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 Thursday 12 July 2018, 10.20-12.00, The Tomlinson Centre, Queenbridge Road, London E8 3ND

Item no.	Item	Lead and action for boards	Documentation	Page No.	Time
1.	Welcome, introductions and apologies		Verbal	-	10.20
2.	Declarations of Interests	Chair *For noting*	2. ICB Register of Interests	4 - 5	
3.	Questions from the Public	Chair	Verbal	-	10.25
4.	Minutes of the Previous Meeting and Action Log	Chair *For approval* *For noting*	4.1 Minutes of Joint ICBs meeting in common, 21 March 2018 (public session) 4.2 ICB Action Log	6 – 18 19	10.30
5.	Extension of Community Health Services Contract with the Homerton University Hospital NHS Trust	David Maher/ Lee Walker *For approval*	5. ICB-2018-07-12 CHS contract extension	20 - 32	10.35
6.	ICB Development session	Devora Wolfson/ Jonathan McShane *For noting*	Verbal	-	10.45

7.	Building a movement to 'make every contact count' in Hackney and the City' – proposed approach	Jayne Taylor/ Anne Canning *For approval*	7. ICB-2018-07-12 MECC proposal	33 - 56	10.50
8.	Transforming Hackney's Integrated Learning Disabilities Service (ILDS) update	Siobhan Harper/ Simon Galczynski Simon Cribbens *For approval*	8. ICB-2018-07-12 LD update	57 - 70	11.00
9.	Neighbourhood Development Programme Update	Tracey Fletcher/ Nina Griffith *For noting*	9. ICB-2018-07-12 Neighbourhoods update	71 - 84	11.10
10.	Integrated Commissioning Evaluation Update	Anna Garner / Matt Irani *For noting*	10. ICB-2018-07-12 IC Evaluation	85 - 89	11.20
11.	IT Enabler Programme- IT project leads proposal	David Maher *For noting*	11. ICB-2018-07-12 IT Enabler Proposals	90 - 96	11.30
12.	City and Hackney system – Assessment of ICS Readiness	Devora Wolfson/ Devora Wolfson/Jonathan McShane *For discussion and noting*	12. ICB-2018-07-12 C&H system – assessment of ICS readiness	97 - 104	11.35
13.	Consolidated Finance Budget Report as at May 2018 - Month 02	Sunil Thakker / Ian Williams / Mark Jarvis *For noting*	13. ICB-2018-07-12 Consolidated Finance Report M02	105 - 117	11.45
14.	Integrated Commissioning Escalated Risk Register	Devora Wolfson/ Georgia Denegri *For noting*	14. ICB-2018-07-12 IC Risk Register	118 - 124	11.50
15.	AOB & Reflections	Chair *For discussion*	Verbal	-	11.55

16.	Date of next meeting: 14 September 2018, 3.00 – 5.00pm Committee Room 2, 2nd floor, West Wing, Guildhall, London EC2P 2EJ	Chair *For noting*	Verbal	-	12.00
17.	Integrated Commissioning Boards Forward Plan	*For information*	ICB Forward Plan	125 - 126	-

Integrated Commissioning
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
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
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
Sunil	Thakker		Transformation Board Member - CHCCG	City & Hackney CCG	Joint Chief Finance Officer	Non-Pecuniary Interest
				Chartered Institute of Public Finance and Accountancy	Member	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
Honor	Rhodes	05/04/2017	Member - City / Hackney Integrated Commissioning Boards	Tavistock Relationships	Director of Strategic Devleopment	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

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
Anntoinette	Bramble	28/04/2017	Deputy Mayor, Hackney Council	Hackney Council	Deputy Mayor	Pecuniary Interest
Dhruv	Patel	28/04/2017	Chair - City of London Corporation Integrated Commissioning Sub-Committee	n/a	Landlord	Pecuniary Interest
Peter	Kane	12/05/2017	Attendee - City Integrated Commissioning Board	City of London Corporation	Chamberlain	Pecuniary Interest
Geoffrey	Taylor	26/04/2017	Member - Hackney Integrated Commissioning Board	London Borough of Hackney	Member	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
Andrew	Carter	05/06/2017	Attendee - City Integrated Commissioning Board	City of London Corporation	Director of Community & Children's Services	Pecuniary Interest
David	Maher	20/01/2017	Managing Director & Programme Sponsor	City and Hackney Clinical Commissioning Group	Member of Cross sector Social Value Steering Group	Non-Pecuniary Interest
Rebecca	Rennison	11/12/2017	Member - Hackney Integrated Commissioning Board	Target Ovarian Cancer	Director of Public Affairs and Services	Pecuniary Interest
Ruby	Sayed	13/12/2017	Member - City Integrated Commissioning Board	City of London Corporation	Elected member	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
Ellie	Ward	22/01/2018	Integration Programme Manager, City of London Corporation	City of London Corporation	Integration Programme Manager	Pecuniary Interest
Mark	Rickets	16/05/2018	CCG Chair Primary Care Quality Programme Board Chair (GP Lead)	GP Confederation	Nightingale Practice is a Member	Professional financial interest
Feryal	Demirci	TBC	Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks	London Borough of Hackney	TBC	TBC

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 21 March 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 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

