length of stay,
- Improve the ward environment for City and Hackney, with Thames House patients providing a larger more recently refurbished ward
- Improve the utilisation of the Trust's estate and enable efficiency savings, which will be re-invested into local City and Hackney mental health services including Older People's services. The savings and re-investment have been agreed within the 2018-19 ELFT contract variation and form part of the City and Hackney QIPP registered with NHSE. All of Hackney's savings will be re-invested in mental health.

In conclusion, the proposal to merge Cedar Lodge with Thames Ward, at Mile End Hospital delivers more cost effective, higher quality inpatient care, and improves utilisation of estates. Thames Ward is a purpose built older person's ward with sufficient capacity to meet the future requirements to provide inpatient longer term health care needs due to dementia for Older People from Tower Hamlets, Hackney and The City even allowing for demographic growth in the older adult population.

A travel analysis shows that, whilst there will be some increase in travel times, the impact on journey times is not excessive. Furthermore, family and carers of City and Hackney residents in Thames Ward will be able to access assistance to enable them to regularly visit the ward in Mile End. The number of patients being transferred is about 5, making the scale of the change small. All patients and families will be prepared for the transition.

This service change will not have any adverse impacts on the wider healthcare system or on the care pathway for City and Hackney patients with dementia requiring longer term care. Furthermore, it is not anticipated that there will be a change or increase in the number of patients being transferred to the Mary Seacole Nursing Home. This proposal has been approved by both the City of London and London Borough of Hackney Oversight and Scrutiny Committees and the Planned Care Core Leadership Group and the City and Hackney Health and Social Care Transformation Board. The Patient Public Involvement Committee and the Older Person's Reference Group have been consulted. Feedback from the consultation process and the response to the feedback is presented in Section 6 so that it can be determined whether the issues raised have been sufficiently addressed by the responses.

The Transformation Board endorsed the proposal provided the proposal to the ICB also contained a record of the questions and concerns raised and the responses made. These are presented in Section 6.4 of the proposal in the Stakeholder Consultation section.

Recommendations:

The City Integrated Commissioning Board is asked:

- to **ENDORSE** this proposal.

The Hackney Integrated Commissioning Board is asked:

- to **ENDORSE** this proposal.

Links to Key Priorities:

This proposal contributes a significant proportion of the MH QIPP savings target which is registered with NHSE by the CCG. It is planned that the savings will be re-invested in the delivery of the Mental Health 5YFV and the delivery of a less hospital and more community focused model of care for older people. Both of these elements are key national and local priorities.

Specific implications for City

The service is open to City residents. There are currently no City of London residents on Cedar Lodge or Thames House at present. Travel times for City residents are not adversely impact on due to the proximity of Mile End to the City.

Specific implications for Hackney

Travel times for Hackney residents will increase by on average between 12 minutes. ELFT will provide transport for more difficult journeys. Based on the transport analysis contained in this paper it is concluded that the Thames location is acceptable.

Patient and Public Involvement and Impact:

The Older Person's Reference Group and the Patient Public Involvement Group (PPi) were consulted. PPI representatives also sit on the Planned Care Core Leadership Group, which was also consulted. Carers of patients at Cedar Lodge are being engaged in the process and if the merger goes ahead, patients will be prepared.

Clinical/practitioner input and engagement:

Dr Waleed Fawzi, Consultant Psychiatrist, Older Person's Clinical Lead (ELFT) Dr Rhiannon England, Mental Health Clinical Lead (CCG)

Impact on / Overlap with Existing Services:

The services form part of a pathway with the short stay dementia ward (Columbia) which is directly above Thames. There is also a transfer to nursing and residential care homes once psychiatric and behavioural symptoms are sufficiently diminished. There is not anticipated increase in referrals onwards to nursing and residential care homes.

Main Report

1.1 Service Change Proposal and Rationale

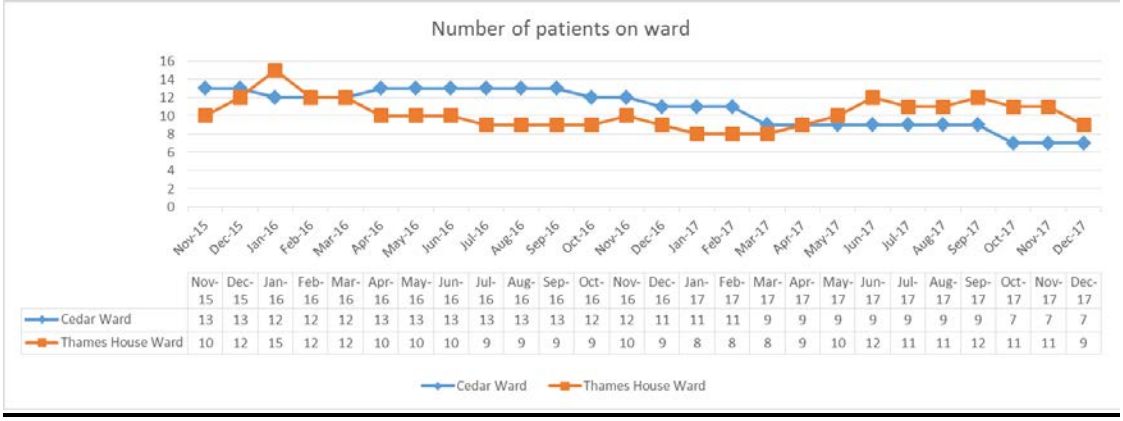
Cedar Lodge is a 13 bed longer term unit for patients with behavioural and psychiatric symptoms of dementia, which are severe enough to warrant a longer term stay in an inpatient healthcare environment. Cedar Lodge had been one of three wards based on The Lodge site in City and Hackney, but following the merger of other wards with wards on the Mile End Hospital site, Cedar Lodge is now isolated from other adult mental health and physical health care units.

The proposal is to close Cedar Lodge, and to use Thames House, at Mile End Hospital in Tower Hamlets, as a shared facility serving The City, Hackney and Tower Hamlets. Thames House is an 18 bed dementia longer term ward, covering the same patient cohort as Cedar Lodge.

As Table 1 illustrates, the occupancy of both Cedar Lodge and Thames House has steadily reduced since November 2015. This has been achieved by reducing delayed discharges through improvements in the discharge system and discharge pathway. The psychiatric ward environment provided by Thames and Cedar is only appropriate for patients with

behavioural and psychiatric symptoms. Once these are no longer present, patients are more appropriately cared for in nursing home, particularly if physical healthcare needs are more predominate and behavioural issues have diminished.

Table 1



As a result of this fall in occupancy, currently both Cedar Lodge and Thames House are significantly under-utilised. It is anticipated that Thames House will have just 5 patients by the end of March when the merger is planned to take place. Similarly, it is expected that there will only be 5 City & Hackney patients who would need to transfer to Thames House, should the merger proceed.

Currently there are 7 patients on Cedar Lodge. Three of these patients have been assessed as now requiring nursing home care and are in the process of being transferred to Mary Secole Nursing Home. It is anticipated that 2 of these patients will have moved to Mary Secole Nursing Home, by the end of March.

Table 2 Anticipated Occupancy & Gender Mix – Thames Ward (March 2018)

Borough	Male	Female	Total
City & Hackney	**3**	**2**	**5**
Tower Hamlets	**2**	**3**	**5**
Total	**5**	**5**	**10**

The table below shows the number of admissions and discharges per annum over the last two years. As can be seen, over the last two years, the rate of discharges has exceeded the rate of admissions leading to a decline in numbers. Furthermore, the rate of admissions per annum across both wards is between 7-10 patients.

Table 3: Admissions and discharges per annum (calendar years).

Cedar Ward	15-16	16-17	Total
Admissions	1	2	3
Discharges	3	9	12
Thames Ward	**15-16**	**16-17**	**Total**
Admissions	6	8	14
Discharges	9	11	20

The average length of stay is currently 3-6 months, however, 25-50% may people need a longer period depending on the case mix on the ward at any one time. The table below models a scenario where only 33.3 % of the occupants of the ward stay up to 6 months, 33.3% stay up to 12 months and 33.3% stay up to 3 years. Notably, for the sake of creating a robust model, we have assumed that the ward's case mix and lengths of stay are on the upper end of what we might typically expect. Nevertheless, the modelling indicates that with its current bed compliment of 18 beds the ward could still take up to 20 admissions in any given year with these lengths of stay. This is more than double the actual rate of admission per annum in the last two years.

Table 4: Capacity Model based on current LOS (ward has capacity for c21 admissions per annum – double the current admission rate)

ALOS	% LOS at any one point in time	No. beds occupied	Capacity for admissions per annum
6 months	33.3%	6	12
12 months	33.3%	6	6
2 years	33.3 %	6	3
Total	100%	18	21

Thames House is a high quality, recently refurbished ward on the Mile End Hospital site, built to support 18 people with longer term mental health needs due to dementia. Thames House is the preferred location for consolidation of older peoples inpatient services because it is the larger of the two wards and has sufficient capacity to accommodate the anticipated demand from both City & Hackney and Tower Hamlets. It is a recently refurbished, dementia friendly ward, with proximity to the other Older Persons Inpatient wards on the Mile End Site as well as direct access to specialist support based at the Tower Hamlets Centre for Mental Health.

Merging the wards would complete the modernisation of Older Adults inpatient services in City and Hackney and Tower Hamlets, which has focused on centralising services on the Mile End site to provide more cost effective, higher quality inpatient care, and improve utilisation of estates.

This proposal would:

- eliminate the current risks related to service isolation of Cedar Ward , namely staff cover and access to rapid response services,

- enhance the utilisation of Thames House at Mile End Hospital, which is currently operating below capacity,
- enable investment to enhance the staffing skill mix at Thames House, improving quality of care and helping to optimise length of stay,
- improve the ward environment for City and Hackney, with Thames House patients providing a larger more recently refurbished ward
- Improve the utilisation of the Trust's estate and enable efficiency savings, which will be re-invested into local City and Hackney mental health services.

The East London NHS Foundation NHS Trust and local Commissioners are committed to ensuring ongoing access to high quality Continuing Care provision. The merger of Cedar Lodge and Thames House is part of this process of improvement. The plan also includes the intention to enhance the clinical capability and capacity of local nursing home providers to provide Continuing Care for Older Adults with Dementia. In the future this will enable continuing care to be provided in a more appropriate, non- hospital setting closer to the patient's family and friends.

In addition, there are plans to improve community care and support for people with dementia and their carers. These plans include improved support for carers, shared care plans and more responsive support in times of crisis. Some of this extra support will be also available within primary care and will further supported by the new primary care neighbourhood model. Finally psychiatric liaison has been expanded to ensure that people with mental health problems, including dementia receive specialist mental health interventions, diagnosis and signposting when they are in an acute hospital.

It has been agreed in the ELFT 2018-18 contract variation that the closure of Cedar Ward will deliver a minimum recurrent savings of £680,000. All to this total will be re-invested into ELFT's City and Hackney mental health services including Older Peoples Mental Health Services. The recurrent savings and investments is registered with NHSE as a City and Hackney CCG QIPP. None of the QIPP will be extracted by ELFT as part of a Cost Improvement Programme (CIP). It has been agreed in the ELFT 207-19 contract that the extracted savings will contribute to the following investments:

- The creation of shared care plans for all people diagnosed with dementia
- The expansion of psychiatric liaison team to ensure that people with mental health problems, including dementia receive specialist mental health interventions, diagnosis and signposting when they are in an acute hospital
- The creation of 24/7 crisis response services capable of visiting people in their own homes.

Pending the decision of this Commission we would be anticipate the move to Thames House being completed by 1st April 2018.

2.0 Care Pathway

Only a small proportion of people with dementia will require longer term inpatient care as part of their individualised care pathway. As discussed, patients are admitted to either Cedar Lodge or Thames House because they have challenging behaviour or care needs, which can only be met in an inpatient setting. As their dementia progresses, often their needs change and become primarily focused on physical health and personal care, which can then

most appropriately met in a nursing home. At that point they would be transferred to an appropriate nursing home

The closure of Cedar Lodge and the move of these continuing care beds to Thames House at Mile End Hospital will mean a change in the location of the continuing care inpatient provision for City and Hackney patients. However, this service change will not have any adverse impacts on the wider healthcare system or on the care pathway for City and Hackney patients with dementia requiring longer term care. Furthermore, it is not anticipated that there will be a change or increase in the number of patients being transferred to the Mary Secole Nursing Home. These decisions will continue to be made as they are currently i.e. on an individual basis, taking into consideration what is the most appropriate care setting and what is in the best interests of the patient.

3.0 Wider Strategy of Nursing and Care Home Input

This proposal sits within a wider strategy of improved support for nursing homes and care homes particularly around challenging behaviour improving the quality of stimulation and activities. The Dementia Alliance has now completed a programme of training to 158 nursing and care homes staff, which included managing challenging behaviour. The programme is now funded on an on-going basis. The Dementia Alliance has also provided Reminiscence Pods (Rem-Pods) for use in nursing homes and care homes and provided training in how to engage patients in reminiscence work using the pods. Following positive feedback on the use of the pods it is planned that the number of pods in circulation around nursing homes care homes and wards such as Thames will be increased.

In 2018-19 the Dementia Alliance will be working closely with the Unplanned Care Board to develop further develop proposals for nursing home support. One option being reviewed at present is In-reach Support to nursing and care homes possibly as part of a wider older person crisis response service. A version of this has been implemented in Newham by the current project manager of the Dementia Alliance. Similar versions of the model being considered are Sutton (community rapid response service), Nottingham (Dementia Outreach team), East and North Hertfordshire (Specialist team at home). The In-reach support has the following aims:

- Provide a comprehensive assessment of mental health needs of older people with dementia in care and nursing homes particularly those with challenging behaviours and or psychological symptoms and formulate person centred plans
- Promote quality of care, access to diagnosis and treatment through early assessment of older people showing signs and symptoms of dementia
- Support, educate and train care homes staff (non-specialist staff) in the management and care of older people with dementia to improve standard of care and wellbeing.
- Work in partnership with primary care services, secondary care and third sector organisations to facilitate care and hospital transfer where admissions were necessary

Costed proposals will be produced by the Alliance in 2018-19 for consideration for implementation in 2019-20.

4.0 Future Demand

As can be seen from table 2 above, following the merger, Thames ward will have a total of 10 patients. In the short term we would expect patient numbers to fluctuate between 8 and 12. Consequently occupancy on the 18 bedded ward will therefore be between 44% and 67%. This leaves plenty of spare capacity, whist ensuring the ward is maintains a viable level of occupancy.

Over the next 10 years the number of people with dementia is expected to increase. The table below is based on figures from the April 2016 City and Hackney JSNA for Mental Health and the Tower Hamlets JSNA for Older Adults. The figures show an estimated increase in the dementia population of City, Hackney and Tower Hamlets of 39% over a 10 year period. If we were to assume that there is a comparable increase in the demand for dementia continuing care from 2018-2028, then this would result in a Thames ward bed usage of 14-16 beds or 78-89% occupancy. In other words, there appears to be sufficient capacity to absorb the demand increase. Furthermore, the joint strategy of Tower Hamlets and City and Hackney CCG is to improve the capability of local nursing and residential care homes to accept patients with behavioural and psychiatric symptoms. Over the next 10 years this will reduce the demand for inpatient beds on Thames Ward creating further spare capacity.

Table 5: Estimated growth in City, Hackney and Tower Hamlets Dementia Populations

Date	Hackney	City of London	Tower Hamlets	Total	% Growth
2015	1238	93	826	2157	0%
2020	1422	139	961	2522	17%
2025	1672	191	1140	3003	39%

5.0 Impact of Changes for City & Hackney Service Users

It is recognised that that the move to Thames ward will be unsettling for the five individual patients, who would transfer to Mile End Hospital, and for their families. In each of these cases the Consultant Psychiatrist and nursing staff, who know and are currently caring for the patients, will work closely with them and their family to re-assess their specific needs, agree individualised transfer plans and prepare them for the move. Family and carers will also be given the opportunity to visit Thames House prior to change taking place.

Accessibility for Family & Carers

The Trust recognises the importance for older people in hospital of being able to be visited regularly by their family and carers. Therefore additional travel assistance will be offered to carers where the journey to Thames ward is significantly more complex than the journey would have been to the Cedar Lodge

How the Transport Assistance Assessment Works

At the time of admission the care co-ordinator will, in collaboration with the carer, determine if the journey to Thames House is significantly more complex than the journey would have been to Cedar Lodge. In coming to this determination the care co-ordinators will take into account:

- Mobility issues.
- Journey time.
- Number of transport changes needed to complete the journey.
- Physical, sensory or mental health problems that make travelling by public transport difficult.
- Personal safety considerations, including travelling after dark.

In situations where a journey is agreed as significantly more complex the care co-coordinator will determine with the carer how the Trust might support the individual to maintain their visiting arrangements to Thames ward. This might include the provision of taxis, payment towards parking costs or provision of hospital transport. The transport arrangements will be reviewed regularly by the ward team and the carer throughout the patients stay.

In general, previous appraisals of travel times from Hackney to Mile End have shown that the potential impact on patient and carer travel time would not be excessive as there are a number of public transport routes. An analysis that was undertaken shows the following differences in average travel times for Hackney residents:

Table 4: Average Travel Times

	Travel time to the Lodge	Travel Time to Mile End
Walking	35 mins	57 mins
Cycling	11 mins	19 mins
Driving	8 mins	13 mins
Public Transport	21 mins	33 mins

The table above refers to average travel times, however it is important to understand the impact on individual journey times. In the table below we have compared the current travel times, by public transport, for the actual carers or family of the patients currently on Cedar Lodge with their travel times to Mile End Hospital. As can be seen, although journey times, for most, increased the average increase in time was 12 minutes. Furthermore, the longest journey time was for a carer who was based out of the borough in Frien Barnet and had long distances to travel anyway.

Table 5 – Comparison of Individual Carers Travel Times

Point of travel	How often they visit	Current travel time	Travel time to Mile End	
Frien Barnet	Some weekends	**1 hour 10 minutes** 4 changes	1 hour 16 minutes 2 changes	6 mins increase – simpler journey
London Fields	Daily	24 minutes 1 bus	34 minutes 2 buses	10 mins increase
Homerton	Daily	13 Minutes Walking	41 minutes 2 buses	28 minutes increase
Shoreditch	Daily	35 minutes 2 changes	34 Minutes 2 changes	1 minute decrease
Stamford Hill	Daily	41 minutes 2 changes	58 minutes 3 changes	17 minutes increase
Victoria Park	Occasionally	18 minutes 1bus	30 minutes 1 bus	12 minutes increase

Notably, since the Dementia Assessment ward moved from Hackney to Columbia Ward in Mile End, none of carers or family from The City or Hackney have taken up the offer of assistance with transport. Furthermore all carers reported that they found the journey times manageable.

Quality Benefits

In terms of the scale, these proposals would see the transfer of 5 patients from a ward in Hackney to a ward in Tower Hamlets. This represents a comparatively small-scale service change.

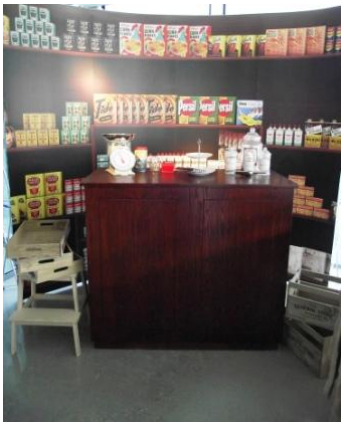
Overall the merger of Cedar Ward and Thames House will deliver a number quality benefits:

- Patients would be accommodated in a dementia-friendly unit, which has recently been refurbished, designed specifically for the older adult population. Further enhancements to the ward environment are also planned including the addition of Reminiscence Pods
- Cedar Lodge is currently the only remaining Older Persons ward on the Lodge site. Consequently there are clinical risks linked to it being isolated from other adult mental health and physical health care units. In contrast, Thames House is co-located with other older persons inpatient and community services on the Mile End Hospital site. The move to Thames House will therefore improve the care delivered to patients by locating highly expert clinicians in a centralised location thereby enhancing the delivery of integrated multi-disciplinary care, and creating a centre of excellence for dementia care.
- Being co-located with other mental health services would enable staff cover at short

notice, and the service would have access to rapid response services, which are located at Tower Hamlets Centre for Mental Health.

- The Mile End site meets the recommendations of the Royal College of Psychiatrists to locate inpatient care on a hospital site delivering physical inpatient healthcare to older people.
- The Mile End site has sufficient space available to provide large bedrooms and high quality day and therapy areas.
- Further environmental enhancements - As mentioned above, the extra space available at Thames makes it possible to introduce Reminiscence Pods. The pods have interactive software including old films, television shows and life stories and they can be designed to meet the needs of people with different cultural backgrounds e.g. the Windrush pods aim to resonate with people from the Caribbean. The Pods have been successfully trialled at Columbia ward, and it is planned to introduce Reminiscence Pods on Thames House as well.

Figure 1: RemPod Images.



6.0 Stakeholder Consultation

6.1 Scrutiny Committee

This proposal was endorsed by both the City of London Overview and Scrutiny Committee in February 2018 and approved by the London Borough of Hackney Oversight and Scrutiny Committees in February 2018.

6.2 OPRG and PPI Consultation

There was a presentation and consultation with the Older Person's Reference Group (OPRG) in January 2018. the CCG's Patient and Public Involvement Committee (PPI) on February 22nd. The OPRG and the PPI highlighted the following issues. The responses from ELFT and the CCG are also set out below.

- **Comment: Transport difficulties giving rise to access issues for visitors, not only in reaching the vicinity of the hospital, but the long walk to the Hospital**

from the nearest bus stops and the long corridors within it.