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

FORMALLY IN ATTENDANCE

Philip Glanville - Mayor of Hackney

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

David Maher - Acting Managing Director, City & Hackney CCG

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

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

Devora Wolfson –Programme Director, Integrated Commissioning

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

Siobhan Harper - Planned Care Workstream Director

Amy Wilkinson - CYPM Workstream Director

Angela Scattergood - CYPM Workstream Senior Responsible Officer

Nina Griffith - Unplanned Care Workstream Director

Jackie Brett - Hackney VCS Representative

Sonia Khan - Head of Policy & Partnerships, London Borough of Hackney

Joanne Blackwood - London Borough of Hackney

APOLOGIES

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

Cllr Rebecca Rennison, Cabinet Member for Finance & Housing Needs

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

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

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

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

STANDING INVITEES

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

OFFICERS PRESENT

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

Mark Jarvis - Head of Finance, City of London Corporation

Devora Wolfson –Programme Director, Integrated Commissioning

Ellie Ward - Integration Programme Manager, City of London Corporation

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

Siobhan Harper - Planned Care Workstream Director

Amy Wilkinson - CYPM Workstream Director

Angela Scattergood - CYPM Workstream Senior Responsible Officer

Nina Griffith - Unplanned Care Workstream Director

Jackie Brett - Hackney VCS Representative

Sonia Khan - Head of Policy & Partnerships, London Borough of Hackney

Joanne Blackwood - London Borough of Hackney

APOLOGIES

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

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. Clare Highton, Haren Patel and Gary Marlowe declared an interest, as GPs, relating to Item 8 - Proposal for Award of a Single Outcomes-Based Contract for Clinical Locally enhanced Services. It was agreed that Randall Anderson would chair the meeting for the duration of that item.

2.2. Jake Ferguson and Jon Williams declared an interest relating to Item 9 - Enabler Funding Proposals.

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

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

3. Questions from the Public

3.1. Michael Vidal, a patient representative, submitted the following question:

'Either within the various workstream budgets of funded centrally what provision has been made for the funding of engagement activities. I note from the papers from the planned care workstream that there will be a significant number of engagement activities that would be needed.'

3.2. Devora Wolfson responded that the programme has been providing funding to Healthwatch for an engagement post, and Item 9 sought the ICBs' consent to continue with this arrangement. There is also significant commitment within the workstreams for community and user engagement, drawing on the resources of the partner organisations.

4. Minutes of the Previous Meeting (Public Session)

4.1. The City Integrated Commissioning Board:

- **APPROVED** the minutes of the Joint ICB meeting on 28 February 2018;
- **APPROVED** the minutes of the Joint ICB meeting held in private on 31 January 2018; 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 28 February 2018;
- **APPROVED** the minutes of the Joint ICB meeting held in private on 31 January 2018; and
- **NOTED** progress on actions recorded on the action log

5. Transformation of Outpatients Services

5.1. Siobhan Harper presented the report on outpatient transformation (OPT), which is one of 'Asks' of the Planned Care Workstream. 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 report identified specific funding requirements of £450k to pay for 4 members of staff to deliver the review and to pay for clinical backfill.

5.2. An earlier draft of the report was discussed at the Transformation Board on 9 March. There was overall support amongst Board members for the principle and ambition of the plans for outpatient transformation. There were concerns amongst HUHFT colleagues about the timing of proposals, but these areas have been mitigated by revising the plan's timescales and allowing for additional flexibility in plan delivery.

5.3. Dhruv Patel asked whether there was a clear picture of the impact on City residents, given that the Homerton Hospital (HUHFT) accounted for only 9% of secondary care for City residents. It was noted that this may be an opportunity for the Neighbourhood model to have an impact, and the Planned Care team is discussing the localisation of delivery with the Neighbourhoods team.

5.4. Gary Marlowe noted that if the work on OPT is successful, the knowledge and experience gained will be applicable by other trusts. Also, the project is about improving patent involvement, which effects City and Hackney residents equally.

5.5. From the perspective of changing clinical behaviours and culture, it was noted that the project will be led by HUHFT, and they are keen to ensure that the work is done properly and is a foundation for culture change. It is essential that the review creates a strong consensus.

5.6. Jonathan McShane noted that it would be helpful for board papers to be explicit about the impact on service users and to express this in an accessible way. Siobhan Harper assured members that putting patient experience at the forefront of outpatient services is the primary driver of this project. It was noted much of this work would be invisible to patients as it is relayed through the GPs, but it will radically improve the quality of care.

5.7. Anntoinette Bramble asked for future reports to make explicit reference to the focus on priority demographics. It was noted that this would be raised within the forthcoming IC governance review.

5.8. The Hackney Integrated Commissioning Board:

- **CONSIDERED** and **APPROVED** the proposal and project plan; and
- **APPROVED** 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.

5.9. The City Integrated Commissioning Board:

- **CONSIDERED** and **APPROVED** the proposal and project plan; and
- **ENDORSED** 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.

6. London Borough of Hackney Advice and Debt Review

6.1. Sonia Khan provided 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. The review has produced a number of key findings which are informing immediate responses as well as contributing to the re-design of the advice model from April 2019.

6.2. The review includes widespread engagement; all organisations delivering advice in Hackney have been invited to participate, and LBH is paying to backfill people's time to enable this.