Response: ELFT undertook a comparison of carer travel times for the patients currently on Cedar ward for the journey by public transport from their homes to Thames Ward. This is contained in this paper and shows an average increase in time of 11 minutes compared to their travel times to Cedar Ward. Furthermore, ELFT have offered to provide transport for carers who experience travel difficulties. Whilst we acknowledge that there has been some increase in travel times we consider the average increase in travel times is not excessive and the arrangements put in place for more difficult journeys to be sufficient. Notably, the change in travel times mirrors that experienced by carers of patients who moved from the wards close to Cedar to Columbia ward, which is just above Thames House. These travel arrangements were also approved at the time by the Scrutiny Committees and since the move no carers found it necessary to request travel assistance from the Trust despite the offer being available. The Mile End Hospital site is 0.4 miles and 8 minutes walk from Stepney Green tube station and 13 minutes and 0.6 miles from Mile End tube station. There are also a number of buses on the Mile End road 6 minutes walk, and Globe Road.

- **Comment: The quality of the environment for patients and visitors: the Hospital in the past has lacked the usual facilities such as a shop to buy essentials, 'comforts' etc, exacerbated by the dearth of shops in the immediate locality. What improvements are still needed to bring it into line with other hospitals locally?**

  Response: Mile End Hospital has tea shop and a canteen open to visitors. In addition, the Mile End Hospital site also has a restaurant and a café. The Mile Hospital is 4 minutes walk from the Mile End Road, which contains a range of shops including a Sainsbury's local selling a range of essentially and food and magazines, which is 6 minutes walk from Mile End Hospital. In addition, the CCG and ELFT are happy to explore any recommendations for improving what is sold on the hospital site with the OPRG and with a view to taking these up with hospital site management.

- **Comment: The adequacy of therapeutic facilities/activities to keep patients occupied and 'engaged'.**

  Response: Thames House is a larger ward and has more space for therapeutic activities than Cedar ward. Furthermore, the merger will lead to a fuller staff compliment and this will improve the provision of therapies and activities for patients. New therapeutic facilities are also planned including the provision of Rem-pods and we are keen to work with the OPRG on how therapeutic facilities and the therapeutic environment might be improved.

- **Comment: The 'questionable' policy of reducing bed capacity for a category of patients amongst whom the incidence of dementia is known to be increasing and projected to increase further.**

  We have considered the impact of the projected increase in dementia on ward capacity. Based on projections contained in the JSNAs covering City and Hackney and Tower Hamlets we have assumed a 40% increase up until 2025. Our capacity planning shows that Thames House has the spare capacity to cope with this increase. However, in addition, both City and Hackney and Tower Hamlets will be pursuing a strategy of improving and increasing support to nursing and care homes for challenging behaviour. This will exert a downward pressure on demand.

- **Comment: The concern that 'savings' may not be redirected into improved care for dementia patients in the community but diverted to other purposes to meet efficiency targets, forfeiting the opportunity to bolster community-based social care provision under integrated commissioning.**
  As stated in our paper the savings attributable to City and Hackney in the merger will all be re-invested in local City and Hackney mental health services. This includes new investment in older people's services and community based mental health services.

The OPRG and PPI also requested a ward visit and engagement with the design of the ward environment. A visit for the OPRG and PPI representatives has been arranged for 9th March to both Cedar Ward and Thames Ward. Following this it is planned that there will be further engagement from both groups in the ward environment over aspects such as art work, signage, library, therapeutic facilities e.g. Rem-pods and so forth.

6.3 Planned Care Core Leadership Group

The proposal was presented to the Planned Care Core Leadership Group on 27.2.18. The Board raised similar issues to the PPI committee and OPRG. In addition the Planned Care Board asked about the wider strategy towards dementia care. The strategy of greater support for care homes and nursing homes, as set out in this paper was described. The Planned Care Board also asked about the reason for the fall in bed occupancy. In response reference was made to the statement within this paper that this has been principally caused by not keeping on Cedar ward if they no longer have psychiatric or behavioural issues. The Planned Care Core Leadership Group endorsed this proposal.

6.4 The Transformation Board

The proposal was present to the City and Hackney Health and Social Care Transformation Board on 9.3.18. The Board recommended that the ICB approve the proposal provided the proposal also contained a record of the questions and concerns raised at the Board meeting and the response. The record is as follows:

Comment: The Planned Care Core Leadership Group did not fully endorse the proposal.
Response: Whilst it is acknowledged that not all members were support the Core Leadership Group as a whole did endorse the proposal as recorded in the minutes of the meeting.

Comment: The consultation has not been through enough and there are still issues that need to be addressed.
Response: All the issues addressed during the consultation process have been responded to. A record of the issues raised and the responses is included in this

document. We will leave it up to the Transformation Board, ICB and CCG Governing Body to determine whether those responses are sufficient.

Comment: This meets short term need but there is a need for long term planning also in terms of funding things need to be sorted.
Response: The paper contains planning projections up until the period 2025 which indicate that there is sufficient spare capacity on the merged ward to copied with the projected increase in demand due to the demographic growth in dementia. These projections are based on JSNA estimates for the City of London, Tower Hamlets and Hackney.

Comment: From a Planned Care point of view, we would want to focus on the longer term strategy as part of the pooling proposals on CHC etc. The Question is when can we produce some assurance on this as this is perceived as a slight loss of service.
Response: There is no loss of service. Patients on Cedar ward will be transferred over to Thames House. There is more than enough capacity to continue to take patients from both boroughs in the merged ward. In terms of the longer term strategy, as the paper states, we are committed to improving the capacity and capability of nursing and residential homes to cope with psychiatric symptoms of dementia and challenging behaviour. The dementia alliance has already trained 158 nursing and care home staff in coping with challenging behaviour. Plans to build on this work are set out in this document in Section 3.

Comment: we need to make sure that if people are out of the borough we do not lose sight of them.
Response: this is agreed. The provider ELFT covers both boroughs and we share robust reporting mechanisms with Tower Hamlets in joint meetings with ELFT. Reporting has worked well for City and Hackney patients who merged with Columbia Ward in Tower Hamlets.

7. Future Plans for Cedar Lodge

The two already vacated wards on the Lodge site have been developed into Vivienne Cohen House, a base for the Specialist Psychotherapy Service and the North Hackney Recovery Team.

Various options are currently being explored for the re- use of Cedar Lodge. These include:

- The option of Cedar Ward being utilised as a base for providing Intermediate Care Beds for Hackney
- Providing a new Team Base for City & Hackney CAMHS
- Providing a new Team Base for additional Adult Mental Health Community Services covering City & Hackney – this would create, with those services already in the adjacent Vivienne Cohen House a community hub for Adult

8. Conclusion and Recommendations

- The proposal to merge Cedar Lodge with Thames Ward, at Mile End Hospital delivers more cost effective, safer, higher quality inpatient care, and improves utilisation of estates.
- Thames Ward is a purpose built Older Person's ward with sufficient capacity to meet the future requirements to provide inpatient continuing health care needs due to dementia for Older People from Tower Hamlets, Hackney and The City .
- Family and carers of City and Hackney residents in Thames Ward will be able to access assistance to enable them to regularly visit the ward in Mile End.

The ICB is therefore asked to support this proposal.

Sign-off:

London Borough of Hackney _____Anne Canning, Group Director of Children, Adults & Community Health

City of London Corporation _____Simon Cribbens, Assistant Director or Commissioning & Partnerships

City & Hackney CCG _____ David Maher, Acting Managing Director

Title:	**Proposals for Mental Health Recurrent Funding (18/19 – Mental Health Investment Standard)** 1) Primary Care Step-down ADHD (CYP Workstream) 2) VSO IAPT (Planned Care Workstream) 3) SMI Physical Health Checks (Prevention Workstream)
Date:	12th March 2018
Lead Officer:	Dr Rhiannon England (MH Clinical Lead) Dan Burningham (Mental Health Programme Director)
Author(s):	Dan Burningham (Mental Health Programme Director) Greg Condon, Mental Health Programme Manager
Committee(s):	**1. Primary Care Step-down ADHD, ASD Increase demand management** City and Hackney CAMHS Alliance (approved) CYP Integrated Commissioning Workstream (approved) **2. VSO IAPT** City and Hackney Psychological Therapies Alliance (approved) Planned Care Integrated Commissioning Workstream (approved) **3. SMI Physical Health Checks** Primary Care Mental Health Alliance (GP Confederation, ELFT, CEG, Family Action CCG) (approved). Prevention Workstream Directors (directors only review approved) **4. City and Hackney Health and Social Care Transformation Board** (approved)
Public / Non-public	Public

Executive Summary:

This paper present three recurrent funding proposals for 2018-19 to help the achievement of NHSE 5YFV targets. All proposals can be funded within the 2018-19budget allocation, which ensures the CCG achieves the NHSE's Mental Health Investment Standard. Each proposal also embodies principles of integrative care had workstream consultation and extensive consultation within the alliances.

1. Primary Care Step-down ADHD, ASD Increase demand management
Workstream: CYP
Staffing: Primary Care Liaison ADHD Specialist Nurse – Band 7
Cost: £67,000
Contract: with CAMHS Alliance
Providers: East London NHS Foundation Trust

There is currently a caseload of approximately **200** young people with a diagnosis of ADHD in treatment. This falls about 50% below our prevalence estimates for ADHD of 3.6% for boys and 0.9% for girls (source: Holder SE et al, 2013/AADD UK website 2018), highlighting a significant identification and treatment gap for this cohort of vulnerable young people. The fact that demand outstrips supply is also evident from the waiting list, which is 115. To cover the gap in demand and reduce waiting time we propose adding 1 WTE additional resource to this service. There also is a strong case for improving the early identification of new cases by increasing the capacity of Specialist CAMHS to improve early identification in primary care, assess and manage new cases and allow for the flow of stable cases out of specialist services, with easy step-up when required.

In line with 'Future in Mind' (Department of Health and NHS England) and the Five Year Forward View for Mental Health, the proposal will improve access to assessment, effective support and treatment we propose to review structures and facilitate closer working with colleagues in primary care.

The investment proposal has four strands which are interlinked:

Strand 1: Primary Care Liaison CAMHS ADHD Nurse (Band 7/8A) with discharge back to GP for stable cases (1 WTE)

- Step Down Stable Cases
- Step Up Concerning Cases
- Improve identification of new cases
- Expansion within Neurodevelopmental Pathway
- Parenting Group jointly with Tier 2 CAMHS

Strand 2: Move to Annual Reviews within CAMHS for more complex cases
Strand 3: Parent Support Groups
Strand 4: Strategy for Early Identification of Cases

2. VSO IAPT
Workstream: Planned Care
Staffing: 3WTE low intensity therapists
Cost: £131,880
Contract: with Psychological Therapies Alliance
Providers: Bikur Cholim, Derman and Mind

The VSO IAPT providers (Mind, Bikur Cholim and Derman) are currently funded to provide high intensity IAPT but not low intensity IAPT. They currently achieve excellent recovery rates and waiting times. Funding low intensity IAPT would:

- Help achieve the NHSE 5YFV IAPT access rate target
- Increase access rates to BME groups
- Enable the VSO to operate a stepped model of care in line with IAPT guidance.

3. SMI Physical Health Checks
Workstream: Prevention
Staffing: 2 HCAs

Cost: £97,000
Contract: with Psychological Therapies Alliance
Provider: ELFT
People with a serious mental illness (SMI) have poorer physical health than the general population and die on average 15 years earlier than those without. In response NHSE has

FYFV set targets for monitoring the % of the SMI population, who receive a physical health check.

It has been found to be more efficient and effective for patients who are seen regularly in secondary care mental to have their physical health check in secondary care. This effectively brings together someone's mental health and physical healthcare in one place.

To address the issues listed above and help reduce the inequality in physical health between SMI and the general population and ensure full compliance with NHSE's targets for physical health checks it is proposed that Health Care Assistants are employed, who work across primary and secondary care.

Total proposed recurrent investment from all proposals: £295,880

Comments from the Transformation Board

A concern was raised that GPs should be recompensed for Physical Health checks and it was confirmed that this would be the case. It was queried whether having specialist mental health HCAs rather than generic HCAs would make care less integrated. In response the Board was informed that the HCAs are focusing on patients in secondary care mental health who may not be reached by primary care but who still need a physical health check under NHSE FYFV plans. It was noted that the scheme is highly innovative. The proposals were endorsed by the Transformation Board.

Recommendations:

The City Integrated Commissioning Board is asked to:

- **NOTE** all Recurrent Investments – to meet 18/19 Mental Health Investment Standard
- **ENDORSE** and **RECOMMEND** the Primary Care Step Down ADHD Service (CYP Workstream)
- **ENDORSE** and **RECOMMEND** the VSO IAPT Service (Planned Care Workstream)
- **ENDORSE** and **RECOMMEND** the SMI Secondary Care Physical Health Checks (Primary Care MH Alliance/Unplanned Care)

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Links to Key Priorities:

ADHD

1. NHSE FYFV Target to increase CYP IAPT access to 35%

IAPT VSO

2. NHSE FYFV Target to increase IAPT access to 25%
3. Local and National targets to improve BME access to IAPT therapies
4. NHS FYFV targets for 50% of people with SMI to have a physical health check

Specific implications for City

None

Specific implications for Hackney

None

Patient and Public Involvement and Impact:

Service user and public representatives sit on the Planned Care and CYP Core Leadership Group respectively.

Clinical/practitioner input and engagement:

Dr Rhiannon England, Clinical Lead MH (CCG)
Dr Jenny Parker, (Consultant Child & Adolescent Psychiatrist - ELFT)
Dr Julie Proctor, (Consultant Clinical Psychologist – ELFT)
Dr Mosun Dorgu, (Consultant Child & Adolescent Psychiatrist –ELFT)

Impact on / Overlap with Existing Services:

1. ADHD
The service will offload existing Tier diagnosis services to enable primary care to manage the on-going treatment of cases. Greater capacity in Tier 3 will allow improvements in identification and access thus reducing impact on Tier 3 services later owing to increasing complexity of cases.

2.VSO IAPT
The service will extend existing VSO IAPT provision into low intensity therapies. At present only high intensity therapy is provided.

3.SMI Physical Healthcheck
These are completed largely by HCAs, practice nurses and GPs in GP practices. These additional HCAs will complement the existing workforce.

Main Report

(Please note, the main report is divided in to three sections for each strand requiring approval)

SECTION 1: CAMHS Primary Care Step Down - ADHD

1.1 Background

Attention Deficit Hyperactivity Disorder (ADHD) is a behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. Recent follow-up studies of children with ADHD show that ADHD persists from childhood to adolescence in 50%–80% of cases, and into adulthood in 35%–65% of cases (Owens 2015).

Outcome research shows that boys with ADHD experience significantly more impairment in psychosocial, educational and neuropsychological functioning when compared with those without ADHD (Biederman 2012). Girls with ADHD have significantly higher risks for antisocial disorders, major depression and anxiety disorders as adults when compared to girls without ADHD (Biederman 2010), as well as higher rates of attempted suicides (22% vs 6%, Hinshaw 2012). Children with comorbid ADHD and conduct disorder engage in more delinquency behaviours than their peers. Such children may grow up to be at high risk for criminal activity and further psychopathology (Lichtenstein, NEJM, 2012)

Outcomes for children treated for ADHD are significantly better when compared to untreated ADHD. In a systematic review (Shaw 2012), outcomes from 351 studies were grouped into 9 major categories: academic, antisocial behavior, driving, non-medicinal drug use/addictive behavior, obesity, occupation, services use, self-esteem, and social function outcomes. Without treatment, those with ADHD had poorer long-term outcomes in all categories compared with people without ADHD, and treatment for ADHD improved long-term outcomes compared with untreated ADHD, although not usually to normal levels.

Further to this, the case for specific parenting intervention and treatment is highlighted for ADHD children who are punished physically as they are significantly more likely to display severe ADHD/conduct disorder symptoms in adolescence. In addition, children reared by mothers who had emotional problems or were substance abusers are at significant risk for severe symptomology in adolescence (Morgan 2015).

Local Demographic Change

City & Hackney has a growing population with an estimated 15% increase in population since 2011. Based on the narrower criteria of ICD-10, Hyperkinetic Disorder is estimated to occur in about 1–2% of children and young people in the UK. Using the broader criteria of DSM-IV, ADHD is thought to affect 3.6% for boys and 0.9% for girls (source: Holder SE et al, 2013/AADD UK website 2018),

Estimates for current prevalence in City and Hackney (0-16years – population 76,600 - 2016) of ADHD (6%) and Hyperkinetic Disorder (1.5%)

- ADHD (6%) – 1,724

- HK (1.5%) – 1,149

There is currently a caseload of approximately **200** young people with a diagnosis of ADHD in treatment. This falls far below prevalence estimates, highlighting a significant identification and treatment gap for this cohort of vulnerable young people.

1.2 City and Hackney Current Provision for ADHD

ELFT Specialist CAMHS provides the diagnostic assessment and treatment for ADHD in City and Hackney in both the Neurodevelopmental Pathway and to a smaller extent in the CAMHS Disability service. A Consultant Child and Adolescent Psychiatry led multidisciplinary assessment Specialist CAMHS service is required for diagnosing ADHD in children and young people.

NICE guidance treatment for ADHD recommends psychological, parenting, medication or combination of same. Many families have attended Specialist CAMHS for 10+ years from time of diagnosis and initiation of medical treatment to discharge/transition from CAMHS at 18 years. Some families who decline treatment following assessment are discharged from the service and can attend ADHD parent drop in sessions. Maintenance of medication for stable cases does not require ongoing management by a Specialist ADHD CAMHS service.

There is a strong case for improving the early identification of new cases by increasing the capacity of Specialist CAMHS to improve early identification in primary care, assess and manage new cases and allow for the flow of stable cases out of specialist services, with easy step-up when required.

1.3 Shared care guidelines

Drug treatment of ADHD should only be initiated by an appropriately qualified healthcare professional with expertise in ADHD and should be based on a comprehensive assessment and diagnosis. Drug treatment is not indicated in all patients with this syndrome and the decision to use the drug must be based on a thorough assessment of the severity of the symptoms.

Within East London NHS Foundation Trust (ELFT), initiation of drug treatment for ADHD is in accordance with current NICE guidance.

1.4 Assessment

- All young people meeting the referral criteria will be given a full and comprehensive assessment by the multi-disciplinary team, including a child and adolescent psychiatrist or paediatrician. An assessment report will be sent to the GP.
- Once diagnosed with ADHD, there will be a discussion with the patient and their family or carers about treatment options, including medication. Treatment aims, available options, medication and alternative/additional interventions, side effects and the monitoring protocol will be discussed.
- The possibility of stopping medication and reasons should also be discussed.

1.5 Physical Screen

- The CAMHS team will undertake a baseline physical examination of any young person before commencing medication. This will include measurement of height, weight, pulse,

blood pressure and heart sounds. A more thorough physical examination may be required in some young people, particularly if there is a medical or family history of serious cardiac disease, a history of sudden death in young family members, or abnormal findings on cardiac examination.

- For those young people up to 16 years of age requiring a more thorough cardiac assessment (which may require ECG measurement and interpretation), a referral will be made to the Paediatric department at the local acute Trust.
- Routine blood tests and ECGs are not routinely recommended unless there is a clinical indication.
- If there are concerns regarding the young person's physical health,
- a referral to the GP or paediatrician for further assessment may be considered.

1.6 Medication Treatment

For new patients commencing drug treatment, medication should be initiated by the CAMHS doctor. Unless contraindicated, methylphenidate should be the first line of drug treatment; atomoxetine, dexamfetamine or lisdexamfetamine are alternatives.

Doses used should be in accordance with the current edition of the BNF and relevant NICE guidance, and any interactions, cautions and contraindications should be taken into account. During the titration phase, doses are gradually increased until there is no further clinical improvement in ADHD (that is, symptom reduction, behaviour change, improvements in education and/or relationships) and side effects are tolerable.

Once the dose is stabilised, usually within 1 month of commencing treatment, the CAMHS psychiatrist will contact the patient's GP and request that the prescription of the treatment is continued under a formal shared care arrangement. The CAMHS team will prescribe ADHD treatment until the GP starts providing repeat prescriptions.

Symptoms and side effects should be recorded at each dose change on standard scales (for example, Conners' 10-item scale) by parents and teachers, and progress reviewed regularly. Treatment should generally be continued for as long as it is effective, and **should be reviewed at least annually**. The symptoms of hyperactivity may diminish during the course of adolescence, though patients may continue to complain of impulsivity and inattention. It is common to tail off treatment as the young person completes their schooling. This should be done gradually to avoid rebound effects. However, in some cases, patients may require continuing medication into adulthood and transfer of care to adult services should be arranged.

1.7 Shared Care Model

The intention of shared care should be explained to the patient/carer and be accepted by them prior to commencement of shared care. Patients are under regular follow-up and this provides an opportunity to discuss drug therapy. Intrinsic in the shared care agreement is that the prescribing doctor should be appropriately supported by a system of communication and cooperation in the management of patients. The doctor who prescribes the medicine has the clinical responsibility for the drug and the consequence of its use.

<u>Consultant</u>

1. Initiate treatment and prescribe until is stable, usually 1 month or longer if

appropriate.

2. Ensure that patient/carers understand their treatment regimen and any monitoring or follow up that is required (using advocacy if appropriate).
3. Once patient is stabilised on therapy, requested shared care with GP.
4. Clinical supervision of the patient by routine clinic follow-up on a regular basis.
5. Send a letter to the GP after each clinic attendance ensuring current dose is stated. Inform GP of any changes to the prescription in writing and otherwise inform GP of the young person's progress on a **minimum 6 monthly basis**.
6. Evaluate any reported adverse effects by GP or patient.
7. Inform GP of patients who do not attend clinic appointments.
8. Inform GP, by letter, of clinic visits and action taken for management of patient.
9. Ensure that backup advice is available for patient and GP at all times.
10. Advise the GP of which specialist will provide future monitoring of the patient, should they need to continue treatment once they reach adulthood.
11. Inform and decide with GP any action if patient has not been reviewed within 6 months of the last appointment. This may include the decision to continue treatment as before.