6.3. Ellie Ward noted that the City of London Corporation is also reviewing its advice services and it would be useful to have a discussion with LBH.

6.4. **ACTION ICBMar18-1:** To meet and consider whether there is any learning or approaches that can be shared between the advice reviews in LBH and CoLC. (Ellie Ward / Sonia Khan)

6.5. **ACTION ICBMar18-2:** To discuss how the advice services of Hackney and the City can fit into the Neighbourhoods model of care. (Nina Griffith / Sonia Khan / Ellie Ward)

6.6. The Mayor of Hackney noted that the driver for the advice services is the evolution of best practice and the improvement of outcomes for services users. It is not motivated by a savings agenda.

6.7. The Hackney Integrated Commissioning Board:

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

7. Care Workstream Assurance Review

7.1. Devora Wolfson introduced the reports on the progress that the care workstreams are making and their plans for the coming year (including the updated 'asks' for 2018/19). The submissions had been reviewed by members

of the Integrated Commissioning Steering Group (ICSG) and reviewed and endorsed by the Transformation Board on 9 March 2018.

CYPM

7.2. Clare Highton noted that 'business as usual' (BaU) was not clearly reflected in the CYPM submission. Amy Wilkinson responded that a business performance and oversight group has been set up within the workstream to look at BaU, and although it was not reflected in this particular Assurance Review point 2 submission, there is a lot of work being done, which will be shown in the point 3 submission.

7.3. Gary Marlowe noted that there is a need to change the relationship culture between primary and secondary care in terms of paediatrics. There is also a challenge in convincing parents that primary care practitioners have the skills and resources to look after child patients.

7.4. The boards noted that there is significant provider representation on the workstream and a task and finish group is being set up to build on this with greater clinical input. The boards also noted the progress made on patient engagement within the workstream, especially with young people.

Prevention

7.5. Jake Ferguson asked a question about the decision making process for making cuts with regards the projected £1m of savings from the re-commissioning of contracts. Anne Canning responded that the focus is on improving outcomes and reducing costs through evidence-based interventions, rather than making cuts. There was a large piece of co-production work done with resident representatives, and we are committed to this.

Unplanned Care

7.6. It was noted that urgent care pathways are confusing for patients, especially within London. Nine Griffith reported that the workstream is engaging widely to understand user behavior and will be commissioning a piece of work to focus on this issue.

7.7. The City Integrated commissioning Board:

- **APPROVED** the responses from the Children, Young People and Maternity Services for Assurance Review point 2 (Appendix 1);
- **APPROVED** the responses from the Prevention, Unplanned Care and Planned Care workstreams for Assurance Review Point 3 (Appendix 1);
- **NOTED** the progress that has been made by the workstreams;

- **APPROVED** 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.
- **APPROVED** 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).

7.8. The Hackney Integrated commissioning Board

- **APPROVED** the responses from the Children, Young People and Maternity Services for Assurance Review point 2 (Appendix 1);
- **APPROVED** the responses from the Prevention, Unplanned Care and Planned Care workstreams for Assurance Review Point 3 (Appendix 1);
- **NOTED** the progress that has been made by the workstreams;
- **APPROVED** 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.
- **APPROVED** 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).

8. Proposal for Award of a Single Outcomes-Based Contract for Clinical Locally Enhanced Services

8.1. *Randall Anderson agreed to act as chair for the duration of this business item, as Clare highton declared a Conflict of Interest.*

8.2. This paper summarised the contract award recommendation that was made by the CCG Contracts Committee 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. As a result of discussions with the Transformation Board, the workstreams had been made more prominent in the design of the contract, and assurance was given that in future years of the contract workstreams would be proactively engaged in the design and redesign.

8.3. The City Integrated Commissioning Board:

- **REVIEWED** and **ENDORSED** the recommendation from the Local GP Provider Contracts Committee to award the single contract to the GP Confederation.

8.4. The Hackney Integrated Commissioning Board:

- **REVIEWED** and **ENDORSED** the recommendation from the Local GP Provider Contracts Committee to award the single contract to the GP Confederation.

9. Enabler Funding Proposals

IT Enabler support for VCS - including introducing scoping for Social Prescribing Software

9.1. Jackie Brett presented this proposal, approved by the IT Enabler Board and Transformation Board, to fund a post for 18 months to scope out the best platform to underpin Social Prescribing in Hackney and City of London, and 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.

9.2. It was noted that the proposals were focused on health, rather than social care, using EMIS.

9.3. Members asked about ongoing costs for the project after the scoping phase. Jackie Brett advised that costs would come from software license fees, and support would be needed from procurement to limit these costs. A business case for future costs would need to be submitted in due course and considered separately, on its own merits. It was noted that any endorsement given here by the ICBs would not be a commitment to future funding.

9.4. The City Integrated Commissioning Board:

- **ENDORSED** funding of £55,800 for a Professional Level 3 post for 18 months, part time (0.8 wte); and
- **NOTED** 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

9.5. The Hackney Integrated Commissioning Board:

- **APPROVED** funding of £55,800 for a Professional Level 3 post for 18 months, part time (0.8 wte); and
- **NOTED** 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

Engagement Enabler Funding

9.6. Jon Williams presented proposals seeking to ensure effective public engagement and involvement in the care work streams and associated work beyond March 2018. This includes supporting the public and patient representatives involved in the programme and the use of co-production to the support development and review of services.