General Practitioner

1. All young people who present with characteristic symptoms of ADHD should be referred for an assessment.
2. Treatment for ADHD would need to be initiated by the specialist.
3. Young people diagnosed outside of the borough and already taking medication should be referred for reassessment and ongoing monitoring. The GP should continue to prescribe in the intervening period unless this is contraindicated. If any adverse effects or contraindications are identified, this should be communicated to the CAMHS Consultant Psychiatrist.
4. Upon acceptance of shared care request from CAMHS, provide the patient with prescriptions of the stated medication in line with the specialist's recommendation.
5. If the GP has a specific concern about prescribing for a particular patient under this Shared Care Protocol, they should discuss this with the CAMHS Consultant Psychiatrist.
6. Methylphenidate, dexamfetamine and lisdexamfetamine are Schedule 2 Controlled Drugs and prescriptions must be issued on a monthly basis. Medications requests for longer than a month (e.g. covering patient holidays) should be discussed with CAMHS team and can be issued at the prescriber's discretion.
7. Requests for an alteration in the regular dosage should be referred back to the CAMHS team.
8. Report and discuss with CAMHS consultant any adverse effects of medication, possible drug interactions, changes to the patient's medication regimen, deteriorating behaviour, or relevant medical information including any test results.

CCG

1. To provide feedback to trusts via Trust Medicines Committee.
2. To support GPs to make the decision whether or not to accept clinical responsibility for prescribing.

3. To support trusts in resolving issues that may arise as a result of shared care.

Patient/Carer

1. Ensure they have a clear understanding of their treatment.
2. Report any adverse effects to their GP or specialist.
3. Report any changes in symptoms to the GP or specialist. ‘

See Appendix 1 for flowchart of current ADHD shared care protocol

Issues and Resources at Specialist CAMHS

- Active ADHD Cases: approximately 200
- ADHD assessments: approx. 10-12 per month

Current Treatment offered

1. Medication reviews – 6 monthly or more often for initiation and where needed. Initiation often requires 4 or more reviews to titrate to the correct dose. This is repeated for each new medication trialled if first line is not successful.
2. ADHD management parenting group: planned to started again in December 2017 as new Psychologist and Nurse Prescriber in post
3. Therapeutic interventions when needed, such as family therapy or psychology sessions

Table 1: Number of sessions of each clinician in the ADHD team

Prescriber	Sessions
Consultant 1	4
Consultant 2	2 (for co-morbid ASD cases)
Clinical Nurse Specialist	8
Specialist doctor	4
FY2	4
Non-prescriber	
Clinical psychologist	4
Family therapist	2
FY1	4

Issues in the ADHD Clinic

- High volume of referrals to pathway
- Quality of information in referrals from primary care limited by constraints within primary care (i.e. information on school functioning)
- Large amount of time spent screening referrals for suitability for further assessment/ADHD pathway
- Delay in cases moving through assessment clinics due to demand
- Difficult to achieve on-time 6 monthly reviews due to capacity issues (Consultant time)
- No ability to move on/step down stable cases from tier 3 specialist input
- Increasing demand for behavioural management / parenting support as appropriate

(NICE guidelines)

- Families with children with ADHD excluded from tier 2 parenting courses in the borough

1.8 Proposal

Aims

- **To improve the capacity of Specialist CAMHS to improve early identification and treatment of ADHD**
- **To reduce the negative impact of untreated and late treated ADHD on children and young people and their families in City and Hackney**

The increasing recognition of ADHD symptoms across health and education services and potential benefits of treatment are positive for early intervention, promoting resilience in families and preventing further mental health conditions that can be secondary to ADHD such as mood disorders and conduct disorder. There are clear issues with demand and capacity within ADHD services in City & Hackney. Currently the numbers of young people actively accessing treatment for ADHD / Hyperkinetic Disorder falls far below prevalence estimates, highlighting a significant treatment gap for this cohort of vulnerable young people.

In line with 'Future in Mind' (Department of Health and NHS England), to improve access to assessment, effective support and treatment we propose to review structures and facilitate better working between colleagues in primary care and the service.

ELFT have completed a QI project for Autism Spectrum Disorder post-care in City and Hackney that has resulted in highly regarded and effective post-diagnostic support for families. ELFT have currently undertaking a QI Project on demand and capacity for ADHD assessment and treatment and initial results suggest demand is 127% of capacity within the service.

Overall the current proposal is to improve awareness and understanding of ADHD across services in primary care, moving away from tiered services and encouraging timely access to clinically effective care. Simplifying structures is likely to offer easier access to support for families. Increase in capacity will allow specialist services to offer more assessment, but also to improve the post-diagnosis care offer.

The proposals below are interlinked, with the improvements speculated achievable when all proposals are adopted together.

1) Primary Care Liaison CAMHS ADHD Nurse (Band 7/8A) with discharge back to GP for stable cases (1 WTE)

- **Step Down Stable Cases**

This service would operate as a seamless shared care model across CAMHS and primary care for children and young people with a diagnosis of ADHD up to their 18th birthday.

The post-holder would work with cases of children and young people whose mental health has been stable with medication for ADHD over the previous 6 months and can be safely

and appropriately treated by their GP with support from a CAMHS specialist practitioner. The post-holder would work closely with multidisciplinary colleagues at Specialist CAMHS to identify cases suitable for transfer to Primary Care and facilitate transition to primary care. Within the first year the post-holder can facilitate and attend regular meetings with the family and their GP who would provide ongoing medication prescription. The children and young people would be transferred to primary care with the GP being responsible medically; to ensure 3 monthly physical health monitoring recommendations are met as per NICE guidelines, e.g. with a practice nurse.

The post-holder would attend some practice meetings (frequency to be agreed with each practice and dependant on need and number of children with ADHD managed) in order to build relationships with colleagues in primary care and to be able to provide advice and training relevant to ADHD care.

The aim of the service would be to work with children, young people and their carers for up to 1 year before being fully transferred to the care of the GP only and this would be made clear on introduction to the service. It is anticipated that some children and young people may need to remain with the service for an additional 1 year before full transfer to GP only. Following the transfer of each case to primary care, the Primary Care Liaison Nurse would be expected to record on EMIS. Access to and training in relation to EMIS would be organised by the primary care team.

- **Step Up Concerning Cases**

The post-holder will provide consultation to GP on individual cases where there are queries about care/management. The post-holder will join GP's in consultation where appropriate and/or offer a direct appointment in primary care. In the event of increased need, deterioration in mental state or crisis then a re-referral to Specialist CAMHS can be made by the GP following consultation with the post-holder and, where appropriate, facilitated by the post-holder. Cases will not need to be re-assessed and can be directly allocated to the appropriate pathway. Following recovery or resolution of crisis, the child/young person could be re-allocated to the Primary Care Liaison Nurse.

- **Improve identification of new cases**

The post-holder will provide consultation to primary care colleagues about cases whom they consider to be at risk of ADHD. The post-holder can facilitate screening for possible ADHD and onward referral for further assessment when appropriate. An important aspect of this early identification will include training for colleagues in primary care and in schools via CAMHS alliance schools project.

- **Expansion within Neurodevelopmental Pathway**

Once established for ADHD cases the same pathway would be suitable for other young people within the Neurodevelopmental Pathway who are also stable, but remain on medication such as Melatonin for sleep disturbance, or low dose SSRI for anxiety in ASD.

- **Parenting Group jointly with Tier 2 CAMHS**

To enhance compliance with NICE guidelines and improve access to appropriate treatment. The Primary Care Liaison Nurse could jointly run some Parenting Group sessions with Tier 2 services (parents of children with ADHD are currently excluded from such parenting groups

in the borough.

The post would be suitable for a nurse with significant CAMHS experience and preferably with a Nurse Prescriber qualification. It is proposed that the post would be graded at Band 7/ Band 8a with Band 8a available to a Nurse Prescriber. If the successful candidate is not a Nurse Prescriber then they would be able to apply for regarding at Band 8a on completion of Nurse Prescriber training which they would be expected to complete at the earliest opportunity.

2) Move to Annual Reviews within CAMHS for more complex cases

For young people whose treatment with ADHD medication is more complex (such as co-occurring with another mental health condition such as Autism Spectrum Condition) then review of medication treatment with a Specialist could be completed annually rather than the current arrangement of every 6 months. Annual review would include review of treatment effectiveness/efficacy as per NICE guidelines, physical checks (height, weight, BP and Pulse) and any other liaison or investigation as is appropriate. Interim physical reviews should be completed within primary care. Families and stakeholders, including primary care, could ask for an earlier review where necessary.

3) Parent Support Groups

Where more clinical time is made available by reduction in frequency of reviews or discharge back to GP care then the provision of regular drop-in parent support and psycho-education groups may be possible. A similar format run in City & Hackney CAMHS for ASD Pathway is very successful and provides a containing, safe space for parents to access support and advice. This also usefully serves as contact point to identify families and young people who may need more intensive treatment or brief work. Parents feel that they have direct access to CAMHS as and when needed. GPs have also reported that they can helpfully signpost families to these 'drop-ins' when in need or crisis.

4) Strategy for Early Identification of Cases

The National Survey of Children's Health (NSCH) 2003–2011 (USA data) highlighted the average age of current ADHD diagnosis was 6.2 years:

- "Mild" ADHD diagnosed at 7 years,
- "Moderate" ADHD diagnosed at 6.1 years
- "Severe" ADHD diagnosed at 4.4 years

With the above proposals it is envisaged that some Consultant time would be freed (by reduction of reviews and step down of cases), this would be used to enhance strategy for identifying cases at the earliest point possible. This could involve a strategy group to include tier 2 CAMHS partners, Paediatrics, Primary Care and Schools.

1.9 Outcomes

NICE guidance for the management of ADHD states that monitoring *"should be reviewed by the healthcare professional responsible for treatment".* Therefore, it does not specify that needs to be done by specialist/CAMHS services. This would suggest the possibility of children and young people with a diagnosis of ADHD and on stable medication being able to be fully transferred to the care of the patient's GP for continuing monitoring of physical

health.
The British National Formulary makes reference to the prescription of controlled drugs in children and young people and we have been unable to find any specific requirement that they need to be under specialist care.

In addition, NICE guidance (please see the link attached for further information: https://www.nice.org.uk/guidance/cg72/chapter/recommendations#how-to-use-drugs-for-the-treatment-of-adhd) states:

1.*5.3.2 Drug treatment should only be initiated by an appropriately qualified healthcare professional with expertise in ADHD and should be based on a comprehensive assessment and diagnosis. Continued prescribing and monitoring of drug therapy may be performed by general practitioners, under shared care arrangements [4]. [2008]*
In the monitoring section, *1.8.4 Monitoring side effects and the potential for misuse in children, young people and adults*. It only mentions "healthcare professionals" without being specific to specialist care. Please see example below within this section:
1.8.4.1 Healthcare professionals should consider using standard symptom and side effect rating scales throughout the course of treatment as an adjunct to clinical assessment for people with ADHD. [2008]
1.8.1.4 Following titration and dose stabilisation, prescribing and monitoring should be carried out under locally agreed shared care arrangements with primary care. [2008]

Furthermore, there is another link from NICE guidance https://www.nice.org.uk/guidance/ta98; which includes: *Treatment with methylphenidate, atomoxetine or dexamfetamine should only be started after a specialist who is an expert in ADHD has thoroughly assessed the child or adolescent and confirmed the diagnosis. Once treatment has been started it can be continued and monitored by a GP.*

Therefore, based on the information below we do not think that children under controlled drugs need to be under specialist care for ongoing treatment and monitoring and can be under healthcare professional care. However, diagnosis and titration of medication needs to be started by a specialist. Enhanced screening in primary care in conjunction with PCLP will aid identification of cases earlier. Training and consultation with GPs will raise awareness of ADHD and reduce hurdles of information barriers and access to further assessment. Shifting capacity from routine reviews of stable clients to providing a wider range of support and intervention could positively impact on outcomes and patient & family experience. Families' value input from CAMHS when they need it, rather than attending routine appointments which are often not attended.

1.10 Proposed Pathway for transfer to Primary Care

- Post-holder to work jointly with Neurodevelopmental team members to identify in the ADHD pathway those children and young people with ADHD medication with stable symptoms under control
- Care Coordinator to liaise with Primary Care Liaison Nurse who will support the discharge from Specialist CAMHS to GP;
    - meet with the family prior to transfer of care
    - case closure at CAMHS
    - meet jointly with GP or Practice Nurse within 3 months of transfer care

  - meet jointly with GP at 6 months post transfer care to primary care
  - primary care service to review physical health at 9 months
  - optional 4th meeting jointly with GP at 1 year (on request of GP or family or mutually agreed)
- Primary Care Liaison Nurse to support GP for physical examination according to NICE guidelines; facilitate appointment, training for GP and primary care practice nurse
- GP to continue repeat prescription (this is already in place at present)
- If crisis/deterioration, Primary Care Liaison Nurse to support GP/primary care staff and provide other strategies (e.g., liaison with school, social services, other agencies, consider medication changes).
- If crisis/deterioration still present, Primary Care Liaison Nurse to discuss case in Specialist CAMHS MDT ADHD meeting re further strategies to put on place
- If crisis/deterioration still not under control after implementing further strategies, to re referred back to Specialist CAMHS
- Open case to Specialist CAMHS
- Case will be directly allocated to ADHD team
- If no crisis/deterioration, case will remain under GP care with Primary Care Liaison Nurse providing support as and when requested

1.11 Pathway for referral from Primary Care of suspected cases of ADHD

- Primary Care Liaison Nurse to offer consultation to GP re concerns
- Primary Care Liaison Nurse to consider joining GP appointment with the family
- Primary Care Liaison Nurse to complete screening for ADHD where appropriate and have consent from relevant family members to do so
- Where screening highlights possible ADHD, then Primary Care Liaison Nurse to facilitate referral to Specialist CAMHS for further assessment, direct to Neurodevelopmental pathway
- Where screening highlights possible mental health difficulties, then Primary Care Liaison Nurse to facilitate referral to the appropriate CAMHS service
- Outcome of screening to be feedback by Primary Care Liaison Nurse to GP and family
- Primary Care Liaison Nurse can provide sign posting advice to other services for GP where appropriate and where within limits of expertise and knowledge.

1.12 Finance / Staffing

Primary Care Liaison ADHD Specialist Nurse – Band 7
(Cost: £67,000)

Re-defining the shared care model with GP's and shifting capacity within specialist CAMHS from 6th monthly to annual reviews would increase demand for routine physical check-ups within GP surgeries by one visit per year for children retained within Specialist CAMHS.

1.13 Reference

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SECTION 2: Low Intensity VSO IAPT

2.1 Background

The Mental Health Five Year Forward View sets out an ambitious target to increase IAPT access to 25%.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21

At least 25% of people with common MH conditions access psychological therapies each year.	15.8%	16.8%	19%	22%	25%

In order to meet NHSE's targets and to ensure access from BME and other hard to reach communities we have commissioned Voluntary Sector Organisations (VS0s) to become IAPT providers. Three VSOs were commissioned by City and Hackney CCG to provide high intensity IAPT treatments as follows:

- Derman, to provide IAPT services for the Turkish and Kurdish communities – 1 WTE high intensity therapist.
- Bikur Cholim to provide IAPT services to the Orthodox Jewish community - 1 WTE high intensity therapist.
- Mind, who have good access rates from Black African and Black Caribbean and other hard to reach communities such as socially and economically disadvantaged residents were commissioned to provide IAPT - 1 WTE high intensity therapist.

As a result access to high intensity IAPT treatments for BME has increased and all three providers are achieving NHSE IAPT targets for waiting times and recovery rates. Notably recovery rates in the Turkish and Kurdish communities

2.1 Investment Proposal

Based on the successful implementation of high intensity IAPT interventions it is proposed that the services are expanded to include low intensity work. This will ensure that services comply with the stepped care model that is a cornerstone of IAPT service delivery and it will also help City and Hackney achieve its IAPT targets and will further improve access from BME and other hard to reach communities.

The IAPT stepped care model works on the following principles:

- Step 1: self-help, information giving
- Step 2: guided self -help/low intensity work with a trained low intensity worker 6-10 sessions
- Step 3: high intensity IAPT typically 1-1 work with a qualified therapist 8-12 sessions

The advantage of the Stepped Care model is that people, who need additional work can move up a step and that those, who need lower levels of support, do not consume more expensive high intensity support. The CCG has already commissioned Step 3 and would be well advised to commission Step 2 which produces higher access rates and higher recovery rates for a lower level of investment.

2.3 Costs and Contractual Arrangements

As with high intensity VSO, IAPT provision, the providers will be contracted through the Psychological Therapies Alliance. This means that their work will be monitored and supported not just by the CCG but also by a group of psychological therapy providers that included the HUH PCP service which is now a highly established IAPT provider.

The table below sets out the proposed costs for each provider. In terms of recurrent funding each provider is given funds to recruit a 1 WTE trained therapist. There is notably an £8K variation in costs based on different overhead rates and pay rates between organisations. This variation will be examined in the March 2018 Alliance Board to test whether the differences are reasonable.

Provider	WTE LI therapist	Recurrent Cost p.a. including on costs
Derman	1	£43,880
Bikur Cholim	1	£40,000
Mind	1	£48,000
Total		**£131,880**

This proposal can be fully funded within the current mental health budget for 2018-19 and it falls within the funding allocated to mental health under NHSE's Investment Standard. The standard is intended to ensure that CCGs are funded to commission services which deliver FYFV targets such as IAPT expansion.

SECTION 3: SMI Physical Health

3.1 Case for Change

People with a serious mental illness (SMI) have poorer physical health than the general population and die on average 15 years earlier than those without. In response NHSE has set targets for monitoring the % of the SMI population, who receive a physical health check.

There have been many initiatives to improve the physical health of mental health patients including SMI QoF and CQUINs. Whilst are some payments attached to CQUIN and QOF, neither payments cover the whole physical healthcare requirement as defined by NHSE and NICE. Notably, the annual recording of substance misuse, cholesterol and HbA1C is not covered by QOF. The CQUIN for secondary care is time limited and only extends to patients on CPA, which is a small % of patients with severe mental illness. Finally QOF may itself be phased out shortly.

The CCG has already set aside funding to cover physical health checks for patients on the SMI register who are in primary care. However, it has been found to be more efficient and effective for patients who are seen regularly in secondary care mental to have their physical health check in secondary care. This effectively brings together someone's mental health and physical healthcare in one place. The issue at present are:

- It is not clear where the physical health check should be done which can lead to either duplication or people falling through the gap
- Funding via the CQUIN and QOF does not sufficiently cover the NHSE requirements
- Primary care recording on EMIS and the secondary care RiO system are still not sufficiently linked to enable a single consistent record and the monitoring of checks against NHSE targets.

3.2 The Proposal

To address the issues listed above and help reduce the inequality in physical health between SMI and the general population and ensure full compliance with NHSE's targets for physical health checks it is proposed that Health Care Assistants are employed, who work across primary and secondary care.

The number of patients on the SMI register who are in secondary care is estimated to be c1,500 at any one point in time at c3,000 per annum. This is based on the number in the psychotic super-cluster receiving ELFT services. Some of these will receive a physical health check inpatient services however a number will require a check in community teams.

We would propose that we fund 2 WTEs HCAs to work in the CMHTs and use both RIO and EMIS systems to perform investigations and enter health data on patients attending the CMHTs. The HCAs therefore must have access to EMIS for all GP practices from their base.

The employment of HCAs working across the secondary care-primary care interface will enable much better links along the care pathway and allow direct communication between HCAs in primary care and secondary care. In addition it will embed the cultural changes needed to ensure secondary care feel a professional obligation and sense of ownership of physical issues as well as mental health ones.

3.3 Performance Indicators

The effectiveness of the HCAs will be measured by the following KPIs:

- 90% of people on the GP SMI QOF register, who are in secondary care mental health will receive a fully NHSE compliant physical health check (based on the Lester tool).
- An increase in wellbeing interventions including exercise on prescription, smoking cessation, substance misuse and social prescribing.

These will reported through the primary care mental health dashboard, which runs off EMIS web.

3.4 Job Role

The HCA s would be based in the two CMHTs- North and South. Both CMHTs would need EMIS licences and access to all EMIS records across the 43 practices for HCA use. This is an essential component of the job- so if this is not possible then we could not commission the role.

The role of the HCA would be:

a) To look at the appointments list and check patients EMIS records to see what physical health check data for SMI QoF and antipsychotic drug monitoring is outstanding.
b) Offer a physical health check to patients following them seeing their key worker
c) Complete needed tasks including bloods, ECGs, lifestyle advice and onward referral where needed- eg for smoking cessation, exercise on prescription etc (blood taking equipment and ECG machine must be available, as well as courier services)
d) Enter the data onto the mental health template on EMIS and the corresponding RIO entry.
e) Liaise with the practice nurse or GP where needed.
f) Enter onto the RIO care plan for CPA patients
g) Ensure the care plan is sent to GP
h) Consider other health interventions such as encouraging bowel screening, cervical screening, sexual health screening where needed.
i) Inform patients of the need for annual screening with GP if on antipsychotics and give meds leaflet
j) Train mental health staff on the use of the Lester Tool, local resources etc.
k) Participate in general HCA training/HCA group
l) Encourage patients with other LTCs to be compliant with meds and promote self care

3.5 Costs and contractual arrangement

It is proposed that the HCAs are employed by ELFT and line managed by ELFT so that they are clearly linked to secondary care. However it is also essential that the HCAs have a clear link to primary care and access to primary care expertise and knowledge. For this reason it is proposed that the HCAs have a primary care based supervisor for their work.

It is proposed that GP reviews of medication and physical health are paid for at a rate of £40 per review, which is the current rate for mental health review. It is assumed that there will be up to two reviews per annum. Based on data from the service and the CEG it is estimated that up to 200 ADHD patients will be on medication and managed in primary care. This creates a cost of £16,000.

It is also proposed that the budget for this contract sits within the Primary Care Mental Health Alliance. This will ensure that the contract is accountable to the Alliance Board, which includes Primary Care, Secondary Care and CEG (data analytics) representatives.