9.7. **ACTION ICBMar18-3:** To bring a report back to the ICBs in December 2018 with recommendations to safeguard the mainstreaming of co-production within the IC Programme. (Jon Williams / Catherine Macadam)

9.8. The Hackney Integrated Commissioning Board:

- **APPROVED** 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;
- **APPROVED** this work with identified funding of £45,000 from within existing resources Integrated Commissioning s256 agreement between the CCG and London Borough of Hackney; and
- **NOTED** plans will also be developed during this time period for how the functions of the Engagement Enabler Group can continue in a sustainable way.

9.9. The City Integrated Commissioning Board:

- **ENDORSED** 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;
- **ENDORSED** this work with identified funding of £45,000 from within existing resources Integrated Commissioning s256 agreement between the CCG and London Borough of Hackney; and
- **NOTED** plans will also be developed during this time period for how the functions of the Engagement Enabler Group can continue in a sustainable way.

10. Proposal to Merge Cedar Lodge with Thames House

10.1. Dan Burningham present an outline proposal to merge the 13-bed Cedar Lodge with the 18-bed Thames house (both of which are long term dementia wards for people with behavioural and psychiatric symptoms) to create a shared older adult dementia inpatient ward at Thames House. This proposal

is intended to improve ward environments, reduce risk to patients, to improve the skill mix of staff and to improve the utilisation of Mile End Hospital.

10.2. Honor Rhodes asked whether there are travel issues for carers relating to the change in ward location. Dan Burningham responded that carers receive transport assistance from ELFT, and there are no significant changes to carer journey time (which would see an average increase of 10 minutes).

10.3. **ACTION ICBMar18-4:** To give consideration to extending provisions for carers to enable overnight stays on wards or hotel provision where it is appropriate. (Dan Burningham)

10.4. The City Integrated Commissioning Board **ENDORSED** the proposal.

10.5. The Hackney Integrated Commissioning Board **ENDORSED** the proposal.

11. Mental Health Investment

11.1. Dan Burningham presented three recurrent funding proposals (totaling £295,880 of investment) for 2018-19 to help the achievement of NHSE 5YFV targets. All proposals could be funded within the 2018-19 budget allocation, ensuring the CCG achieves the NHSE's Mental Health Investment Standard. Each proposal also embodies principles of integrative care and had been developed through extensive consultation within the workstreams and alliances.

11.2. It was noted that the City of London is represented in the CAMHS alliance, and whilst services may be based in Hackney, there is provision of those services in the City. It was noted that it would be helpful if there were IAPT outreach services based in the Neaman practice.

11.3. **ACTION ICBMar18-6:** to discuss VCS support to targeting particular BME groups in order to improve access to mental health services. (Dan Burningham / Jake Ferguson)

11.4. The City Integrated Commissioning Board:

- **NOTED** all Recurrent Investments – to meet 18/19 Mental Health Investment Standard
- **ENDORSED and RECOMMENDED** the Primary Care Step Down ADHD Service (CYP Workstream)
- **ENDORSED and RECOMMENDED** the VSO IAPT Service (Planned Care Workstream)
- **ENDORSED and RECOMMENDED** the SMI Secondary Care Physical Health Checks (Primary Care MH Alliance/Unplanned Care)

11.5. The Hackney Integrated Commissioning Board:

- **NOTED** all Recurrent Investments – to meet 18/19 Mental Health Investment Standard
- **ENDORSED and RECOMMENDED** the Primary Care Step Down ADHD Service (CYP Workstream)
- **ENDORSED and RECOMMENDED** the VSO IAPT Service (Planned Care Workstream)
- **ENDORSED and RECOMMENDED** the SMI Secondary Care Physical Health Checks (Primary Care MH Alliance/Unplanned Care)

12. Integrated Commissioning Governance Review Specification

12.1. Devora Wolfson set 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 to improve systems and ways of working. A draft specification set out the aims and scope of the review, as well as specific lines of enquiry.

12.2. It was suggested that the governance review should include safeguarding within its scope. Members noted that we need to be careful about the range of scope and the expectations of the review. The proposal should have a very clear focus on outcomes.

12.3. Members were divided on the value of spending money on an external review. Some felt that a better approach would be for leaders to get together and agree solutions to the issues we already know about; while others noted the merits of bringing in an external perspective to produce independent recommendations, and felt that the £25,000 proposed would not actually be enough to carry out the review properly.

12.4. It was **AGREED** that the decision on the governance review should be postponed until a further paper could be considered at the ICB meeting in June.

12.5. It was **AGREED** that the IC Governance Review Steering Group (set up by the Transformation Board) should refine the scope and deliverables for the review and bring a more detailed proposal to the ICBs for decision in June 2018.

13. Integrated Finance Report - Month 10

13.1. Philippa Lowe presented the update on finance (income & expenditure) performance for the period from April 2016 to January 2017 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, which was 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.

13.2. The City Integrated Commissioning Board **NOTED** the report.

13.3. The Hackney Integrated Commissioning Board **NOTED** the report.

14. Reflections on Meeting

14.1. The Chair expressed thanks to Haren Patel and Jonathan McShane, who would no longer be on the ICB membership in June, for their contributions as members of the Integrated Commissioning Board since its inception in March 2017, and for their work in the wider health and social care system.

14.2. Honor Rhodes led the ICB in thanking Clare Highton for her skill, enthusiasm and passion in leading the CCG since its foundation, and her commitment to improving the lives of Hackney and City residents in her long career as a GP and as a leader within the health and social care system.

14.3. Philip Glanville echoed this praise on behalf of the London Borough of Hackney, noting that the success of the partnership working in Hackney and the City are a tribute to the innovation and intellectual vigour shown by Clare Highton.

15. Any Other Business

15.1. There was no other business.

City and Hackney Integrated Commissioning Boards Action Tracker - 2018/19

Ref No	Action	Assigned to	Assigned from	Assigned date	Due date	Status	Update
ICBMar18-1	Advice and Debt review - to meet and consider whether there is any learning or approaches that can be shared between the advice reviews in London Borough Hackney and City of London Corporation.	Ellie Ward / Sonia Khan	City and Hackney Integrated Commissioning Boards	21/03/2018		Open	In progress
ICBMar18-2	To discuss how the advice services of Hackney and the City can fit into the Neighbourhoods model of care	Nina Griffith / Socia Khan / Ellie Ward	City and Hackney Integrated Commissioning Boards	21/03/2018		Open	In progress. Nina Griffith and Sonia Khan have met to explore how neighbourhoods could fit with the advice and debt review. They agreed to re-convene at the point that the review is starting to form recommendations so they can consider how this fits into neighbourhoods.
ICBMar18-3	Engagement enabler funding - To bring a report back to the ICBs in December 2018 with recommendations to safeguard the mainstreaming of co-production within the IC Programme.	Jon Williams / Catherine Macadam	City and Hackney Integrated Commissioning Boards	21/03/2018	06/12/2018	Open	Due in December 2018.

Closed actions since last ICB

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 TB/ICB	Nina Griffith	City and Hackney Integrated Commissioning Boards	28/02/2018	12/07/2018	Closed	On the agenda.
ICBMar18-4	Merger of Cedar Lodge with Thames House - To give consideration to extending provisions for carers to enable overnight stays on wards or hotel provision where it is appropriate. ()	Dan Burningham	City and Hackney Integrated Commissioning Boards	21/03/2018		Closed	Dan Burningham has discussed this request with the ELFT Borough Director and the OP Medical Lead. It was felt that the ward environment would not be an appropriate place for visitors to stay overnight due to high levels of challenging behaviour on the ward.
ICBMar18-4	Mental Health Investment - To discuss VCS support to targeting particular BME groups in order to improve acess to mental health services.	Dan Burningham / Jake Ferguson	City and Hackney Integrated Commissioning Boards	21/03/2018		Closed	Dan Burningham met with Jake Ferguson and colleagues on 30 April 2018. It was agreed that VCS support would be further pursued in the mental health alliances. The CAMHS Alliance is currently liaising with HCVS over BME engagement. The Psychological Therapies Alliance will also be engaging VSO BME representatives and groups.

Title:	Extension of Community Health Services Contract with the Homerton University Hospital NHS Foundation Trust
Date:	12 July 2018
Lead Officer:	David Maher, Managing Director, City and Hackney CCG
Author:	Lee Walker and David Spells
Committee(s):	CCG Finance and Performance Committee – invitation to comment - 20 June 2018 Transformation Board – invitation to comment - 27 June 2018 Governing Body development session – for discussion – 29 June 2018 Integrated Commissioning Board – for decision (pooled budgets) – 12 July 2018 Integrated Commissioning Board development session – for discussion – 20 July 2018 CCG Governing Body – for decision (aligned budgets) – 27 July 2018
Public / Non-public	Public

Executive Summary:

The CCG has an obligation to ensure that commissioned Community Health Services (CHS) are adequate and that the service model is integrated with locally commissioned health and social care services. The current model of CHS is essentially the same model that was transferred from the PCT in 2013.

Some London CCGs have transformed CHS by commissioning CHS through provider partnerships made up of the Mental Health Trust, the GP Federation and the Acute Trust (Tower Hamlets CCG), procuring CHS as a single 5+2 year contract that includes GP out of hours and discharge services (Bromley CCG) or combining health and social care in a 'Village Team' model that base the local services around the patient (Central London CCG). Our neighbouring CCGs of Newham and Waltham Forest both plan to re-procure CHS contracts this year.

In City and Hackney there was extensive investment and several years of work put into developing the 'One Hackney' service and there is now an ambition to develop the 'Neighbourhood' model during 2018/19 as the main way to drive the integration of out of hospital services in the community and for this work to lead onto the commissioning/procurement of a substantive out of hospital service during 2019/20.

The current CHS contract with the Homerton University Hospital NHS FT (HUHNFT) was awarded for an April 2017 to March 2019 term. At the current pace of the development, the CHS contract will need to be extended for a further one year to allow time for development of the Neighbourhood model and to allow for the

completion of either a collaborative or competitive procurement before the service commences in 2020.