The following costs:

- **Staff**: 2WTE HCA's £78,000 p.a. including on costs, non-pay, estates and corporate overheads and licensing costs.
- **Primary Care based supervision:** £3,000
- **GP reviews for patients discharged to primary care:** £16,000
  Total £97,000

Title:	**Proposals for Mental Health Non-Recurrent Funding (17/18 – remaining Mental Health Investment Standard)** 1) 16-25 Mental Health Transition Service Pilot (CYP Workstream) 2) Service User Network (SUN) substance misuse service pilot (Prevention) 3) Frequent Attenders pilot (Unplanned Care Workstream) 4) Low Intensity VSO IAPT (Planned Care Workstream)
Date:	12th March 2018
Lead Officer:	Dr Rhiannon England (MH Clinical Lead) Dan Burningham (Mental Health Programme Director)
Author(s):	Dr Rhiannon England (Mental Health Clinical Lead) Dan Burningham (Mental Health Programme Director) Greg Condon (Mental Health Programme Manager) Fawzia Bakht (Mental Health Project Manager)
Committee(s):	**1. 16-25 Mental Health Transition Service Pilot** CYP Workstream City and Hackney CAMHS Alliance **2. Service User Network (SUN) substance misuse service pilot** Prevention Workstream City and Hackney Psychological Therapies Alliance **3. Frequent Attenders pilot** Unplanned Care Workstream City and Hackney Psychological Therapies Alliance **4. Low Intensity VSO IAPT** Planned Care Core Leadership Group City and Hackney Psychological Therapies Alliance
Public / Non-public	Public

Executive Summary:

These proposals for non-recurrent investment emerged from the work of the mental health alliances in consultation with the Integrated Care Workstreams. The proposals support the following local integrated care objectives: improving the transition from CYP to adult services; stronger links between psychological therapies and substance misuse; using mental health interventions to reduce frequent attendance in acute care; using the third sector to expand IAPT access for BME in line with 5YFV targets. These proposals can be funded from within the 2017-18 mental health Investment Standard (Parity of Esteem). Making this investment will ensure that the CCG achieves the Investment Standard for 2017-18. There are plans in place for each investment to ensure sustainability. The proposed non-recurrent investment totals **£465,258** and consists of the following 4 schemes:

1.16-25 Mental Health Transition Service Pilot
Workstream: CYP
Staffing: Therapists (1.5 WTE); Support Worker (0.4 WTE); Service Manager (0.4 WTE)
Cost: £250, 000 (over 2 years) £125,000 p.a.
Contract: with CAMHS Alliance
Providers: Off Centre

Commissioning guidance and strong evidence identify adult services as often inappropriate to meet the mental health needs of young adults who began complex mental health care pathways in childhood who are going through transition. During transition CAMHS stop seeing these highly vulnerable young people and adult services are not established to meet their needs. This is reflected locally where many of these young adults end up referred to the VSO Off-Centre instead of a referral in to adult services. This system is currently at breaking point with demand for off-centre including levels of complexity increasing dramatically. This proposal aims to deploy commissioning guidance recommendations and local demand to deliver an age appropriate service to our most vulnerable young people going through transition. Once the project contributes to the achievement of IAPT access targets it will be made sustainable through IAPT FYFV funding in CCG baselines.

2. Service User Network (SUN) substance misuse pilot Cost: £15,213
Workstream: Prevention
Staffing:0.2 WTE B4 Peer Support; 0.2 WTE B6 Clinician
Cost: £15,213
Contract: with Psychological Therapies Alliance
Provider: ELFT

The SUN project has a strong track record in providing open access group therapy to people experiencing a mental health crisis. This investment will extend the work of the project into the City and Hackney Recovery Centre for substance misuse at Mare Street run by Westminster Drugs Project, which is also an open access service. Public Health Hackney have identified a gap in provision for hard to reach clients with substance misuse issues, who may benefit from access to dedicated support. This will create a more integrated pathway between recovery and psychological crisis support and will help increase access particularly for people with a serious mental illness. If successful the pilot will be made sustainable as part of the funding allocated to expand the Recovery Centre.

3. Frequent Attenders
Workstream: Unplanned Care
Staffing: 1 WTE Counsellor; 0.5 WTE Psychotherapist
Cost: £160,00
Contract: with Psychological Therapies Alliance
Providers: Family Action + Social Prescribing Provider + a Psychological Therapy provider TBC by Alliance

A key driver of City and Hackney's above average rate of A&E admissions is frequent attender many of whom have mental health difficulties. This pilot combines psychological

therapies with emotional and practical support, an approach that has been found to be effective with frequent attenders, many of whom are reluctant to admit they have mental health problems. This pilot builds on the work of PCPCS who work with frequent attenders at GP practices and Family Action who are already engaged with A&E frequent attenders. The investment will co-ordinate the different approaches and link them into the other Unplanned Care Board initiatives. If the pilot proves successful in reducing attendances recurrent funding would be sought. One source would be the economic benefits released through reduced attendance.

4. Low Intensity VSO IAPT
Workstream: Planned Care
Cost: £40,045
Contract: with Psychological Therapies Alliance
Providers: Bikur Cholim, Derman, Mind

The VSO IAPT providers (Mind, Bikur Cholim and Derman) are currently funded to provide high intensity IAPT but not low intensity IAPT. They currently achieve excellent recovery rates and waiting times. Funding low intensity IAPT would:

- Help achieve the NHSE 5YFV IAPT access rate target
- Increase access rates to BME groups
- Enable the VSO to operate a stepped model of care in line with IAPT guidance.

This non-recurrent funding will provide training for existing VSO employees to develop the skills needed to run low intensity IAPT therapies. This combined with the recurrent funding for new recruitment (see recurrent funding proposal) will deliver an increase in IAPT access rates in line with FYFV targets in a highly cost effective manner. This proposal is sustainable because once therapists have been trained they will be practicing for a number of years beyond the expiry of the funding.

Total non-recurrent investment: £465,258

The proposals were endorsed by the Transformation Board without comment.

Recommendations:

The City Integrated Commissioning Board is asked to:

- **NOTE** the Non-Recurrent Investments – to meet 17/18 Mental Health Investment Standard
- **ENDORSE** and **RECOMMEND** the 16-25 Mental Health Transition Service Pilot (CYP Workstream)
- **ENDORSE** and **RECOMMEND** the SUN substance misuse service pilot (Prevention Workstream)
- **ENDORSE** and **RECOMMEND** the Frequent Attenders pilot (Unplanned Care Workstream)
- **ENDORSE** and **RECOMMEND** VSO Low Intensity IAPT funding (Planned Care Workstream)

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- **ENDORSE** and **RECOMMEND** the Frequent Attenders pilot (Unplanned Care Workstream)
- **ENDORSE** and **RECOMMEND** VSO Low Intensity IAPT funding (Planned Care Workstream)

Links to Key Priorities:

1. 16-25 Mental Health Transition Service Pilot (CYP Workstream): more integrated care pathways (CYP to adult)

2. SUN substance misuse service pilot (Prevention Workstream): reducing unnecessary hospital admissions.

3. Frequent Attenders pilot (Unplanned Care Workstream): reducing A&E admission rates and frequent acute admissions.

4. Low Intensity IAPT: increased access to psychological therapies for BME groups

Specific implications for City

All services are accessible to the City of London residents.

Specific implications for Hackney

All services will be based in Hackney providing optimised accessibility for Hackney patients. Otherwise implication for Hackney residents are the same as for the City

Patient and Public Involvement and Impact:

Service User Reference Group members reviewed these proposals via governance as part of the three associated workstreams and the Mental Health Co-ordinating Committee.

Clinical/practitioner input and engagement:

1. **16-26 Mental Health Transition Service Pilot**
   Dr Rhiannon England, Clinical Lead MH (CCG)
   Dr Laura Smith (LBH)

2. **SUN Substance Misuse Service Pilot**
   Dr Rhiannon England, Clinical Lead MH (CCG)
   Dr David Bridle, Clinical Director, City and Hackney (ELFT)

3. **Frequent Attenders Pilot**
   Dr Rhiannon England, Clinical Lead MH (CCG)
   Dr David Bridle, Clinical Director, City and Hackney (ELFT)

4. **Low Intensity VSO IAPT**
   Dr Rhiannon England, Clinical Lead MH (CCG)
   Jon Wheatley Clinical Psychologist (HUH)
   Kornillia Givessi, Psychotherapist (Mind)

Impact on / Overlap with Existing Services:

1. **16-26 Mental Health Transition Service Pilot**
   The service will offload adult mental health care management of these conditions thus reducing waiting times which are currently an issue. It will also providing appropriate services locally that's more appropriate for this age group. The service could reduce inappropriate referrals to Gynaecological and Urology acute care services.
2. **SUN Substance MisuseService Pilot**
   The service will strengthen the work of the Recovery Centre
3. **Frequent Attenders Pilot**
   The service will aim to reduce frequent attendances at A&E and on acute wards**.**
4. **Low Intensity VSO IAPT**
   Increased psychological therapies access reducing the pressure on waiting times across service providers.

Main Report
(Please note, the main report is divided into three sections for each strand requiring approval)

SECTION 1: 18-25 Mental Health Transition Service

1.1 Background

Despite previous guidance, which has highlighted that all young people with health and mental health needs are at risk during transition (*No health without mental health - HM Government (2011)*) little change has been made (Transition from children's to adults' services for young people using health or social care services – NICE 2016)

It is also the age at which the young person already in contact with mental health services will move from child and adolescent services (CAMHS) to adult services (AMHS). Young people with mental health problems whose needs have been met primarily by paediatric services, education or social care may find that there is no equivalent service for adults (Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services – Joint Commissioning Panel (2012)).

The period of transition into adulthood is a critical time in a young person's life. It is crucial to work towards breaking the cycle of mental ill health at this stage to avoid problems continuing into adulthood. Specialist care, tailored to address the needs of young people in these years, can be vital. In addition to treatment and care which addresses the mental health problem, young people need to be supported in planning a way out of services, and in building up skills and confidence to take with them into adulthood (*Supporting Young People's Mental Health Eight Points for Action: A Policy Briefing from the Mental Health Foundation*)

"*The ways in which young people become adults has become more complicated and diverse but policies have generally failed to keep up with such changes. The age structuring on which many policies are based is often complex, inconsistent and working against the principle of resources following need." (The Social Exclusion Unit (2005*))

Despite this, artificial barriers remain and young people find themselves having outgrown children's services, or being excluded from these on the basis of their age, but finding that adult services are not appropriate for their needs either: "*The way mental health services are currently structured creates gaps through which young people may fall as they undergo the transition from CAMHS to AMHS" (Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services – Joint Commissioning Panel (2012))*

(For examples of this problem locally in City and Hackney, see Appendix Case Studies).

Improved provision of age-appropriate services for young adults between the ages of 16-25 is urgently needed (*Mental Health Foundation*). There should be universal agreement as to the age range services for young adults should cover, as there remains a significant degree of inconsistency.

A person-centred service for young people between the ages of 16-25 is needed to take account of changing care and support needs as young people move into adulthood. This should be available in all areas. Services for young adults must work within a range of generic care settings (e.g. sexual health clinics, GPs surgeries, youth centres and further and higher education settings) and engage further with the voluntary sector, schools and employers in order to provide the holistic support that many young adults need (*Supporting Young People's Mental Health Eight Points for Action: A Policy Briefing from the Mental Health Foundation.*

Commissioning effective transitions services should lead to reduced numbers of young people lost to services at this critical time and reduced periods of untreated illness and poor outcomes. This should, in turn, lead to reduced morbidity, thus reducing downstream demand on generic services. Commissioners should ensure that the quality and productivity of services for young people at the point of transition are improved in line with best practice.

1.1 Key issues locally

In City and Hackney, 18-25s are covered by Adult Mental Health Services, however Adult Services are often deemed unsuitable for these young adults, and local CAMHS often refer during the process transition to their CAMHS Alliance partner Off-Centre (City and Hackney Transition CQUIN). Off Centre is a voluntary sector organisation that has specialised in working with ages 11-25, providing therapy as well as some targeted psychosocial services. It is accredited with BACP and clinical staff are experienced counsellors, psychotherapists or art psychotherapists. Off Centre is valued by young people because it is an alternative to statutory provision, i.e. it is perceived as young person-centred and a safe space. The service is open access and professionals will refer young people to Off Centre when a referral to a CAMHS or adult service is felt to be inappropriate or where the Off Centre offer better suits the young person's needs.

Age of clients

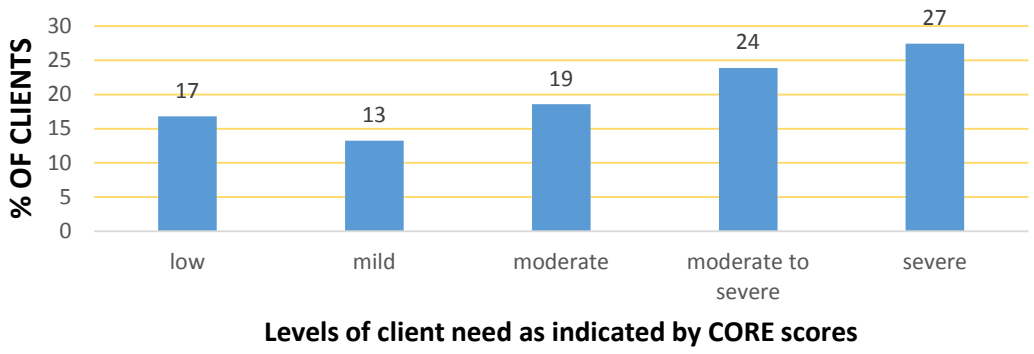
In the year to 31.10.17, the breakdown of client age at time of referral was:

11-16 years	19%
17-18 years	21%
19-21 years	33%
22-25 years	27%

Increasing demands and complexity

A marked increase has been seen in the level of clinical need in new therapy referrals. Over half of new clients in 16/17 presented with needs that were in the moderate to severe range of CORE scores. This has been a trend in the last 3+ years, prior to which the majority of Off Centre's clients would have needs deemed mild to moderate at first assessment. This is shown in the chart below. Historically Off-Centre provided clinical intervention that would be classified as having mild to moderate mental health problems. However, over the last 3 years there has been a dramatic shift towards clients being assessed as having a moderate to severe mental health issue.

Figure 1: Client CORE scores at first assessment



Presenting conditions:

Presenting issues among 16-21 years olds in 2017 are shown below (in numerical order). Some 86% had more than five presenting issues.

Issue	% of YPs	Issue	% of YPs
Anxiety	82%	Physical abuse	15%
Depression	79%	School Difficulties /Conduct	15%
Stress	71%	Sexual exploitation	15%
Parent/Child	63%	Physical Health	11%
Relationships	63%	Sexual abuse	11%
Isolation	60%	Emerging Personality Disorder	10%
Low self esteem	55%	Sexuality	10%
Family breakdown	52%	Aggression	8%
Suicidal Ideation	47%	Parenting	6%
Identity	45%	Young carer	6%
Self-harm	45%	Foster placement	5%
Sleep disturbance/Insomnia	45%	Leaving Care	5%
Anger	37%	Abortion	3%
Emotional/psychological abuse	31%	Honour based violence	3%
Bullying	29%	Immigration	3%
Domestic Violence	29%	Miscarriage	3%
Panic Attacks	26%	Psychiatric Diagnosis	3%
Disordered eating	23%	Drugs / Drink Partner	2%
Parental mental health	23%	Forced marriage	2%
Parental neglect	23%	Homeless	2%
Victim of crime	23%	Offending Behaviour	2%
Bereavement	21%	Psychotic symptoms	2%
Drugs / Drink Self	21%		
Post Traumatic symptoms	21%		
Previous suicide attempts	21%		
Rape/Sexual Assault	19%		
Drugs / Drink Parent	15%		

Gap in Provision

Data shows that 43% of referrals to Off Centre that are identified as moderate to severe or severe come from local statutory CAMHS providers. This equates to approximately 72 patients per year. The vast majority of these are young people who are in transition to adulthood i.e. running up to and passing the age of 18 which is the cut off age for CAMHS in City and Hackney.

Referral Sources

In the year to 31.10.17, the breakdown of referral sources was:

Self	29%
Self, on advice of GP or other professional	10%
Family/friends	14%
School/college	4%
Local authority	7%
NHS	13%
VCS	2%
Other professional	9%
Other	12%

The increased level of need has meant that Off Centre's previously standard intervention (12 sessions) has no longer been sufficient to address the needs of an increasing proportion of clients, who will receive up to 24 sessions or in some cases more.

1.2 Proposal

The proposal is to run a two year pilot for a 16-25 mental health transition service for young adults that have complex needs where referrals have come from Tier 3 CAMHS or CHAMRAS and core scores at assessment are greater than 20 (Moderate/Severe to Severe). Young people with mild/moderate scores will be seen by adult IAPT services.

The service would ensure that this vulnerable cohort of young people who often fall between children and adult services are supported with a bespoke service tailored to their assessed needs reducing avoidable revolving door issues as well as reducing statutory partner's time in responding to their needs. A range of therapy interventions would be provided. Interventions offered currently are counselling, psychotherapy (including psychodynamic), art psychotherapy and EMDR. Psychotherapy would be the core provision of the service with therapeutic Group work and Key working support providing step in, step up and step down support dependent on complexity of individual young person's issues and a programme of support would be co-produced with the young person during an Assessment.

Intervention

Psychotherapy and versions of creative therapies – duration 12 – 24 weeks.
> 42 unique young people / young adults per annum.

Group Intervention

Therapeutic Group work, tailored to the needs of identified vulnerable young people, for example NEET – run on a cyclical basis for both new clients to step in to support and also

step down to from individual psychotherapy.
> 30 unique young people / young adults per annum.

Key Working
Co-ordinated practical and emotional support for a period of between 12 and 16 weeks based on co-produced support plan with specific identified agreed outcomes.
20 YP per annum. (at least 50% of these YP will be unique).

Key Service Interfaces:

1. CAMHS Alliance Partners
2. Psychological Therapy Alliance Partners
3. Primary Care Pathways / Physical Health Pathways
4. Adult IAPT Employment Advisers for those young adults who are NEET.
5. Young Hackney Substance Misuse Services.
6. HPM

Sustainability
During the pilot the service will adapt towards becoming an adult IAPT service that specialised in young adults (18-25). To secure on-going funding, the service will meet the standards and accepted therapeutic provision for adult IAPT and contribute to City and Hackney Adult IAPT performance figures. For clients with complex needs it is envisaged that a Step 4 level will be necessary with the remaining cases sitting within Step 3 and potentially a step 2. This will ultimately contribute to the City and Hackney strategic objective of meeting the 25% adult IAPT access target by 2020/21. A key part of this work will be ensuring that YP are actively helped into education/training/work/volunteering through IAPT employment links. Similarly for the 16-18 cohort, the activity will count towards the CYP IAPT access target of 35% by 2021 where Off-Centre is able to submit to NHS Digital and contribute to the Mental Health Services Data Set (MHSDS) for both children and adults.

1.3 Proposed KPIs

KPI No	KPI Description	Threshold	Consequence of Breach
KPI 1	% assessed within 6 weeks	75%	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI 2	% assessed within 18 weeks	95%	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI 3	% of patient entering treatment (second appointment) within 18 weeks	85%	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI 4	% of patients completing treatment having a pre and post intervention having completed CROM, PROM and PREM	98%	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI 5	% of patients completing treatment showing significant improvement in agreed service CROM	TBC based on agreed benchmarking	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI 6	% of patients completing treatment showing significant improvement in agreed service PROM	TBC based on agreed benchmarking	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI 7	% of patients completing treatment identifying they are satisfied with the service or above	TBC based on agreed benchmarking	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI8	% of patients who are NEET referred to IAPT Employment Advisers	95%	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI9	% of patients who have identified substance misuse referred to Young Hackney	95%	Remedial plan to be submitted to CCG with agreed timeframes and penalties
KPI10	% of previous A&E users not using A&E in reporting period	75%	

Measure No	Measure Description	Measure (threshold)
M1	No of referrals accepted for assessment / entering 1:1 treatment	>42 unique YP per year
M2	No of referrals accepted for assessment / entering group treatment	>30 unique YP per year
M3	No of referrals accepted for assessment / entering Key work support	>20 per year
M4	Breakdown of clients based on Core Score at Assessment	-
M5	Breakdown of clients by referral source	-
M6	Number of clients referred to Young Hackney substance misuse service	-

M7	Number of clients referred to Primary Care / Physical Health service	-
M8	Greater than 10 point improvement in CORE Score	36% of Clients
M9	Greater than 5 point improvement in CORE Score	60% of Clients

1.4 Staffing Costs

TWO year project / pilot - £125,000 per annum

	WTE	Service Running Cost per Year
1:1 Psychotherapist (18 years+)	0.5	£27,000
1:1 Creative / Art Therapist (<18 years)	0.5	£27,000
Group Therapist	0.5	£27,000
Support Worker	0.4	£14,000
Service Manager	0.4	£30,000
Total cost to CCG		**£125,000pa**

1.5 Finance Summary

£250,000 (over two years) - Pilot

Appendix: Case Study Examples of Service Gaps

RB: 19 year old male, White British, referred by psychiatrist at TCOS, previous CAMHS intervention

Presenting issues: ***Depression and anxiety, PTSD/ dissociation, diagnosis of EUPD, manic episodes, hearing voices, eating disorder, OCD, self-harm (cutting), suicidal ideation, suicidal attempts and one past voluntary admission to psychiatric ward at HUH***

R was referred to Off Centre as the psychiatrist felt it was a more appropriate service for the client to be seen in. TCOS did not feel he would benefit from treatment in their MBT group for adults with EUPD due to his vulnerable presentation and young age.
The therapist at Off Centre worked with R for 6 months, the work is coming to an end in April. R has engaged well with his therapist and has spoken in depth about his childhood experiences and his relationships with family and peers. R was brought up in a strict religious sect that forbade any contact with the outside world and where R had to hide his homosexuality.

R was physically bullied at school for being over-weight and witnessed extreme rage from his father whilst growing up, who would throw things, shout and punch walls on a regular basis. R spent his childhood in a very restricted environment where he was unable to mix with other children outside of the sect, was not allowed to watch T.V, listen to music or wear modern clothes. R describes being very isolated and experiencing extreme anxiety from a very young age.