This paper summarises the CCG's Finance and Performance Committee's intention to extend the existing CHS contract by one year until 31st March 2020 to ensure continuity of community health services while further development of the local out of hospital service model continues. This will allow for full engagement with Workstreams, the Transformation Board and other stakeholder in the service redesign. It will also allow for the application of a robust procurement model which improves our capabilities to work as an integrated system.

The engagement and developmental work will be overseen by a Community Services 2020 Task and Finish Team, reporting to the ICB Collectively workstreams are to develop and Transformation Board to endorse model for Community Services redesign supporting the Neighbourhoods model.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board noted the proposed extension of the CHS contract and broadly endorsed the approach for developing the vision for the future community health services and beyond in City and Hackney.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the content of the report
- To **APPROVE** the recommendation for a one year extension of the HUHNFT CHS contract where the budget is pooled.
- To **ENDORSE** a recommendation to the CCG Governing Body that there is a one year extension to the HUHNFT CHS contract where the budget is aligned.
- To **NOTE** that competitive tendering and public procurement is not required provided that the contract value for 2019/20 does not exceed 50% of the original contract value (for 2017/19). The contract will be extended on the basis of the outcome of a rebasing exercise which is currently underway.
- To **NOTE** that at the ICB Development meeting on 20 July 2018, ICB will start considering the scope of an integrated community service which will follow this contract extension and commence in 2020.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the content of the report
- To **APPROVE** the recommendation for a one year extension of the HUHNFT CHS contract where the budget is pooled.

- To **APPROVE** a recommendation to the CCG Governing Body that there is a one year extension to the HUHNFT CHS contract where the budget is aligned.
- To **NOTE** that competitive tendering and public procurement is not required provided that the contract value for 2019/20 does not exceed 50% of the original contract value (for 2017/19). The contract will be extended on the basis of the outcome of a rebasing exercise which is currently underway.
- To **NOTE** that at the ICB Development meeting on 20 July 2018, ICB will start considering the scope of an integrated community service which will follow this contract extension and commence in 2020.

Links to Key Priorities:

Community Services play a key role in facilitating discharge from hospital and, when integrated with primary care, can prevent unnecessary admissions and reduce outpatient attendances. These have been the key priorities for the Better Care Fund for several years and is aligned to the objective that pressure on the NHS Hospital services should be reduced and that hospital, social care and community health care provision should work together effectively.

Bringing together physical and mental health services outside of hospital has been an explicit priority for the NHS since the publication of the Five Year Forward View and is seen as an effective way to improve life expectancy and quality of life for patients with enduring mental health conditions.

The integrated commissioning partners have endorsed a set of collective ambitions which align to this piece of work. Collectively we are seeking to:

- Improve the health and wellbeing of local people with a focus on prevention and public health, providing care closer to home, outside institutional settings where appropriate, and meeting the aspirations and priorities of the 2 Health and Wellbeing Board strategies;
- 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 community based care;
- Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health;
- Ensure we deliver parity of esteem between physical and mental health and ensure that we address the physical and mental health needs of our residents holistically
- 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
- Build partnerships between health and social care for the benefit of the population;

All 4 integrated commissioning workstreams have explicit ambitions to improve the capability of community services to integrate around the patient and improve health and care outcomes. As examples:

- Planned Care is developing a strategy to redesign outpatient services.
- Unplanned Care is leading on the design principles for Neighbourhoods.
- Prevention is engaged in implementing a Making Every Contact Count (MECC) protocol
- Children, Young People and Maternity is supporting the development of CAMH services to have a deeper connection with communities and schools and support early intervention.

Specific implications for City

It is important to maintain continuity of CHS service provision while the development of the Neighbourhood model continues – a practical way to help deliver this is through the extension of the contract with an existing service provider.

Specific implications for Hackney

The implications for Hackney are the same as for the City above.

Patient and Public Involvement and Impact:

The proposal to extend the contract is subject to an activity and cost rebasing exercise but there are no material changes to service provision at this point.

There will be no detriment or reduction in service provision to patients or the public by extending the CHS contract however patient and public engagement will need to take place during the development of the out of hospital services model as the level of service provision could change and have a direct impact on specific groups of patients.

Clinical/practitioner input and engagement:

HUH Community Health Services are subject to routine debate and scrutiny through a clinically chaired CQRM and subject to detailed reviews as part of the CCG Clinical Executive Committee's review of clinically commissioned services.

Clinicians are key to developing the Neighbourhood model and determining the way that CHS should be delivered in future.

The design and delivery group required for this will be worked up as part of a further update to the Transformation Board and Integrated Commissioning Board in

September. It is planned that this will take the form of a **Task and Finish Team**, reporting directly to the ICB.

Impact on / Overlap with Existing Services:

This extension is essential to ensuring the future viability and success of a properly integrated neighbourhood model of care which puts services at the heart of communities and places patients at the centre of the service delivery model.

The current proposal does not impact/overlap with existing services, however it is expected that the Integrate Commissioning Board will wish to use the 12 month contract extension, to build a delivery plan for community services which puts neighbourhoods at the heart of service delivery and establish a Task and Finish Group. We are describing this ambition as **Community Services 2020.**

Main Report

Background and Current Position

The CCG has an obligation to ensure that commissioned Community Health Services (CHS) are adequate and that the service model is integrated with other locally commissioned health and social care services. The current model of commissioned CHS is essentially the same model that was transferred from the PCT in 2013.

Although extensive investment was put into developing the 'One Hackney' service, and there is now an ambition to develop the 'Neighbourhood' service model during 2018/19, City and Hackney is some way behind other CCGs in updating community services.

Neighbourhoods will develop into the main way of delivering integrated out of hospital services in the community. A new model of Community Services, based on neighbourhoods, will be procured by April 2020. There is a practical issue to overcome in that the current CHS contract with the Homerton University Hospital NHS FT (HUHNFT), awarded in April 2017, will expire in March 2019. The CCG has an obligation to send commissioning intentions to the HUHNFT 6 months before the contract expiry date to confirm what it intends to commission in the following year or to serve notice on the commissioned services.

This paper sets out the CCGs intention to extend the existing CHS contract by one year until 31st March 2020 to ensure continuity of services while development of the local service model continues.

Contract Rebasing

It is important that the contract value for the 2019/20 period is value for money for commissioners and provides adequate resource for the provider to deliver the services. Work has already started on a rebasing of the CHS contract prior to the extension being confirmed.

The scope of the rebasing exercise is to review the costs of the existing services and determine a contract price that will be paid to HUHNFT for CHS delivery in 2019/20. The rebasing will check cost assumptions which have not been reviewed since the last rebasing in 2014. There is general agreement between HUHNFT and the CCG that it is the right time for a rebasing exercise.

Terms of reference have been drafted by the CCG, shared with HUHNFT and it is anticipated that the work will be completed by the end of August 2018. The aim of the rebasing is to review the existing CHS contract and to recognise the full costs for each

service including indirect costs and overheads, in line with recent developments in contract provision, with the aim of delivering an agreed funding schedule for City and Hackney CHS for 2019/20. The exercise will also review and report on estate costs linked to the CHS contract.

A process and principles for the review have been established:

- The review will be conducted on an Open Book basis;
- The review will be conducted in accordance with NHS Approved Costing Guidance currently in force;
- The review will be conducted by a Joint Project Group as a sub group of the Homerton SPR;
- The Joint Review Group will be chaired by the CFO of City & Hackney CCG or his nominated representative and include members drawn from both City & Hackney CCG and Homerton FT;
- The findings of the review will be subject to review by an independent third party nominated jointly by the CCG and HUHNFT.

CHS Contract Extension, Competitive Tendering and Public Procurement

After the rebasing exercise has been complete a contract extension will be executed before the end of March 2019. This will be preceded by a commissioning intentions letter being sent to the provider at the end of September 2017, 6 months before the contract expiry date.

The existing CHS contract was let using a Negotiated Procedure without Prior Publication after the publication of the Prior Information Notice (a form of market testing) that established that 'competition was absent for technical reasons'. This allowed the CCG to enter into a direct negotiation with HUHNFT before awarding the CHS contract.

Under the Public Contracts Regulations 2015, additional services can be commissioned from the original contractor that were not included in the initial procurement where a change of contractor cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, services or installations procured under the initial procurement, or, would cause significant inconvenience or substantial duplication of costs for the contracting authority; provided that any increase in contract value does not exceed 50% of the value of the original contract (Regulation 72(b)).

In the event that the contract value for 2019/20, after rebasing, does not exceed 50% of the original 2017/19 contract value then the contract extension could go ahead without competitive tendering. If the value exceeds 50% then the CCG would need to repeat the Prior Information Notice exercise and test the market to confirm that

competition continues to be absent. This would require that the publication of the Prior Information Notice received no qualified response.

The commissioning of a Community Service model in 2020 is an exciting opportunity to realise our commitment to neighbourhood based services for our residents. The CCG Finance and Performance Committee have noted that this extension facilitates full engagement with Transformation Board members in their vision for how Community Services in 2020 could be realised. It also provides an appropriate timescale for our principles of co-production with patients to be meaningfully applied.

Equalities and other Implications:
There is no proposed change in the services currently provided during the extension period.

Proposals
This paper sets out the CCGs intention to extend the existing CHS contract by one year until 31st March 2020 to ensure continuity of services while development of the local service model continues.

Alternative options which are viable but not recommended are:

- Running a competitive tender to award the one year CHS extension contract; this could result in the contract being awarded to another provider and cause disruption.
- Allowing the CHS contract to expire and commissioning services on an ad hoc / non-contractual basis; this does not provide certainty of supply for the commissioner or certainty of income for the provider.
- Accelerating the implementation of an out of hospital services model. This would potentially require the model to be commissioned before it is fully developed.

Conclusion
At this time the most practical option is to extend the CHS contract for one year, after the rebasing exercise has been completed, which will allow appropriate planning and engagement with TB and community partners over a 18 month period leading to the development of a new Community Services model based on Neighbourhoods and a collaborative procurement exercise to be completed before the new contract is awarded.

Community Services 2020 Procurement

Although it is not the subject of this paper, an outline of a potential procurement process is described here to provide background and context. Starting in September 2018:

1. An initial proposal setting out the commissioning intentions for Community Services 2020 will be presented to the Integrated Commissioning Board before commissioning intentions are sent to providers. This will set out the potential options for combining CHS, Mental Health, Children Services, Locally Enhanced Services and Adult Social Care funding (all to be confirmed) into an integrated service fund which will be used to commission a Community Services model by April 2020.