When R began therapy he was very self-critical and talked about anger with little or no affect. Since coming for therapy he has been able to express his emotions better and to reflect on his experiences both in the past and present and how they have affected him. He

has managed to cope when a recent relationship ended and has become less self-critical.
R recently stood up for himself when he was treated unfairly and has been able to express/externalise some of his anger. R has recently started to open up about his disordered eating suicidal/thoughts of poisoning himself and has described in detail how he would do this.
R is still being held with enhanced primary care at the Donald Winnicott Centre and I am re-referring to St. Ann's for psychological support for his eating disorder. His therapist at Off Centre feels he would benefit from much longer term therapy than Off Centre is able to offer and will be considering a referral to the Institute of Psychotrauma for when St. Ann's close him.

SV: 18 year old female, Black British, referred by CAMHS transition team and TCOS

Presenting issues: ***Depression and anxiety, diagnosis of EUPD, self-harm (cutting and burning), stress, suicidal ideation, multiple suicide attempts (overdoses), multiple admissions to Coburn adolescent unit, bullying, sexual abuse (by older sister), sexual assault by trusted friend***

S was referred by CAMHS initially and had been told about Off Centre by an art psychotherapist working at the Coborn. S felt art psychotherapy was particularly helpful for her as she finds it hard to talk about her experiences. However as S was admitted multiple times since her referral to Off Centre her CAMHS transitions worker requested that she be held on our waiting list until their work was complete. S turned 18 in late 2017 and was diagnosed by TCOS with EUPD. A practitioner at TCOS contacted Off Centre to request that

S was seen by us for art psychotherapy to help ease her transition into adult services, as it was felt that she would engage better with a young person's service.

S has been offered a short term contract of 12 weeks by an art psychotherapist at Off Centre and this work has just begun.

MB: 23 year old male , gay and of mixed heritage- who was referred to our service by his psychiatrist following the violent death of his brother who was witnessed attempting to escape from the wreckage of a burning car that the client believed to be suspicious.

Presenting issues: ***Drug misuse (meth amphetamines), homelessness, estranged and difficult family relationships due to his sexuality, complex grief, isolation, family breakdown (absent father), victim of hate crime and homophobic bullying, lack of motivation, identity issues.***

M was offered a 24 week contract of art psychotherapy at Off Centre. He was able, through the use of art making, to get in touch with the painful loss of his brother and explore his fears that his brother had been murdered in a gang related incident. The client was forced to leave his house with no possessions when he was the victim of an unprovoked physical attack by someone living in his house and had go back into temporary accommodation, with no washing or cooking facilities. He felt unable to continue working in his job and was signed off with stress by his doctor. His mental health declined significantly and he appeared

dishevelled and unkempt during sessions. His clinical assessment score was high at 27, indicating severe depression and anxiety.

After 10 weeks he was eventually rehoused with drug users who were injecting drugs and he became overwhelmed with anxiety and an obsessive fear that they would overdose and he would discover the bodies.

M was able to explore his childhood experiences of bullying and what 'home' meant to him and how his felt unsafe. M identified that he had difficulties trusting others due to his poor family relationships and that he had a tendency to push people away when they got too close.
M was able to go back to work, start a music production course and begin dating and making new friends by the end of our work. He had more hopes for the future and managed to stay off drugs for the entire period he was engaged in therapy, which was a significant shift from the year before. His plan was to save money to move to a privately rented house share so he could leave the housing association flat he was sharing with drug users.

AH, 22 year old, male, White British

Presenting issues: Anxiety and depression, suspected/emerging EUPD, suicidal ideation, hospital admission following past attempt (overdose), self-harm (head-butting, punching or kicking walls), psychotic symptoms (hears voices telling him to kill himself), grief (of great grandmother), anger/aggression, drink/drugs (past), loss of baby, absent father, PTSD symptoms, risk taking behaviour, disordered eating, isolation

A was referred by his probation officer after hospital admission following an overdose. This was triggered by a court case where he was found guilty and given a suspended sentence for an incident of domestic abuse. The client admitted feelings of guilt about what he had done, but also disclosed that he had been a victim of domestic violence by his girlfriend on a number of occasions, prior to this one incident.

The client was raised in part by his grandparents and was emotionally/psychologically and physically abused by his grandfather. He was also bullied at primary school for being over-weight and consequently got into a lot of fights/trouble at school.

A has engaged well in therapy thinking about his grief around the loss of his great grandmother who he was very close to and who he found dead at the age of 16. A has had nightmares and flashbacks around this experience. A coped by taking a lot of drugs and drinking heavily, but has been clean for over a year. A has spoken about the more recent loss of his partner's baby (through miscarriage) and the differing ways they managed this. A felt that his girlfriend distanced herself from her feelings but A was very upset/affected by the loss.

In therapy A has explored and expressed anger towards his dad, who he has no relationship with but has also thought about how his lack of a male role model has affected him. A has explored his difficult relationships with his mother, who he describes as controlling and his sister, who used to bully him. Since being in therapy he has explored the possibility of

meeting with his dad and was surprised by his mother's support around this issue.

At the start of therapy A described how his mood swings felt out of his control and he feared making another attempt on his life (A's first attempt was very impulsive and he regularly heard voices telling him to take an overdose). A coped with this by getting in the car and driving dangerously or riding a motorbike without a helmet.

A would often lose his temper and self-harm by head butting, punching or kicking the wall. The work with A is coming towards the end. He has currently had 15 sessions and a referral has been made and been accepted by TCOS.

A has stated that he feels therapy has helped him to express things in a non-violent way, that he no longer punches walls or gets into confrontations, that he has stopped bottling things up and that his anger and anxiety have reduced significantly. A has recently started working in a paid job that he enjoys and is committed to.

SECTION 2: Service User Network (SUN) Substance Misuse Pilot

2.1 Background

The SUN (Service User Network) in Hackney was developed based on the therapeutic community model and a psychosocial approach to mental health services. The SUN aims to support people in a mental health crisis by offering easily accessible community groups. Members can self-refer and attend the thrice week groups as often as they wish. The groups are run by two facilitators, a clinician and a peer support lead.

As can be seen below the group has a strong track record of supporting people in crisis and reducing admissions to psychiatric wards and A&E. However at present many high users of inpatient wards and A&E are people with substance misuse problems. This group often have an undiagnosed mental health problem masked by the substance misuse which means they do not enter mental health services easily. To address this it is proposed that the SUN project is expanded to provide a group in a substance misuse setting i.e. the Recovery Centre.

2.2. Service model and outcomes

At the SUN project group members have the chance to talk about their difficulties, learn new coping strategies, share information and support their peers. Peer support in the community from other group members can be set up during groups. The group encourages the participants to expand their social network and promotes social inclusion. Members have the opportunity to contribute by co-facilitating groups and it is planned that they could join in promotional events in the future. The SUN project started in February 2016.

Since then 217 people have self-referred to the service and 142 have attended at least one group. Attendees report a decrease in the number of visit to A&E and unplanned GP visits.

The average number of visits to A&E prior attending the SUN is 1.5 visits, three months after attending the SUN is 1.05 visits and six months after is 1 visit. The average number of unplanned visits to their GP prior attending the SUN is 2.5 visits, three months after attending the SUN is 2.4 visits and six months after is 0.2 visit. The reports of the SUN service satisfaction survey indicate a high level of overall satisfaction. The September 2017 survey found that 86% of respondents strongly agreed or agreed with the statement 'I am satisfied with the SUN project', 9% were neutral and 5% did not agree.

The SUN project was developed from a model designed to support frequent users of A&E and mental health wards with a diagnosed personality disorder (PD) (Miller and Crawford, 2010). People with PD often present in crisis yet remain hard to engage in services. Treatment models have highlighted the role social networks play in mitigating a crisis as well as the need for open access services to respond to recurring crises. These approaches have been shown to build a sense of inclusion and empowerment, as well as reducing contact with services, in particular unplanned contacts and in-patient admissions (Miller and Crawford, 2010). This approach reflect a recent shift to broadening the role of service users and peer support across mental health services (Gillard and Holley, 2014).

The impact of a crisis on service use

Respondents reported high rates of unplanned GP visits, A&E attendances and MH hospital admissions and over the previous year:

- 34/40 participants had past contact with MH services.
- 18/40 had made unplanned GP visits for MH issues (95 visits in the past year).
- 20/40 had presented at A&E with MH issues (37 visits in the past year).
- 23/40) had been admitted to a MH ward (1140 days in the past year).

The HTT succeeded in mitigating this as those receiving support from the HTT had spent fewer days in hospital on average. Those under the HTT had spent on average 16.7 days on the ward while those who called the SUN but did not attend spent 23.6 days admitted on average. (Table 1)

23/40 (58%) of people interviewed had a MH admission in the last year spending a total of **1140 days on a ward**, an average of 50 days a year. In contrast 16/103 (16%) those who engaged with the SUN Project in the last year had been admitted.

A retrospective survey of SUN attenders ward admissions:
Between September 2016 and October 2017 16/103 of those who attended the SUN had a MH admission. Clearly engaging even some of those seeking crisis support in the community could provide strong savings to the NHS.

2.3 Proposal

The proposal is to extend the SUN (Service User Network) in collaboration with the Hackney Recovery Service to run an additional SUN session located at the Hackney Recovery Service for people with substance misuse issues. Public Health Hackney have identified a gap in provision for hard to reach group with substance misuse issues who may benefit from access to dedicated support. Currently the SUN runs three sessions a week at the Salvation

Army base at 70 Mare St, London E8 4RT. These sessions run on Monday evenings and on Wednesday and Friday early afternoons. The suggestion would be to run a fourth weekly SUN session at the Hackney Recovery Service at 110 Mare Street, London E8 3SG on Tuesday or Thursday afternoons, depending on the availability of accommodation.

2.4 Staffing

The additional staff needed for the addition session would be:

1) Two Band 4 Peer Supporters for half a day each (0.1 wte (3.75 hours) making a total of 0.2 wte (7.5 hours) Band 4 time.
2) Two Band 6 Clinical Practitioners for half a day each (0.1 wte (3.75 hours) making a total of 0.2 wte (7.5 hours) Band 4 time.
3) Half a day a fortnight of supervision and management from a Band 8b Clinical Psychologist.

Total Cost = £15,213

2.5 Maintaining the Community

The SUN currently attracts on average eight people per group. About 140 people have attended the SUN since its inception any of whom might attend any of the sessions at any time. The SUN currently attracts people with substance misuse problems but we are aware that there are people with substance misuse difficulties, who experience a crisis but do not access the SUN. The expansion of the SUN to include an additional session at the Hackney Recovery Service will make it easier for those with substance misuse problems, who have not attended the SUN to join the SUN community because one of the weekly meetings will take place in a location that is familiar to them. However, any individual experiencing a crisis can join the SUN community and can attend any of the weekly sessions.

SECTION 3: Frequent Attenders Pilot

3.1 Background

City and Hackney an above average rate of A&E admissions compared to the rest of North East London and the rates increased in 2016-17. A key driver of unnecessary A&E admissions is people who frequent attend due to mental health problems. Many of this cohort have medically unexplained symptoms with an underlying mental health problem and/or high levels of anxiety. It has been found that frequent attenders often have their needs better addressed through interventions such as psychological help, the development of coping strategies combined emotional support and practical help and lifestyle interventions such as engagement in community based activities.

3.2 Current Services for frequent attenders

At present, psychological interventions are provided to frequent attenders in primary care by the Tavistock and Portman NHS Foundation Trust PCPCS service. The service is skilled at working with Medically Unexplained Symptoms. However, the service does not focus on frequent attenders to A&E and also does not work as part of an overall frequent attender team.

Family Action provides a Frequent A&E attender service funded by the Big Lottery until February for £135,000 p.a. 2019. The service offers 6-8 sessions of emotional and practical support to frequent attenders combined with the development of an agreed coping strategy which avoids the use of A&E. Of those attending 6+ sessions 48% reduced their A&E attendances. Family Action also offers a Social Prescribing Frequent Admissions Service. Again this offers 6-8 sessions of emotional and practical support but with a focus on people who are frequently admitted into acute beds. The sessions also have a greater emphasis on social prescribing towards community activities. The funding for this service ends in April 2018. Currently 2 WTE therapeutic link worker were funded as part of a 4 month NHSE commissioned pilot. The link workers liaise with the A&E and acute discharge pathway.

3.3 Frequent Attenders with Mental Health Problems Investment Proposal

In view of the importance of reducing unnecessary admissions and A&E attendances it is proposed that there is additional non-recurrent investment to expand the work of existing organisations. This investment will ensure that the pilot work for the social prescribing pathway is extended. It will also fund a psychological intervention for frequent attenders with psychological problems. Finally whilst there is some liaison between psychological interventions and Family Action there is no clear structure to co-ordinate this work. In view of this it is proposed that a specialist psychological therapy provider such as Tavistock and Portman provide supervision to Family Action to help manage psychological complexity and to refer on to more specialist treatment when appropriate. CORE arts provide arts based activities for people who are frequently admitted to hospital and A&E. They achieved a 94% non-admission rate in 2017-18. At present they are focused on working with people from BME backgrounds. This investment would enable CORE or potentially another provider to offer socially prescribed community based activities.

In summary, 160K non recurrent investment is requested to fund the following:

- Provide a social prescribing pathway for frequent attenders combined with emotional and practical support. 1 WTE trained Family Action Counsellor (£60K)
- Provides psychological treatment for more complex frequent attenders 0.4 WTE (£32K) 20 cases per annum.
- Provide supervision for Family action workers engaged in emotional and practical support to help manage underlying psychological complexity and refer on when appropriate 01 WTE (£8K)
- Provide a social prescribing pathway for frequent attenders providing a therapeutic space for vulnerable patients to build self-confidence and skills outside a medical setting, recovery focused moving towards independence with less reliance on social and health services. (£60,000)

Total: £160,000

Please note that providers including TPFT and CORE arts have expressed an interest in providing services to this pathway. However, the Psychological Therapies Alliance would like to formally assess the proposals submitted to ensure that there is clarity over the detail and the process is fair if more than one provider is interested.

3.4 Co-ordinating the Frequent Attender Pathway

In addition the Unplanned Care Workstream has funded a 0.4 WTE Band 7 Frequent Attenders Liaison nurse to act on behalf of the urgent and emergency care system in City and Hackney to facilitate a coordinated response to Frequent Attenders, in partnership with other organisations. The aim is to reduce inappropriate use of health services across the system including Homerton University Hospital, LAS, 111, Mental Health Crisis Line and CHUHSE GP Out of Hours.

In view of this the nurse will provide a central link for the mental health services engaged in frequent attender work and assists the co-ordination of the work. This link could be provided in key forums such as the Frequent Attenders Steering Group and regular case discussion meetings.

3.4 Contractual and Funding Arrangements

This proposal was developed in partnership with members of the Unplanned Care Workstream and further work will take place to provide a more detailed specification. The investment will be made through the Psychological Therapies Alliance, which will monitor the contract performance and report back to the Unplanned Care Workstream.

SECTION 4: Low Intensity VSO IAPT

4.1 Background

The Mental Health Five Year Forward View sets out an ambitious target to increase IAPT access to 25%.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 25% of people with common MH conditions access psychological therapies each year.	15.8%	16.8%	19%	22%	25%

In order to meet NHSE's targets and in order to ensure access from BME and other hard to reach communities we have commissioned Voluntary Sector Organisations (VS0s) to become IAPT providers. Three VSOs were commissioned by City and Hackney CCG to provide high intensity IAPT treatments as follows:

- Derman, to provide IAPT services for the Turkish and Kurdish communities – 1 WTE high intensity therapist
- Bikur Cholim to provide IAPT services to the Orthodox Jewish community - 1 WTE high intensity therapist
- Mind, who have good access rates from Black African and Black Caribbean and other hard to reach communities such as socially and economically disadvantaged residents were commissioned to provide IAPT - 1 WTE high intensity therapist

As a result access to high intensity IAPT treatments for BME has increased and all three providers are achieving NHSE IAPT targets for waiting times and recovery rates. Notably recovery rates in the Turkish and Kurdish communities

4.2 Investment Proposal

Based on the successful implementation of high intensity IAPT interventions it is proposed that the services are expanded to include low intensity work. This will ensure that services comply with the stepped care model that is a cornerstone of IAPT service delivery and it will also help City and Hackney achieve its IAPT targets and will further improve access from BME and other hard to reach communities.

The IAPT stepped care model works on the following principles:

- Step 1: self-help, information giving
- Step 2: guided self -help/low intensity work with a trained low intensity worker 6-10 sessions
- Step 3: high intensity IAPT typically 1-1 work with a qualified therapist 8-12 sessions

The advantage of the Stepped Care model is that people, who need additional work can move up a step and that those, who need lower levels of support, do not consume more expensive high intensity support. The CCG has already commissioned Step 3 and would be well advised to commission Step 2 which produces higher access rates and higher recovery rates for a lower level of investment.

4.3 Costs and Contractual Arrangements

As with high intensity VSO, IAPT provision, the providers will be contracted through the Psychological Therapies Alliance. This means that their work will be monitored and supported not just by the CCG but also by a group of psychological therapy providers that included the HUH PCP service, which is now a highly established IAPT provider.

The table below sets out the proposed costs for each provider. It is also proposed that the providers use non-funding to train existing staff in Low Intensity Therapy. Notably the size of the different training programmes and the amount of training needed accounts for the differences in non-recurrent costs.

Provider	WTE LI therapist	Non recurrent cost (training, supervision)
Derman	1	£22,695
Bikur Cholim	1	£5,000
Mind	1	£12,350
Total		**£40,045**

This proposal can be fully funded within the current mental health budget for 2018-19 and it falls within the funding allocated to mental health under NHSE's Investment Standard. The standard is intended to ensure that CCGs are funded to commission services, which deliver FYFV targets such as IAPT expansion.

Title:	Integrated Commissioning Governance Review Specification
Date:	9 March 2018
Lead Officer:	Devora Wolfson, Integrated Commissioning Programme Director
Author:	Matt Hopkinson, Integrated Commissioning Governance Manager
Committee(s):	Transformation Board – for endorsement – 9 March 2018 Integrated Commissioning Board - for approval - 21 March 2018
Public / Non-public	Public

Executive Summary:

This report sets out proposals for the commissioning of a short term piece of work to review the governance arrangements of the Integrated Commissioning Programme and make recommendations for how we can improve systems and ways of working as we move forward.

The review will be managed by a Governance Review steering group convened by the Transformation Board. The group will be made up of senior level representation from the CCG, ELFT and the local authorities, with support from the CCG Contracting team.

A draft specification (attached as **Appendix 1**) sets out the aims and scope of the review, as well as specific lines of enquiry. It is proposed that competitive quotes are sought from providers. We estimate that the work will take between 15 and 20 days to complete. Accordingly, this paper asks the Integrated Commissioning Board to approve the contract award (to the successful bidder determined by the Governance Review Steering Group) of up to £25,000. This funding will be drawn from existing Integrated Commissioning resources in s256 agreement between the CCG and London Borough of Hackney.

The successful bidder will then conduct the review between April and May 2018, and report back with recommendations to the TB on 30 May and ICB on 14 June 2018.

The Integrated Commissioning Board is asked to approve the specification and approach. The Hackney ICB is asked to agree the release of funding up to £25,000 to pay a successful bidder to be identified by the CCG Acting Managing Director and the Group Director of Children, Adults and Community Health.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the proposed approach to the IC Governance Review;
- To **APPROVE** the specification and timeline for the review;
- To **APPROVE** the release of up to £25,000 from existing Integrated Commissioning resources in s256 agreement between the CCG and London Borough of Hackney.;
- To **AGREE** that the decision to identify a preferred provider will be taken by the CCG Acting Managing Director and the Group Director of Children, Adults and Community Health.

The City Integrated Commissioning Board is asked:

- To **NOTE** the proposed approach to the IC Governance Review;
- To **APPROVE** the specification and timeline for the review.

Links to Key Priorities:

N/A

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

The governance review will look at the effectiveness of patient and public involvement in the Integrated Commissioning programme.

Clinical/practitioner input and engagement:

The governance review will look at the effectiveness of practitioner / clinician involvement in the Integrated Commissioning programme.

Impact on / Overlap with Existing Services:

N/A

Supporting Papers and Evidence:

Appendix 1 - Governance Review Specification

Main Report

General Aims and Scope of the Review

We want to commission a detailed review of the governance of the City and Hackney integrated commissioning programme.

We want to evaluate the effectiveness of our current governance processes and structures during 2017/18, to understand what improvements could be made to take to programme forward in the future and provide recommendations for development of the governance framework in 2018/19.

The review should take the following areas in scope:

- All levels of governance within the Integrated Commissioning Programme, including consideration of the wider context of the governance structures of the partner organisations.
- The effectiveness of those governance arrangements, including:
    - Performance and operation of ICB and TB as boards
    - Workstream governance
    - Flow of decision-making and any barriers to effective operations
    - Structures for providing assurance to statutory bodies and the impact of requirements on programme resources and delivery.
- Consideration of the specific challenges facing the Integrated Commissioning programme in Hackney and the City; working across multiple agencies and statutory bodies; directives received from NHS England; involvement of provider organisations in service commissioning, etc.
- Identification of strengths and successes achieved so far within IC governance.
- Identification of solutions to problems identified.

Specific evaluation questions

Some of the detailed questions that we want the evaluation to look at are:

<u>Capability, Capacity & Culture</u>

- Organisational Structures – to what extent are different partners' business systems and teams aligned? What are the enablers / barriers to working together?

- How effective and streamlined is the governance structure for pooled and aligned budgets?
- Are IC governance arrangements sufficient in resolving issues between partners?
- Membership – Is the membership right for workstreams, TB and ICB? To what extent are members sufficiently briefed / do they have the expertise needed to lead the system?
- Are the IC Governance arrangements adequately resourced?
- To what extent does IC governance enable effective involvement of all partners including providers, voluntary sector and service-users?
- Is appropriate information on quality and performance being analysed and challenged, and is information used effectively to drive improvement?
- How effective are mechanisms to maintain grip on performance and risk?
- Are Board papers clear and robust enough to enable good decision-making?
- Regularity of Meetings – All meetings are currently on a monthly cycle. Could this change as partnership matures?
- To what extent are conflicts of interest being appropriately recorded and managed?

<u>Process & Structure</u>

- Does the governance enable effective leadership, and clarity on roles and accountabilities to deliver the programme?
- Do organisational and data structures enable consistent or transparent reporting and is there clarity on reporting requirements?
- Are workstreams sufficiently empowered, with a clear remit, to operate effectively?
- Partner Governance Transition to workstreams (e.g. from CCG Programme Boards) – how robust are the assurance review and handover processes?
- Are programme support arrangements sufficiently robust (Forward Planning / Minutes / Actions / Meeting Arrangements), and how could they be improved?
- How effective are Enabler Groups and are they effectively tied into the wider governance structure?

Draft Timetable

DATE	MILESTONES
9 March 2018	• Review specification, approach and timescale endorsed by TB
21 March 2018	• Review specification, approach and timescale approved by ICB.

3 April 2018	• Send specification to potential providers seeking submission of bids
17 April 2018	• Deadline for submission of bids by potential providers
W/C 23 April 2018	• Review of bids by Governance Review Steering Group
1 May 2018	• Successful provider notified
May 2018	• Governance Review conducted
27 June 2018	• Governance Review findings and recommendations report to Transformation Board
12 July 2018	• Governance Review findings and recommendations report to Integrated Commissioning Board for approval

Sign-off:

London Borough of Hackney _____Anne Canning, Group Director of Children, Adults and Community Health

City of London Corporation _____Simon Cribbens, Assistant Director or Commissioning and Partnerships.

City & Hackney CCG _____David Maher, Acting Managing Director

Integrated Commissioning Governance Review

1. Background

1.1 What We are Trying to Achieve?

We want to transform the way that we work across City of London Corporation, London Borough of Hackney and City and Hackney CCG in order to improve patient and resident outcomes and experience, and integrate health, social care and well-being services across our providers.

We want to do better with the limited money we have, making savings by being more efficient and effective so that we can invest in more services that City and Hackney people need. We want to support people to look after their own health and wellbeing.

We deliver our transformation programme of work through four care workstreams which are:

- Children and young people
- Planned care
- Prevention
- Unplanned care

We have established a governance structure for the oversight and delivery of the Integrated Commissioning Programme, with associated processes and procedures (See **Appendix 1**).

In City and Hackney, we have a strong drive to do things differently and to create a better, more sustainable system for and with residents and patients that is more effective and better value with our populations. We also have willing partners/providers and some experience of creating alliances. We see co-production and co-design with patients and residents as a key part of how we will achieve this.

1.2 Our Priorities and principles

Our priorities

Our priorities in the Strategic Framework for the care workstreams (Appendix 1) are to:

1. Improve the health and wellbeing of local people with a focus on prevention and public health, and providing care closer to home, outside institutional settings where appropriate, meeting the aspirations and priorities of the 2 Health and Wellbeing strategies;
2. Ensure we have tailored offers to the different needs of our diverse communities;
3. Make progress on addressing health inequalities and improving outcomes;
4. Deliver a shift in focus and resource to prevention and proactive community based care;
5. Ensure we deliver parity of esteem between physical and mental health

6. Promote the integration of health and social care through our local delivery system as a key component of public sector reform;
7. Ensure we maintain financial balance as a system and can achieve our financial plans;
8. Contribute to growth, in particular through early years services;
9. Build partnerships between health and social care for the benefit of the population;
10. Achieve the ambitions of the NEL STP.

Principles
Our delivery principles are:

- **Addressing the wider determinants of health** to address underlying health inequalities, focusing both on direct service commissioning and influencing and advocacy in the wider system
- **Development of 'Neighbourhoods' across City and Hackney with planning and delivery of care at a neighbourhood level where this would improve care and outcomes** re
- **Empowered patients** equipped with skills and information to help them self-manage, access the right services when needed, make informed decisions on the evidence and options for their care and who are active in the co-design of our service delivery arrangements and pathways
- **Strong safe local hospital care** delivering:
    - High quality 7 day services, integrated with mental health resources and networked with other local hospitals where necessary.
    - Fewer face to face outpatients - replaced by digital solutions.
    - Support and expert advice to primary and community care.
    - Demand management of tertiary service.
    - Reductions in variations between teams.
    - Minimal length of stay, thanks to good primary and community based services which command universal clinical confidence.
    - Aligned clinical and practitioner behaviours across primary, community, secondary and social care, which see the community / home as the default and support the delivery of resident care plans.
    - Preventative interventions.

1.3 Integrated Commissioning Structure

Section 75 Agreements: Pooling of budgets
We have established two pooled budgets hosted by each local authority using s75 legislation. At the moment, these budgets are limited in their range to the BCF and other pre-existing Section 75 agreements but we are looking to extend the scope of the pooled budgets over the coming months.

Integrated Commissioning Boards (ICBs)
The City ICB and Hackney ICB were established in April 2017. The terms of reference for the ICBs are attached at **Appendix 2**.

Transformation Board (TB)
The TB is made up of the local system leaders. The Board had its first meeting as part of the new integrated commissioning governance arrangements in April 2017. The TB takes collective ownership and responsibility for developing and delivering our improvement plans and making recommendations to the ICBs and oversees our workstreams and enabler work. The terms of reference are attached at **Appendix 3**.

Care workstreams
The four care workstreams are the delivery arms of the IC programme. The workstream aims are set out as 'asks' and annual priorities, which have been approved for 2017/18 and 2018/19 through the TB and ICBs 9 (**Appendix 4**).

The four care workstreams are at different levels of maturity. All four are subject to ongoing phased review processes, designed to give assurance to the ICBs and the statutory partners prior to workstreams taking on full responsibilities.

Enabler Groups
There are five enabler groups that were set up as part of the devolution programme arrangements and will now support the care workstreams and the TB to deliver their programmes of work.

- IT
- Workforce
- Primary care quality
- Estates
- Communications and engagement

2 Governance Review Specification

2.1 General Aims and Scope of the Review

We want to commission a detailed review of the governance of the City and Hackney integrated commissioning programme.

We want to evaluate the effectiveness of our current governance processes and structures during 2017/18, to understand what improvements could be made to take to programme forward in the future and provide recommendations for development of the governance framework in 2018/19.

The review should take the following areas in scope:

- All levels of governance within the Integrated Commissioning Programme, including consideration of the wider context of the governance structures of the partner organisations.

- The effectiveness of those governance arrangements, including:
    - Performance and operation of ICB and TB as boards
    - Workstream governance
    - Flow of decision-making and any barriers to effective operations
    - Structures for providing assurance to statutory bodies and the impact of requirements on programme resources and delivery.
- Consideration of the specific challenges facing the Integrated Commissioning programme in Hackney and the City; working across multiple agencies and statutory bodies; directives received from NHS England; involvement of provider organisations in service commissioning, etc.
- Identification of strengths and successes achieved so far within IC governance.
- Identification of solutions to problems identified.

2.2 Specific evaluation questions

Some of the detailed questions that we want the evaluation to look at are:

Capability, Capacity & Culture

- Organisational Structures – to what extent are different partners' business systems and teams aligned? What are the enablers / barriers to working together?
- How effective and streamlined is the governance structure for pooled and aligned budgets?
- Are IC governance arrangements sufficient in resolving issues between partners?
- Membership – Is the membership right for workstreams, TB and ICB? To what extent are members sufficiently briefed / do they have the expertise needed to lead the system?
- Are the IC Governance arrangements adequately resourced?
- To what extent does IC governance enable effective involvement of all partners including providers, voluntary sector and service-users?
- Is appropriate information on quality and performance being analysed and challenged, and is information used effectively to drive improvement?
- How effective are mechanisms to maintain grip on performance and risk?
- Are Board papers clear and robust enough to enable good decision-making?
- Regularity of Meetings – All meetings are currently on a monthly cycle. Could this change as partnership matures?
- To what extent are conflicts of interest being appropriately recorded and managed?

Process & Structure

- Does the governance enable effective leadership, and clarity on roles and accountabilities to deliver the programme?

- Do organisational and data structures enable consistent or transparent reporting and is there clarity on reporting requirements?
- Are workstreams sufficiently empowered, with a clear remit, to operate effectively?
- Partner Governance Transition to workstreams (e.g. from CCG Programme Boards) – how robust are the assurance review and handover processes?
- Are programme support arrangements sufficiently robust (Forward Planning / Minutes / Actions / Meeting Arrangements), and how could they be improved?
- How effective are Enabler Groups and are they effectively tied into the wider governance structure?

2.3 Methodology

Applicants to suggest most effective methodology to answer the above questions.

2.4 Outputs/reporting

The successful bidder will need to provide a comprehensive final report to the TB and the ICBs, containing clear recommendations for the local system, to be produced at the end of the contract period in June-July 2018.

2.5 Project management

The project lead will be Devora Wolfson, Integrated Commissioning Programme Director. Devora and her team will be the day-to-day contact for the work. The project lead from the successful bidder is expected to have regular contact with Devora and to work collaboratively with them to develop and deliver the final report and recommendations.

2.6 Provisional Timetable

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9 March 2018	• Review specification, approach and timescale endorsed by TB
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27 June 2018	• Governance Review findings and recommendations report to Transformation Board
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Bidders should provide clear costings for each aspect of the project including a breakdown of activities to be delivered and any assumptions underpinning the costs.

4.10 Bid evaluation criteria/process

Bidders should cover the following information as part of their bid:

- Their previous experience of integration and evaluation of integrated arrangements
- How the work will be conducted and how the listed evaluation questions will be addressed;
- Bidders should provide clear costings for each aspect of the project including a breakdown of activities to be delivered and any assumptions underpinning the costs.

Title:	Consolidated Finance (income & expenditure) report as at January 2018 - Month 10
Date:	5th March 2018
Lead Officer:	Anne Canning, London Borough of Hackney (LBH) Jane Milligan, City & Hackney Clinical Commissioning Group (CCG) Neal Hounsell, City of London Corporation (CoLC)
Author:	Integrated Finance Task & Finish Group CCG: Dilani Russell, Deputy Chief Finance Officer CoLC: Mark Jarvis, Head of Finance, Citizens' Services LBH: Jackie Moylan, Director – Children's, Adults' and Community Health Finance
Committee(s):	Transformation Board – 9th March City Integrated Commissioning Board – 21st March 2018 Hackney Integrated Commissioning Board – 21st March 2018
Public / Non-public	Public

Executive Summary:

This reports on finance (income & expenditure) performance for the period from April 2017 to January 2018 across the CoLC, LBH and CCG Integrated Commissioning Funds.

The forecast variance for the Integrated Commissioning Fund as at Month 10 (January) is £3.6m adverse. This is unchanged from the Month 09 forecast position. Driving the overall adverse forecast outturn is the London Borough of Hackney spend on Learning Disabilities commissioned care packages (outlined within the report). The risks to the position have been flagged in the risk schedule which will be updated and reported on monthly basis.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the report.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the report.

Links to Key Priorities:

N/A

Specific implications for City and Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Impact on / Overlap with Existing Services:

N/A

Supporting Papers and Evidence:

Month 10 Integrated Finance Report

Sign-off:

London Borough of Hackney _____Ian Williams City of London Corporation _____Mark Jarvis City & Hackney CCG ____Sunil Thakker

City of London Corporation
London Borough of Hackney
City and Hackney CCG

Integrated Commissioning Fund
Financial Performance Report

Month 10 (January) Year to date cumulative position

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Consolidated summary of Integrated Commissioning Budgets

	Organisation	Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend	Forecast Fcast Variance £000's	Forecast Prior Mth Variance £000's
Pooled Budgets	City and Hackney CCG	24,947	20,789	21,026	(237)	25,232	(285)	-
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	283	160	104	56	275	8	6
Total		25,230	20,949	21,130	(181)	25,507	(277)	6
Aligned	City and Hackney CCG	367,545	303,738	302,267	1,471	365,826	1,719	1,434
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	6,072	4,413	4,745	(332)	6,257	(185)	(165)
Total		373,617	308,150	307,012	1,138	372,084	1,533	1,269
ICF	City and Hackney CCG	392,492	324,527	323,293	1,233	391,058	1,434	1,434
	London Borough of Hackney Council	102,127	85,106	88,763	(3,658)	106,941	(4,814)	(4,923)
	City of London Corporation	6,355	4,573	4,849	(276)	6,533	(178)	(159)
Total ICF Budgets		**500,974**	**414,205**	**416,906**	**(2,701)**	**504,531**	**(3,557)**	**(3,649)**
CCG Primary Care co-commissioning		44,183	35,161	35,161	0	44,183	-	-
Total		44,183	35,161	35,161	0	44,183	-	-

Notes:

- Unfavourable variances are shown as negative. They are denoted in brackets & red font
- ICF = Integrated Commissioning Fund – comprises of Pooled and Aligned budgets

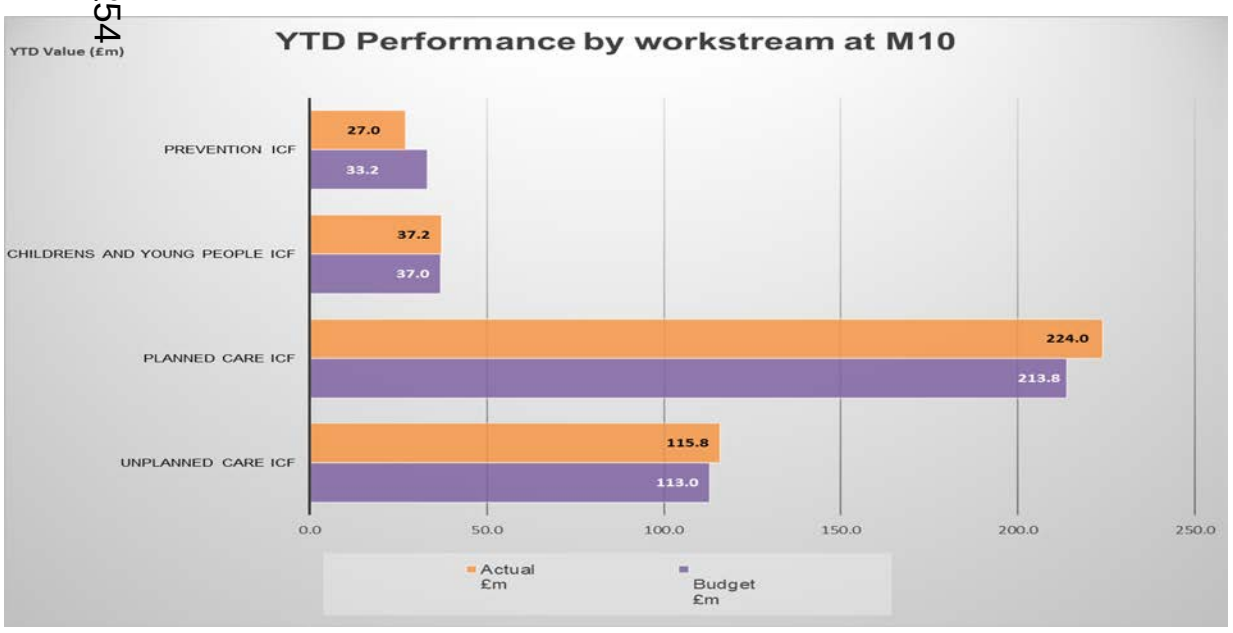
Summary Position at Month 10

- The forecast variance for the Integrated Commissioning Fund as at Month 10 (January) is £3.6m adverse. The position is unchanged from the month 09 reported forecast position of £3.6m adverse.
- The overall forecast position is being driven by London Borough of Hackney, which is forecasting a £4.8m over spend for the year. The adverse position relates to Learning Disabilities commissioned care packages.
- The City of London forecasts over spend of £0.2m against the annual plan. The over spend in public health is expected to be met by Public Health reserves at the end of the year.
- The CCG is forecasting a favourable position of £1.4m. The position reflects recognised savings driven by underspends and reserves funding.
- The **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (BCF) including the Integrated Independence Team (IIT) and Learning Disabilities.
- At present London Borough of Hackney budgets are not split between pooled and aligned due to the fact that pooled funds are contributing to towards the services in aligned funds.
- The CCG took on Primary Care Co- commissioning on 1 April 2017. At M10 these budgets are break even with a forecast break even position at year end.

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Integrated Commissioning Budgets – Performance by workstream

WORKSTREAM	Annual Budget £m	YTD Performance Budget £m	YTD Performance Actual £m	YTD Performance Variance £m	Forecast Fcast Spend £000's	Forecast Fcast Variance £m	Forecast Prior Mth Variance £000's
Unplanned Care ICF	135.8	113.0	115.8	(2.8)	136.1	(0.4)	0.2
Planned Care ICF	257.4	213.8	224.0	(10.2)	265.1	(7.6)	(8.1)
Childrens and Young People ICF	44.4	37.0	37.2	(0.2)	44.8	(0.4)	(0.1)
Prevention ICF	40.5	33.2	27.0	6.2	40.7	(0.2)	(0.3)
All workstreams	**478.2**	**396.9**	**404.0**	**(7.1)**	**486.7**	**(8.6)**	**(8.2)**
Corporate services	21.5	16.2	11.9	4.3	16.5	5.0	4.6
L ocal Authorities (DFG Capital and CoL income)	1.3	1.1	1.1	0.0	1.3	0.0	0.0
Not attributed to Workstreams	**22.8**	**17.3**	**12.9**	**4.4**	**17.8**	**5.0**	**4.6**
Grand Total	**501.0**	**414.2**	**416.9**	**(2.7)**	**504.5**	**(3.6)**	**(3.6)**



Performance by Workstream.

- The report by workstream combines 'Pooled' and 'Aligned' services but excludes chargeable income. CCG corporate services are also excluded and are shown separately as they do not sit within workstreams.
- The workstream position reflects the Integrated Commissioning Fund without the application of mitigating reserve and non recurrent funding to offset over spends.
- The Month 10 combined workstream position is a forecast over spend of £8.6m which is a deterioration of £0.4m on the Month 09 position. This is being driven by Planned Care acute.
- Across the CCG, LBH and CoL,
  - The Planned care workstream is driving the position with a reported forecast variance of £7.6m adverse. This is a deterioration of £0.5m on the Month 09 position. The position includes LBH Learning disabilities overspend of £6.0m which is being driven by undelivered savings from previous years and increase in demand in terms of numbers and complexity of care for clients resulting in higher costs packages. Within the CCG over spends on Continuing Health Care of £0.9m and other acute liens are resulting in an overall over spend of £1.6m.
  - The Unplanned care workstream forecasts an adverse position of £0.4m against the annual budget which is a deterioration of £0.6m on the month 09 position. This change in position is driven by the CCG and reflects an increase in Non Contracted Activity (NCA).

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

City and Hackney CCG – Position Summary at Month 10

	ORG	WORKSTREAM	Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend £000's	Forecast Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Commissioned	Unplanned Care	18,735	15,612	15,612	0	18,735	0	0
		Planned Care	6,202	5,168	5,406	(237)	6,487	(285)	0
		Prevention	10	8	8	0	10	0	0
	Pooled Budgets Grand total		24,947	20,789	21,026	(237)	25,232	(285)	0
Aligned	ORG	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
	Commissioned	Unplanned Care	111,324	92,769	93,541	(772)	112,701	(1,378)	(833)
		Planned Care	186,555	154,634	156,555	(1,921)	188,154	(1,599)	(2,225)
		Prevention	3,761	3,135	3,054	81	3,665	97	0
		Childrens and Young People	44,394	36,995	37,241	(247)	44,802	(408)	(71)
		Corporate and Reserves	21,510	16,204	11,876	4,329	16,504	5,006	4,563
	Aligned Budgets Grand total		367,545	303,738	302,267	1,471	365,826	1,719	1,434
Subtotal of Pooled and Aligned			**392,492**	**324,527**	**323,293**	**1,233**	**391,058**	**1,434**	**1,434**
In Collab	Primary Care Co-commissioning		44,183	35,161	35,161	0	44,183	0	0
Grand Total of including Primary Care Co-commissioning			**436,675**	**359,688**	**358,455**	**1,233**	**435,241**	**1,434**	**1,434**
CCG Total Resource Limit			466,873						
SURPLUS			30,198						

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- Corporate (Running Cost Allowance - RCA) underspends and reserve funding of £5m are off setting overspends at an organisational level. The Month 10 position is an improvement of £0.4m on the Month 09 position .
- Primary Care Co-Commissioning : At month 10, the Primary Medical Service budget is reporting a year to date and forecast position to plan. Whilst there is some pressure in the budget this is being actively managed and is expected to be fully mitigated through contingencies.
- *Continuing Health Care , FNC = Funded Nursing Care
- London Ambulance Service (LAS)

- At Month 10 the CCG is reporting a year to date surplus of £1.2m and a full year surplus of £1.4m. This position represents the continued recognition of additional savings previously reported.
- **Pooled budgets** The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF) ,Integrated Independence Team (IIT) and Learning Disabilities. Within pooled budgets, Learning Disabilities is forecasting an over spend of £0.2m at the year based on updated activity data provided by LBH.
- **Aligned budgets**: The **Unplanned Care** workstream is over spent by £0.7m year to date with a £1.4m forecast over spend which represents a deterioration of £0.5m on the previous month's forecast. This adverse movement is being driven by Non Contracted activity (NCA). The FOT also reflects:
  - Acute over spends within UCLH - £0.8m driven by Adult A&E Non Elective activity. LAS and North Middlesex service are also over spent against budget by £0.2m and £0.1m respectively related to activity.
- The **Planned Care** workstream reports a year to date over spend of £1.9m with a FOT of £1.6m adverse which is an improvement of £0.6m on the Month 10 position. The FOT position reflects:
  - An improvement in the Homerton forecast from £0.6m to £1.1m underspent, which recognises the continued year to date underspend (Mainly related to A&E). This figure includes QIPP delivery of £0.6m.
  - Barts Acute continues to over spend with a forecast variance of £1.5m adverse.
  - CHC and FNC continue to be over spent in the year with a forecast of £0.9m at year end – challenges are still being made to the activity data to review eligibility criteria and address panel backlogs through the workstream CHC Improvement group and CHC Direct.
- Children's and Young people adverse position relates to over spends across almost all acute providers including in UCLH, North Middlesex and Whittington Hospital as well as CHC spot purchase complex care packages.

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Risks and Mitigations Month 10 - City and Hackney CCG

Summary and Progress Report on Financial Risks and Opportunities to 31 January 2017

Ref:		Description	Risks/ (Opps) £'000	Prob. %	Adj. Recurrent £'000	Adj. Non Recurrent £'000	Narrative
1	Risk	Homerton Acute performance	1,000	0%	0	0	Gross position based on historic trend. Net risk based on the trend inclusive of claims and challenges.
2		Bart's Acute performance	2,000	78%	1,552	0	Material adverse movement within CH and across NEL system. Subject to review.
3		Outer sector - Acute performance	2,600	81%	2,094	0	Increased NCL provider over-performance risk contained by reserves.
4		Non-Contracted Activity (NCA) performance	600	67%	400	0	Gross and net risk based on recent change in trend profile.
5		Continuing Healthcare, LD & EOL	1,435	74%	1,066	0	Risk relating to activity increase above plan, high cost patients packages and service provision. Gross risk high given worsening trends and FNC tariff pressure.
6		Non Acute performance	300	19%	56	0	Non acute cost pressure across the portfolio.
7		Programme Costs	200	0%	0	0	In-year non-recurrent costs in support of the integrated commissioning programme and other non-recurrent schemes.
8		Property Costs	300	0%	0	0	Property services cost pressure.
9		Non Recurrent Investment Cost Pressure	3,000	30%	0	900	Underwriting NR investment programme, dispute resolution and other pressures.
10		Primary Care - Rent Revaluation	750	0%	0	0	Retrospective rent increases.
11		Primary Care - Rates	250	0%	0	0	Increased rateable value on properties.
12		QIPP Under Delivery	200	0%	0	0	Under-delivery for schemes within the Operating Plan.
Total Risks			**12,635**	**48%**	**5,168**	**900**	
1	Opps	Acute contract Claims and Challenges	(2,200)	64%	(1,408)	0	Gross position based on historic trend, revised to reflect current probability.
2		Acute Reserves	(1,190)	100%	(1,190)	0	Release of reserve to contain pressures.
3		Programme Costs	(200)	0%	0	0	Breakeven forecast.
4		Contingency (0.5%)	(1,867)	91%	(1,707)	0	Release of contingency.
5		Prescribing	(300)	62%	(187)	0	Net underspend across portfolio.
6		Property Costs	(1,000)	89%	(890)	0	Benefits recognised following negotiated settlement.
7		Running Costs	(1,400)	87%	(1,220)	0	Headroom declared to contain non acute pressures and savings delivery.
8		Prior year Items	(4,000)	23%	0	(900)	Opportunities arising from settlement of disputed items, accruals etc. invoices provided for in prior year resulting in an in-year benefit.
9		Non Recurrent Investment slippage	(300)	0%	0	0	Reviewed and risk assessed and position contained at month 10.
10		QIPP Over Delivery	(200)	0%	0	0	Expectation is on-plan delivery of £5.0m QIPP declared in the Operating Plan.
Total Opportunities			**(12,657)**	**59%**	**(6,602)**	**(900)**	
					(1,434)	**0**	
			Net Underlying Forecast Outturn			**(1,434)**	
			Net Cumulative Brought Forward surplus			**(30,198)**	
			Headline Forecast Outturn Cumulative			**(31,632)**	

City of London Corporation – Position Summary at Month 10

				YTD Performance			Forecast		
	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Comm'ned * DD	Unplanned Care	65	46	3	43	63	2	-
		Planned Care	208	111	101	10	202	6	6
		Prevention	10	3	-	3	10	-	-
Pooled Budgets Grand total			283	160	104	56	275	8	6

	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Aligned Budgets	Comm'ned & DD	Unplanned Care	208	-	-	-	208	-	-
		Planned Care	3,963	3,450	3,191	259	3,880	83	99
		Prevention	1,901	963	1,554	(591)	2,169	(268)	(186)
		Non - exercisable social care services (income)	-	-	-	-	-	-	(78)
Aligned Budgets Grand total			6,072	4,413	4,745	(332)	6,257	(185)	(165)
Grand total			**6,355**	**4,573**	**4,849**	**(276)**	**6,533**	**(178)**	**(159)**

* DD denotes services which are Directly delivered .
* Aligned Pooled budgets include iBCF funding - £179k
* Comm'ned = Commissioned

- At Month 10 the City of London is reporting a forecast full year deficit of £0.2m.
- **Pooled budgets** The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF). They are reporting a forecast under spend of £8k attributable to BCF services within Planned care work stream - Care Navigator Service and Reablement Plus.
- **Aligned budgets** are over spent by £0.3m in the year to date with a forecast variance of £0.2m for the full year. The forecast is being driven by the Prevention workstream which is £0.3m adverse as a result of additional pressures caused by the broadening of the substance misuse and healthy weight / exercise services that are being offered and taken up by City residents including services provided by Square Mile Health (smoking, alcohol and substance misuse). The bulk of these additional costs will be met by Public Health reserves prior to the year end. The Planned Care underspend of £0.1m is due to a change in profile of those in residential care for the 65+ age group. The income shortfall of £0.1m is due to a change in the financial circumstances of a number of clients which has reduced their liability to pay.

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

London Borough of Hackney – Position Summary at Month 10

						YTD Performance			Forecast		
Pooled and Aligned Budgets	ORG Split	WORKSTREAM	Total Annual Budget £000's	Pooled Annual Budget £000's	Aligned Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
	Commissioned & Directly Delivered	LBH Capital BCF (Disabled Facilities Grant)	1,299	1,299	-	1,083	1,053	30	1,299	-	-
		LBH Capital subtotal	1,299	1,299	-	1,083	1,053	30	1,299	-	-
		Unplanned Care (including income)	5,452	1,593	3,859	4,543	6,656	(2,113)	4,438	1,014	1,013
		Planned Care (including income)	60,509	22,640	37,869	50,424	58,707	(8,283)	66,337	(5,828)	(5,936)
		Prevention	34,867	-	34,867	29,056	22,347	6,709	34,867	-	-
		LBH Revenue subtotal	100,828	24,233	76,595	84,023	87,710	(3,687)	105,642	(4,814)	(4,923)
Grand total			**102,127**	**25,532**	**76,595**	**85,106**	**88,763**	**(3,658)**	106,941	(4,814)	(4,923)

102,127

- At Month 10 LBH reports a forecast over spend of £4.8m
- **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (including the Integrated Independence Team IIT) and Learning Disabilities.
- **Planned Care:** The Pooled Planned Care workstream is driving the LBH over spend. Learning Disabilities Commissioned care packages within this work stream is the main area of over spend, with a £6m pressure. There was an adverse movement of £0.2m from the December position. The adverse movement is primarily driven by the following factors:
- Additional care provision for existing clients due to increased care needs with a total cost impact of £126k, of which £24k relates to transition and settlement costs to meet a client's accessibility needs.
- Growth in clients numbers due to new client referrals with an associated cost of £63k, of which £54k relates to a Home Care package that started in May 2017.
- Increase in one-off respite care commissioned with a total cost impact of £24k.
- Savings of £34k achieved as a direct result of the Care Funding Calculator work stream which resulted in the cost of three care packages being reduced.
- The overall budget pressure within LD represents undelivered savings from previous years and increase in demand in terms of numbers and complexity. Further detailed work on spend in this area has highlighted that the deliverability of the savings is compromised by the complexity of need currently funded by Adult Social Care. Discussions are ongoing with CCG colleagues on proposals for a joint funding agreement to contribute to high needs learning disabilities packages which will benefit service users in preventing the escalation of need.

- **Unplanned Care:** The Unplanned Care workstream has not had any significant movement from the December position.
  - The overall Unplanned care forecast under spend relates to Interim Care (£0.6m) and is offset by linked over spends on care packages expenditure which sits in the Planned Care workstream.
  - The favourable forecast also reflects underspends in Substance Misuse (£0.3m) due to declining activity levels.
  - The delay in implementation of Telecare charging coupled with the undelivered savings to date in Housing Related Support are being partially offset by one off additional income.
  - The Planned Care overspend is partially offset by one off forecast underspends in the Unplanned Care reducing the overall overspend to £4.814m
- **Prevention Budgets:** Public Health (constitutes 100% of LBH Prevention budgets) forecasts a breakeven position.

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

London Borough of Hackney – Service Level Position Summary at Month 10

Services	Unplanned Care £'000	Planned Care £'000	Grand Total £'000	Comments
Care Management & Adults Divisional Support	0	(558)	(558)	The CM&ADS position is showing a £558k overspend. This is a favourable movement of £7k on the December position. This improvement is primarily driven by a small reduction in agency staff expenditure. The overall budget pressure breakdown is made up of: • Staffing pressures of £510k within Integrated Learning Disabilities due to additional staffing capacity to manage demands within the service, and improve annual review performance. • A further staffing pressure of £181k within the Adult Social Care Management Team which is due to the high premium for consultancy/locum staff. • The overall pressure has been partially mitigated by underspends across other Care Management Teams within the service area.
Care Support Commissioning	0	(5,913)	(5,913)	The Learning Disabilities service remains the most significant area of pressure with a £5.970m overspend which reflects a £178k adverse movement on the December position. The adverse movement is primarily driven by the following factors: • Additional care provision for existing clients due to increased care needs with a total cost impact of £126k, of which £24k relates to transition and settlement costs to meet a client's accessibility needs. • Growth in clients numbers due to new client referrals with an associated cost of £63k, of which £54k relates to a Home Care package that started in May 2017. • Increase in one-off respite care commissioned with a total cost impact of £24k. • Savings of £34k achieved as a direct result of the Care Funding Calculator work stream which resulted in the cost of three care packages being reduced. The overall budget pressure within LD represents the increasing complexity of care for clients resulting in higher cost packages. The increased cost is currently being funded by Adult Social Care and there are ongoing discussions with the CCG on proposals for a joint funding arrangement to contribute towards high need learning disabilities packages which will benefit service users in preventing the escalation of need.
Mental Health	110	(277)	(166)	The Mental Health service is provided in partnership with the East London Foundation Trust (ELFT), and is forecast to overspend by £167k, , which is a favourable movement of £70k on the December position. This improvement is due to a reduction in expected staff expenditure as a result of delays in the recruitment process. The overall position is made up of two main elements - a £556k pressure on external commissioned care services, offset by a £389k underspend across staffing related expenditure.
Prevention and Re-ablement	889	0	889	The forecast under spend relates to Interim Care (£0.6m) and is offset by linked over spends on care packages expenditure which sits in the Planned Care workstream. There is further underspend Substance Misuse (£0.3m) due to declining activity levels.
Provided Services	0	750	750	The Provider Services forecast position is a £750k underspend relates. This is an improvement of £55k on the December position, which is primarily driven by a reduction in expected staff cost as result of delays within the recruitment process. The overall Provided Services position is made up of: • Housing with Care staffing pressure of £228k. The service is currently under review to seek efficiencies and reduce costs without impacting negatively on service provision. • Day Services & transport is underspending by £731k, which reflect the delivery of savings as part of the previous transformation programme. This underspent budget will be required for the new Oswald Street day centre to be opened in 2018/19. • Meals on Wheels is underspending by £247k which reflects the incremental reduction in demand for the service. The service is currently being reviewed to look at possible options available in redesigning the service.
Commissioning	15	170	185	The full outturn position recognises £597k to support staff costs, and this additional capacity has been to allow for service improvements in the year.
Grand Total	**1,014**	**(5,828)**	**(4,814)**	

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Risks and Mitigations - London Borough of Hackney

London Borough of Hackney

Risks	Full Risk Value £'000	Probability of risk being realised %	Potential Risk Value £'000	Proportion of Total %
Pressures remain within Planned Care (mainly Learning Disabilities Commissioned care packages) as mitigating actions are unlikely to have significant impact in this financial year	4,814	100%	4,814	100%
TOTAL RISKS	**4,814**	**100%**	**4,814**	**100%**

Mitigations	Full Mitigation Value £'000	Probability of success of mitigating action %	Expected Mitigation Value £'000	Proportion of Total %
Management actions through the implementation of initiatives such as the Care Funding Calculator (CFC) will seek to mitigate some of this pressure this financial year.	TBC	TBC	TBC	TBC
Review one off funding	4,814	100%	4,814	100%
Uncommitted Funds Sub-Total	**4,814**	**100%**	**4,814**	**100%**
Actions to Implement				
Actions to Implement Sub-Total	**0**	**0**	**0**	**0**
TOTAL MITIGATION	**0**	**0**	**0**	**0**

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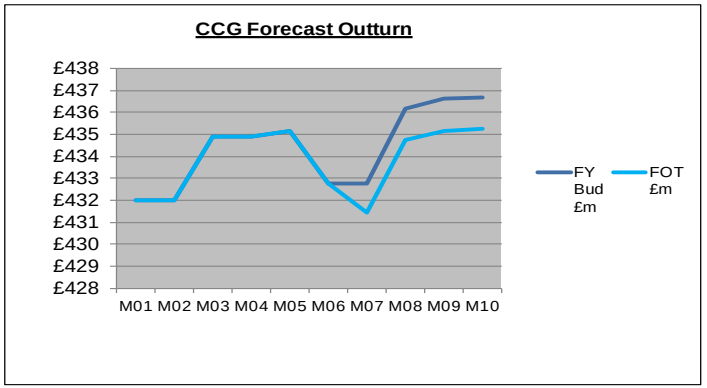
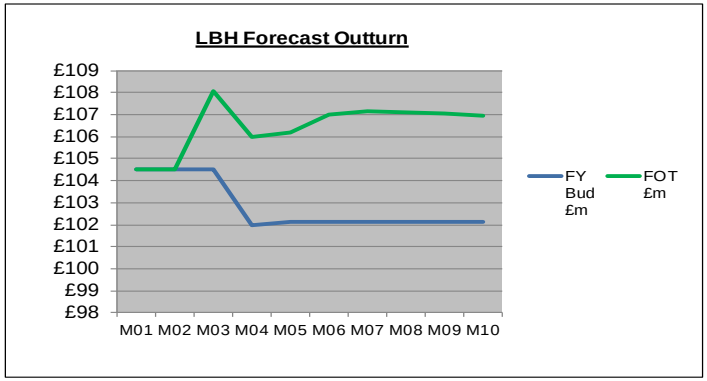
Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Forecast Run Rate at Month 10

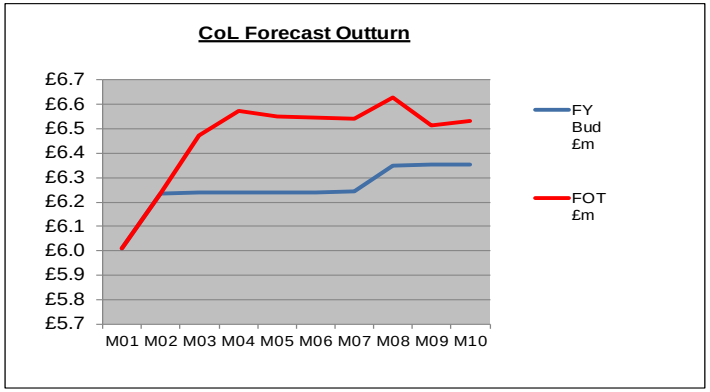
City and Hackney CCG Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	432.0	432.0	-
M02	432.0	432.0	-
M03	434.9	434.9	-
M04	434.9	434.9	-
M05	435.2	435.2	-
M06	432.8	432.8	-
M07	432.8	431.5	1.3
M08	436.2	434.8	1.4
M09	436.6	435.2	1.4
M10	436.7	435.2	1.4



London Borough of Hackney Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	104.5	104.5	0.0
M02	104.5	104.5	0.0
M03	104.5	108.1	(3.5)
M04	102.0	106.0	(4.0)
M05	102.1	106.2	(4.1)
M06	102.1	107.0	(4.9)
M07	102.1	107.1	(5.0)
M08	102.1	107.1	(5.0)
M09	102.1	107.1	(4.9)
M10	102.1	106.9	(4.8)



City of London Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	6.0	6.0	0.0
M02	6.2	6.2	0.0
M03	6.2	6.5	(0.2)
M04	6.2	6.6	(0.3)
M05	6.2	6.6	(0.3)
M06	6.2	6.5	(0.3)
M07	6.2	6.5	(0.3)
M08	6.4	6.6	(0.3)
M09	6.4	6.5	(0.2)
M10	6.4	6.5	(0.2)



- At Month 10 the CCG is forecasting an underspend of £1.43m against the full year budget.
- At Month 10 LBH is forecasting a £4.8m adverse position at year end. This is being driven by Learning Disabilities commissioned care packages. Mitigating actions are being undertaken by management to reduce the overspend.
- At Month 10 the CoLC is forecasting an adverse position of £0.2m for year end due to increasing cost of homecare. This will be mitigated by the application of reserve funding which is not currently reflected in the position.

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Integrated Commissioning Fund – Savings Performance Month 10

City and Hackney CCG

The CCG has a recurrent savings of £5m which has been removed from the respective budgets ,therefore the budgets reported are net of QIPP.

- The CCG has identified an additional saving of £1.4m which is over and above the £5m target is not reflected in the position as advised by NHSE.
- Savings reported at Month 10 are an over achievement of £0.1m to date.
- The full year forecast has been reported achieve the target of £5m. Weekly savings delivery meetings are the platform to address any slippage and identify mitigations.
- There is some risk around the achievement of the additional £5m stretch target (see mitigations table).

London Borough of Hackney

LBH has agreed savings of £3.5m for 2017/18 (this includes delayed telecare charging implementation from 2016/17 of £0.3m), of this we anticipate that we will deliver £3.0m for 2017/18.

The shortfall in savings relates to:

- Housing Related Support (£1,062k savings agreed) - the savings achieved to date is £955k, leaving a shortfall of £107k which is offset by one off additional income.
- Telecare (£362k savings) charging agreed as part of the 2016/17 savings, has been delayed due to issues with the previous provider. The service is now working with a new provider and it is anticipated that the charging will not be implemented until the 2018/19 financial year.

City of London Corporation

- The CoLC have not identified a saving target to date for the 2017/18 financial year

Title:	Integrated Commissioning Register of Escalated Risks - FOR INFORMATION
Date:	9 March 2018
Lead Officer:	Devora Wolfson, Integrated Commissioning Programme Director
Author:	Matt Hopkinson, Integrated Commissioning Governance Manager
Committee(s):	Integrated Commissioning Board, 21 March 2018 Transformation Board, 9 March 2018
Public / Non-public	Public

Executive Summary:

This report presents the TB with a summary of risks escalated from the four care workstreams and from the Integrated Commissioning programme as a whole.

The paper is presented for information.

Integrated Commissioning Programme Escalated Risks

Risk / Event Details				Inherent Scores [pre mitigation]			Mitigation Plan	Action Taken	Residual Scores [post mitigation]			Risk Direction since last report	Target Score		
Reference Number	Workstream / Project	Lead Officer	Risk Description (Cause-Event-Effect)	Likelihood	Severity	Inherent Risk Score	**Scoped programme of work to mitigate this risk** [bullet action plan including timescales and performance metrics where available & appropriate. **All actions should indicate who is responsible for carrying them out**.]	**Monthly update on actions taken to mitigate risk and impact of actions**	Likelihood	Severity	Residual Risk Score		Likelihood	Severity	Target Risk Score
IC5	IC Programme	David Maher / Anne Canning / Simon Cribbens	Workstreams not effectively delivering on their responsibilities leading to poor performance or failure of commissioned services within the scope of s75 agreements.	4	4	**16**	Rigorous process for development of workstreams; Clear governance systems to manage IC processes and provide rigorous oversight (Devora Wolfson / Matt Hopkinson)	Ongoing work on system and process design. Phased approach and piloting will limit the risk to delivery and allow time for lessons learned to be embedded across all workstreams. Transformation Board and ICBs provide oversight to ensure levels of performance are maintained.	3	4	**12**	↓	1	4	**4**
IC9	IC Programme	David Maher / Anne Canning / Simon Cribbens	Failure to agree on a collaborative model to the Integrated Care System (e.g. payment system, risk share model, organisational form) resulting in impact on delivery of services and financial viability of partner organisations.	4	4	**16**	Develop appropriate model in collaboration with full range of stakeholders; Use current phase of Integrated Commissioning to develop partnerships in City & Hackney health and social care networks;	A series of workshops to collaboratively discuss models is underway with engagement from all commissioners and providers. Providers are also meeting together to discuss options and there will be further system-wide discussions. Work done to build relationships between partners in health and social care organisations and commitment of partners to collaboration and integrated service delivery.	3	4	**12**	↓	2	4	**8**
UC1	Unplanned Care	Dylan Jones	Risk that Homerton A&E will not maintain delivery against four hour standard for 16/17 and 17/18.	5	4	**20**	System Resilience Funding part of a wider investment and transformation plan has been signed off. 1.Additional Clinical Capacity 2.Maintaining Flow 3.Additional Bed Capacity 4.Demand management and community pathways Divert ambulance activity: Maintain ParaDoc Model and further integrate, diverting activity from London Ambulance DutyDoctor aim to improve patient access to primary care and manage demand on A&E	HUH have maintained strong operational grip through senior management focus on ED and hospital flow Recent reduction in DToCs should support flow Work to produce a PC admission avoidance DoS (via MiDos) underway – part of Case Notes Review action plan	3	4	**12**	↓	TBC	TBC	TBC

UC2	Unplanned Care	Tracey Fletcher / Nina Griffith	Ongoing difficulties in recruiting GP staff across unplanned care services, including OOH, PUCC and Primary Care puts pressure on the whole C&H health system risk that patients and are thus seen in acute settings such as A&E [impacts HUH 4hour target and cost]	4	5	**20**	Ongoing work to develop a new model of integrating all Primary Care services – expectation that this will protect GP resource CHUHSE contract budget has been modelled to accommodate increased hourly rates required for interim, face to face, OoHs GPs Explore ways to address challenges recruiting GPs through CPEN	Please see column to the left	4	4	**16**	↓	TBC	TBC	TBC
UC3	Unplanned Care	Tracey Fletcher / Nina Griffith	Integrated Urgent Care (111) re-procurement risk of negative impact on quality of service and impact on other urgent care systems Local impact: Increased demand on C&H acute services due to risk averse nature of 111 assessment Challenges recruiting GPs to the CAS Risk that patients will be attracted by quick call answering times from 111 Risk that the new service increases demand for urgent care services, as new patients who were not previously using urgent care services begin using 111	4	4	**16**	Extensive modelling with external support and engagement with stakeholders (patients, clinicians, commissioners). Clinical involvement in service specification development. Re-procurement of service to be overseen by appropriate CCG Committees [Audit and CCG GB] and Unplanned Care Workstream Service to be continually monitored post mobilisation IUC service reporting requirements include audit of onward referral to local services to review appropriateness. Ensure that alternative primary urgent care services are promoted to patients and clinicians to ensure alternate services are frequented by patients [MDCNR] Investigate what existing providers may be able to support health system in event of delay Local promotion of Duty Doctor to encourage patients and health care professionals to choose this service over 111.	The NEL 111 procurement has now been finalised, with go live expected in August 2018. We have agreed to extend the CHUHSE contract for a standalone GP out of hours service until end March 2019. CHUHSE are supporting the workstream to find a sustainable solution. Urgent care reference group established to agree the sustainable solution	3	4	**12**	↓	TBC	TBC	TBC

UC4	Unplanned Care	Simon Galczynski	Improved DTOC levels are not maintained	5	4	**20**	(i) Discharge working group established to develop proposals which will include discharge to assess (ii) Discharge actions included within A&E Delivery plan and monitored by the urgent care board (iii) LBH and Homerton have established a regular DTOC group that is focused on ensuring effective joint arrangements around discharge (iv) Weekly teleconference to discuss performance with Director X. Implement actions from Multi Disciplinary Case Notes Review relating to DToCs X. High impact Change Model (LBH and CoL) has been set up to monitor performance	Weekly teleconference continues and performance continues to improve. London BDF Team confirmed Hackney will not be subject to special measures of risk of loss of funding. X. Meeting with Principle Head of Adult Social Care taken place, action plan being developed to design and deliver a small-scale Case Note Review for DToCs X. Capacity to deliver plans and culture shift required [re High Impact Change Model]	4	2	**8**	⟷	TBC	TBC	TBC
UC5	Unplanned Care	Nina Griffith	Programme Management and Provider resources (managerially and clinical) are insufficient to deliver the design phase of the neighbourhood model	5	4	**20**	Recruit to central Neighbourhoods Programme Team Tap into Clinical and Project resource across the system to support Monitor programme activity via Neighbourhoods Steering Group	The business case for a small central programme team with dedicated information support and a small non-pay budget was approved at the December Integrated Commissioning Board. Work is now underway to develop the job descriptions for this team and recruit to these posts. Additionally clinical and project management resources were approved across each of the main providers (based on their own identified needs) to allow them to design and plan their contribution to the neighbourhood model. This will significantly reduce the risk of non-delivery of the design phase of the neighbourhood programme. Progress will be closely monitored via the Steering Group.	2	3	**6**	↓	TBC	TBC	TBC
UC8	Unplanned Care	Tracey Fletcher / Nina Griffith	Inability to identify, recruit and engage diverse and representative patient engagement	4	4	**16**	Support patient engagement work through Neighbourhoods Business Case Neighbourhoods patient panel to work closely with UPC Workstream and Neighbourhoods Programme	An initial sum to support patient engagement work has been approved through the Business Case. A patient panel has already been convened with four members representing a range of communities and interests. Further patients are being actively recruited. The patient group will work closely with the overall workstream patient enabler group to ensure excellent communication. The first patient panel meeting was held in December with full attendance and excellent participation.	2	4	**8**	↓	TBC	TBC	TBC
UC9	Unplanned Care	Tracey Fletcher / Nina Griffith	Workstream struggles to assume all responsibilities and deliver outcomes as required	4	4	**16**	Introduction of more formal programme governance including risk register, workstream reporting and dashboards Commissioned external piece of OD facilitation so that the workstream can jointly form their vision and strategy, and consider what behaviours are required to deliver	New governance system in place, OD consultation under way. Assurance gateway 3 is in March, this will provide a useful stocktake (draft documentation for this presented to February programme board).	3	4	**12**	↓	TBC	TBC	TBC

UC11	Unplanned Care	Tracey Fletcher / Nina Griffith	Intermediate care beds not available to meet needs	4	4	**16**	Monthly sub group continues to meet to review all available options. Options paper due to be presented Feb 2018. Need to identify funding.	2 possible sites visited and 1 further visit to 3rd option set up late January 18.	3	4	**12**	⟷	TBC	TBC	TBC
UC12	Unplanned Care	Tracey Fletcher / Nina Griffith	If Primary care and Community Services are not sufficiently developed and are not established as a first point of call for patients this could lead to an increase in the number of inappropriate attendances at A&E and unplanned admissions to hospital.	5	4	**20**	Increase the resilience of Hackney nursing homes through enhancing GP provision to the nursing homes contract Increase support to frail housebound patients at risk of admission through the Frail Home Visiting Service (FHV) Provide C&H patients with alternative methods of accessing Primary Care Services [not just A&E] through the Duty Doc Service Reduce the number of inappropriate attendances at A&E and unplanned admissions to hospital through Paradoc Develop and implement Neighbourhood model	Progress is being made on the development of the Neighbourhood model Creation of a DoS (via IT interface MiDos) for primary care admission avoidance services underway as part of Case notes Review Action Plan Urgent care workstream will include focus group with patient to understand what drives them to access different services Proposal to extend paradoc operational hours being taken to UPCPB in February	4	3	**12**	⟷	TBC	TBC	TBC
			CHUHSE OOH contract expires end of November 2017. Risk of gap in out of hour service provision.	5	4	**20**	Contract extended to 1 December 2017 Three month notice period written into extension in case of need for premature ending The CHUHSE contract has been extended from November 2017 - December 2018.	The Unplanned Care Workstream are developing a new integrated urgent care model that will incorporate the face to face element of GPOOH activity. It proposed that CHUHSE continue with a stand alone face to face service as a interim solution to bridge the gap between introduction of the North East London Integrated Urgent Care Service and the new local integrated urgent care model. Risk: The interim solution is awaiting approval from CCG Governing Body. The procurement options to for the interim solution have associated risk of challenge or interest from alternative provider.	5	1	5	↓	TBC	TBC	TBC

UC14	Unplanned Care	Nina Griffith	Workstream fails to successfully integrate patients and the public in the design and development of services; services are not patient focused, and are thus limited in reach and scope	4	4	**16**	Ensure the Unplanned Care Board is plugged-in to Integrated Commissioning related PPI / co-production activities, and utilises the IC Co-production Charter Ensure the Unplanned Care Board works with IC PPI staff, including the Engagement Manager, Healthwatch and CCG PPI Lead Ensure the Unplanned Care Board has a Patient or Healthwatch Representative at every Board meeting Unplanned Care Board to map existing patient and public engagement mechanisms and successful PPI initiatives across the portfolio, develop a PPI and co-production strategy based on this information. Ensure PPI and co-production is a standing item on workstream Board agendas Review PPI activities quarterly at the UPCM Board Neighbourhoods programme has convened a patient panel and secured some resources to support patient engagement	A second patient representative has been appointed to the board. Workstream director presented to the CCG PPI forum and met with both Healthwatch City and Hackney to gain support in identifying broader range of users across our workstreams. All of the programme workstreams have at least one patient representative, and are talking to these individuals about how we involve expert users for more detailed service re-design.	4	4	**16**	**NEW**	TBC	TBC	TBC
UC15	Unplanned Care	Tracey Fletcher / Nina Griffith	Failure to deliver the scoped programme of System Savings for financial year 2018/19	4	4	**16**	Programme of System Savings meetings including reps from HUH, ELFT, CCG, LBH and CoL arranged for period x6 months, Terms of Reference for this group agreed by all partners Regular System Savings updates and items at the Unplanned Care Management Board Thorough investigation of Unplanned Care Acute 'Menu of Opportunities' Longer term, larger, system transformations will be required to deliver savings	the savings target has recently increased from £1.6m to £3.9m - which has driven the no change to the risk rating despite some actions progressing. Savings have been identified for 2018/19 up to value of £1.3m. These will be monitored monthly at the system savings group. Further areas for savings to be worked up have been identified. Neighbourhoods, discharge and urgent care will need to develop more transformational system changes to deliver longer term system savings from 19/20 onwards.	4	4	**16**	**NEW**	TBC	TBC	TBC
PC1	Planned Care	Simon Galczynski / Siobhan Harper	Financial Pressures in the Learning Disabilities Service create challenges for the current IC partnership arrangements and may impact on CLG proposals for future pooled budget developments	5	4	**20**	Partners need to agree a shared transformation and recovery plan for the LD service (Simon Galczynski / Siobhan Harper)	Proposed plans were discussed at the CLG and the TB in February	5	4	**20**	⟷	3	3	**9**

PC2	Planned Care	Simon Galczynski / Siobhan Harper	IAF Targets: IAPT - Cancer 62 day targets at the Homerton have been missed for a number of months this year, and a data submission has been missed by the provider. This could impact on CCG rating.	4	4	**16**	Submit request to NHSE for the data point be reopened to submit the IAPT report (Siobhan Harper)	Provider and CCG have written to NHSE to request the data point be reopened to submit the IAPT report - currently awaiting response WD has escalated performance to the CCG FPC and has written formally to the provider. 62 day target has been delivered in November and December.	4	4	**16**	⟷	3	3	**9**
Pv4	Prevention	Gareth Wall / Jayne Taylor	Risk of no resources being allocated to the delivery of the Big Ticket Item, 'Making Every Contact Count' - without additional resources progress is likely to be limited.	5	3	**15**	Full scoping for delivery of this Big Ticket item to take place in Q3 and Q4 2017/18, including identificaiton of virtual team and potential funding. Ability to make use of contract variations and re-procurements to require the provision of MECC training to all provider organisations	Initial scoping workshop completed. Further work will continue in the new year to assemble the project team and define the scope of the project.	5	3	**15**	⟷	5	1	**5**
CYP M1	CYPM	Amy Wilkinson / CCG Programme Dir.	**Vulnerable women's pathway.** A clear pathway is now in place however there are threats to funding for various services for vulnerable pregnant women because of Local Authority cuts. This includes Substance Misuse and Public Health midwifery services and community services including Bump Buddies. Short term CCG funding may also mean further services for vulnerable women may reduce from 2016 or 2017. The impact of reduced services for vulnerable women could directly results in worse health outcomes for women and children.	4	4	**16**	The following controls are in place: * Maternity programme board submitting proposals for short term funding extensions for these at risk services. However there is a risk the proposals are not prioritised or seen as part of tariff and therefore not funded past March 2016. * The programme board in discussion with HUH about their plans to address funding cuts to specialist midwifery services. These discussions include consideration of contractual levers and mechanisms that could be utilised to mitigate risks, such as CQUINs. * 7 community teams restructured January 2016 to merge team lead and public health midwife role. 1 substance misuse role also deleted. * Bump buddies funding secured for 17/18 (approx 65 women supported p.a.) * Recurrent funding secured for targeted antenatal classes. * Bonding with Baby funding secured for 17/18	Pathway and service offer being reviewed by CCG and MPB as part of clinical leadership programme. Will report Autumn 2017. September 2017 update: The Vulnerable Women pathway will be agreed and ratified by October 2017. November 2017: KE - further comments to be agreed before taking to ICE for ratification.	1	4	**4**	N/A	TBC	TBC	TBC

CYP M2	CYPM	Amy Wilkinson / CCG Programme Dir.	**Maternal deaths.** There were 5 maternal deaths in a 2 year timeframe at HuH which was unusual and concerning. There was a heightened risk of further deaths which needed to be mitigated and there was also a possible impact on women's perception of safety at the Homerton. There was the risk that greater and continued scrutiny unearthed further quality, clinical, safety, staffing and other issues that required swift resolution. The CCG's reputation could also be impacted on negatively. A significant amount of work was undertaken by HuH to strengthen their delivery of quality and safe services with a focus on embedding best practice clinical processes. Staffing and leadership has also been scrutinised with changes to made to improve patient experience and outcomes, but a staffing review is outstanding.	4	5	**20**	The main controls are: * Enhanced scrutiny of performance including review actions, at Quality and Risk Summits (held in March, May, July & September 2015) * Development of a combined action plan to monitor actions and progress and identify themes for improvement. A further meeting for 17th Nov 2017 is scheduled to review evidence and gain assurance that actions have been progressed and positive change realised. This will also help identify any residual areas of work that are not progressing. * CQC re-visit (October 2015) to measure progress since March inspection. The combined action plan contained 53 items and 5 items remain open: 2 items relate to the staffing review, 1 item to the Tavistock leadership programme, 1 item to the maternity vision and strategy and 1 to an outstanding audit (named professional for every woman).	There were 2 further maternal deaths, in July 2016, and in January 2017 taking the total to 7 over a 3 year period. The maternal death in July 2016 was formally reviewed, including external input. The review found that HUH acted appropriately and HUH was praised for the level of consultant involvement in the care of the woman. The main recommendation related to amending admission criteria for early pregnancy unit. We are awaiting the report for the maternal death in January 2017. This report was received at the end of July 2017, which did not raise any concerns regarding the maternity service and identified robust actions which relate to cardiac services. It was proposed to the Maternity Programme Board that the residual risk score could be reduced if the 7th maternal death review does not identify any concerns relating to care provided by the HUH, and once all items on the combined action plan are completed. This proposal was accepted by the Board on 20.03.17. September 2017 update: The HUH maternity service have indicated that they have undertaken a Birth Rate plus midwifery staffing review and the report has been received by the service. The Maternity service have made comments on the findings of the report therefore the final version of the report is still awaited by CHCCG. The MPB has escalated the outstanding actions to the CHCCG CQRM September 2017 meeting. This risk currently sits in the BAF. October 2017 update: Following review of the outstanding actions at the September 2017 CQRM, Clare Highton the CCG Chair has recommended that the maternity strategy is now in place, therefore this item can now be closed. With regards to the medical staffing review the maternity PB asks for quarterly updates on trainee and consultant numbers against establishment, and assurance on rota fill with suitable locums. The birth-rate plus report has been taken to the HUH Trust board in September 2017. The Maternity programme board will ask for quarterly updates with regard to the number of midwifery staff, use of agency midwives and the 'midwife to birth-rate' ratio.	3	5	**15**	⟷	TBC	TBC	TBC
	CYPM																	

CYP M15	CYPM	Amy Wilkinson / CCG Programme Dir.	The Paediatric Audiology Service contracted by HUHFT as part of a block contract was served notice of the intention to divest itself of the historical SLA for Bart's Audiology that provides support to the second and third tier Audiology Service in September 2016. The rationale for this decision was that HUHFT acted as a sub-commissioner and this was not felt to be an appropriate arrangement. The audio vestibular consultant (AVC) input to the service for the Tier 3 service was provided by UCLH who were also served notice. The CHCCG has been in negotiation with the providers to commission a new service from the 1st June 2017. On 11.05.2017 the UCLH AVC team manager confirmed to DS that they were no longer in a position to provide the medical input into the Tier 3 service. There will be a risk to children who require a Tier 3 AVC consultation of their hearing loss diagnosis being delayed if an AVC service is not provided from the 1st June 2017. Approximately 50% of the Tier 3 service is for children from THCCG.	5	3	**15**	The service will require at least 0.5 PA's from an AVC in order to ensure the Tier 3 children are seen and reviewed in a timely manner.	05/07/2017: The Audiology contract has been agreed by all parties and the service specification will be completed by 14/07/2017. The AVC provision will be provided by Hearline for the next 10 months with the intention for the BH audiology service to appoint a consultant to cover this role as UCLH do not have the capacity. there has been no break in service and the back log 40 of children have now been followed up. This service is now fully up and running. The CCG is in the final stages of signing off contracts and MOU with BH and HUH respectively. **28/12/2017**: Tier 3 contract signed and in place. Tier 2 MOU agreed final service specification to be agreed for Tier 2 service and contract signed. The structure of the Tier 2 service after April 2018 to be determined with HUH Community Paediatric team and BARTS Health Audiology team.	2	3	**6**	↓	TBC	TBC	TBC
CYP M16	CYPM	Amy Wilkinson / CCG Programme Dir.	The implementation of the new Child Health Information System (CHIS) by PH England. Concerns about the robustness of the record transfer service (transferring records in and out). Provider trusts report they have not received transfer notifications. This is currently putting babies, children and young people at risk therefore they may not have not have their health needs addressed. Risk of sending late birth notifications which means health visitors are not able to do the new birth visit within 14 days. There is also a potential in missing results for new-born blood spot screening. Providers are responsible for following up abnormal results and this is putting this group of children at risk.	3	5	**15**	Update required from Health Care partners. 99% of City & Hackney GP practices now linked to QMS.	These areas will be formal standing agenda items at the Maternity programme board meetings from November 2017. In light of these actions and no concerns being identified regarding the maternity service at the HUH with the last maternal death, we will reduce the risk on the BAF to 15 and review the risk rating further after the November programme board.	2	4	**8**	↓	TBC	TBC	TBC
CYP M17	CYPM	Amy Wilkinson / CCG Programme Dir.	Recognition of a gap in joint processes around EHCP arrangements for children and young people with complex health needs who do not have an identified learning need. Health support at school is identified outside of the EHCP framework and agreed on a case by case basis with no QA across the range of involved health services currently	5	3	**15**	Governance process proposal to go to the SEND partnership board in December 2017 and the CYPMS work stream. A budget line will need to be secured in order to progress this.	29/11/2017: SD met with home tuition service coordinator and DMO to identify relevant cases. 28/12/2017: This has been taken to the CYPM work steam and the CCG CPB as there is a financial implication to fund theese children appropraitely in order to meet their educational needs.	5	3	**15**	↔	TBC	TBC	TBC

Integrated Commissioning Boards Forward Plan, 2018-19					
Title	**Summary of Decision**	**IC Decision Pathway**	**Care Workstream**	**Reporting Lead**	**Notes**
21-Mar-18					
Transformation of Outpatients	Approve transformation proposals and business case	Transformation Board, 9 February	Planned Care	Simon Cribbens	
Review of London Borough of Hackney Advice Services	To discuss and note **(Hackney ICB Only)**	n/a	All	Anne Canning / Sonia Khan	
Care Worsktream Asks, 2018/19	Discussion and to agree	Transformation Board 9 April 2018	All	Anna Garner	
Workstream Assurance Review Point 2 & 3 - 18/19 Workplans, Financial Plans and Capability, management of risk, competence and capacity for delivery	Discuss and approve the workstream assurance documents for Planned Care, Unplanned Care and Prevention	TB 10 November 2017	Planned Care / Unplanned Care / Prevention	Devora Wolfson / Clara Rutter / Nina Griffiths / Siobhan Harper / Gareth Wall / Jayne Taylor	
Integrated Commissioning Governance Review - Specification	Discuss and approve approach	TB - 9 March 2018	All	Devora Wolfson / Matt Hopkinson	
Integrated Finance Report - Month 10	Discuss and note	TB - 9 March 2018	All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Risk Register	For informaiton		All	Matt Hopkinson	
14-Jun-18					
Integrated Commissioning Strategic Vision and Objectives	Discuss and approve outcomes of the Vision Group	Vision Group	All	Devora Wolfson	
Report on IC Governance Review	Discuss and approve recommendations from the review of IC Governance arrangements	n/a	All	Devora Wolfson	
Intermediate Care Beds	For discussion and approval	TB 8 May 2018	Unplanned Care	Mark Watson Acting Strategic Commissioner Mental Health & Better Care Fund co-ordinator	
Analysis of impact of Universal Credit	Discussion and to note		All	Ian Williams	
Rightcare Stroke Business Case	For discussion and approval	TB April 2018		Anna Garner	
IC Evaluation Update			All	Anna Garner	
Allocation Plan for IT Enabler/Transformation Funds	For discussion and approval	TB April/May	All	Anita Ghosh	
Reprocurement of Carers Services			Prevention	Anne Canning	

IC Evaluation Report	For discussion and noting	n/a	All	Anna Garner / Cordis Bright	
Neighbourhoods Update	For discussion and noting	ICB February 2018	Unplanned Care	Nina Griffith	
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
12-Jul-18					
Business Case for Pooling - Prevention	To approve the business cases for further pooling of budgets	Transformation Board 12 January	Prevention	Anne Canning / Gareth Wall / Jayne Taylor	
Prioritisation & Investment Committee (PIC) Recommendations	For discussion and approval	PIC	All	Anna Garner / Devora Wolfson	
Governance Review Outcomes	For discussion and approval	ICB 21 March; TB June 2018	All	Devora Wolfson	
Local Account (Integrated Report)	For discussion and endorsement	n/a	All	Simon Galczynski / Ellie Ward	
IC Evaluation Report	For discussion and noting	n/a	All	Anna Garner / Cordis Bright	
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
13-Sep-18					
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Evaluation Update			All	Anna Garner	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
11-Oct-18					
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
15-Nov-18					
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
06-Dec-18					
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Evaluation Report	For discussion and noting	n/a	All	Anna Garner / Cordis Bright	

IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
17-Jan-19					
IC Evaluation Report	For discussion and noting	n/a	All	Anna Garner / Cordis Bright	
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
07-Feb-19					
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
14-Mar-19					
Integrated Finance Report	For noting		All	Philippa Lowe / Ian Williams / Mark Jarvis	
IC Evaluation Report	For discussion and noting	n/a	All	Anna Garner / Cordis Bright	
IC Risk Report	For discussion and approval	Transformation Board	All	Devora Wolfson	
Unscheduled Items					
Care Workstream Assurance Review Point 4	Approve assurance of transfomation capacity and capability	Transformation Board - 9/2/2018 - For disussion and endorsement Governing Body - 30/3/2018 - For assurance	Planned Care / Unplanned Care / Prevention	Devora Wolfson / Nina Griffith / Siobhan Harper / Gareth Wall / Jayne Taylor	