   This initial proposal would also say how **conflicts of interest** will be managed during the development of the service model and pricing model.

2. Using a **pan-workstream Task and Finish Team**, the Planned Care workstream will be tasked with leading on engagement with patients and the public and developing service specifications for community services. The workstream developed specifications can then be shared with local stakeholders, providers, CCF, CEC, PPI committees and finally the Transformation Board who will formally recommend to ICB that the new **Community Service 2020 model** is commissioned.

   A key part of this engagement activity will be the development of outcomes which the Community Services will be tasked with achieving for the whole of the registered / resident population of City and Hackney.

   The Community Services 2020 Task and Finish Team will involve all the workstreams and report directly to the ICB, however **the development of the pricing model may need to be developed without provider involvement** so as not to compromise any future procurement.

3. Both the **Community Service model** and **Community Service pricing model** will be presented to ICB for approval before the end of March 2019.

   The ICB will be required to make this decision without the involvement of any potential provider and without conflicts of interest. The ICB will be responsible for deciding whether these services should be commissioned using:
   a. A competitive tender, collaborative dialogue or single provider negotiated process; and
   b. A lead provider, alliance provider model or special purpose vehicle model.

c. A model which commissions CHS as a whole or separates Neighbourhood services from other community services.
d. Some other model.

The ICB will also decide on the duration of the contract to be awarded.

If competitive tendering was required, this would need to commence by April 2019 with the contract award and mobilisation to have commenced by October 2019 – (see timescales illustrated below)

4. Before the start of the 2020/21 financial year, the City of London, London Borough of Hackney and the CCG may wish to explore a Section 75 **pooled funding agreement** which may be used to commission the new services from April 2020.

Supporting Papers and Evidence:

Background information is provided in the Appendices.

Sign-off:

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

Appendix 1: Timeline / Gantt Chart

ACTIVITY	Apr 2018 – Sept 2018	Oct 2018 – Mar 2019	Apr 2019 – Sept 2019	Oct 2019 – Mar 2020
CHS Contract Rebasing	Terms of Reference drafted Data Collection	Rebased Contract Value confirmed Commissioning intentions issued		
Contract Extension		Contract Extension negotiated	Contract Extension in place Contract Signed	
Development of out of Hospital Service Model	Pan workstream task & finish group established	Ongoing development of model		
Collaborative Procurement		Procurement Planning	Procurement Process	Mobilisation
GOVERNANCE	FPC 20 JUNE TB 27 JUNE ICB 12 JULY GB 27 JULY	ICB initial proposal to pool budgets and develop service model	ICB Approval to proceed to market	ICB Approval to award contract

Appendix 2: List Services commissioned through the HUHNFT CHS Contract

Service Line	BCF Service	Pooled / Aligned
ACERS	✓	POOLED
Adult Community Rehabilitation Team	✓	POOLED
Audiology		Aligned
Children's Occupational Therapy		Aligned
Children's Physiotherapy		Aligned
Community Paediatrics		Aligned
Dermatology		Aligned
Dietetics		Aligned
Disability CAMHS		Aligned
First Steps		Aligned
Foot Health		Aligned
Locomotor		Aligned
Locomotor Pain Service		Aligned
Speech and Language Therapy		Aligned
Newborn Hearing Screening		Aligned
PUCC		Aligned
Community Gynaecology		Aligned
Community Children's Nursing		Aligned
Sickle Cell and Thalassaemia		Aligned
Bilingual Advocacy		Aligned
Adult Community Nursing	✓	POOLED
Primary Care Psychology		Aligned
Wheelchair Services		Aligned

Appendix 3: CHS Contract Values (exc CQUIN)

	Recurrent	Non-Recurrent	LBH BCF	CoL BCF	TOTAL
	CCG Funded - Aligned	**CCG Funded - Aligned**	**CCG Funded - POOLED**	**CCG Funded - POOLED**	
2018/19	£27,174,053	£1,273,690	£4,402,107	£232,311	**£33,082,161**
2017/18	£26,681,350	£1,342,486	£4,337,051	£228,878	**£32,589,766**
2016/17	£26,269,596	£798,449	£4,272,957	£225,496	**£31,566,498**
2015/16	£28,151,387	£2,495,500	£1,666,000	£69,000	**£32,381,887**

Title:	Building a movement to 'make every contact count' in Hackney and the City' – proposed approach
Date:	12 July 2018
Lead Officer:	Anne Canning, Workstream SRO
Author:	Jayne Taylor, Prevention Workstream Director
Committee(s):	Prevention Workstream, June 2018 Transformation Board, 27 June 2018 Integrated Commissioning Board, 12 July 2018
Public / Non-public	Public

Executive Summary

Making every contact count (MECC) is about using the vast human resources across NHS, local authorities, voluntary and community sectors to give people consistent, simple messages and signpost them to services that help improve their health and wellbeing.

The proposal outlined in this paper aims to establish a programme of work to empower all frontline staff to have conversations with people about their health and wellbeing, to help embed prevention and support culture change across the health and care system for lasting population health benefits. The proposed approach will build on existing good practice.

Funding for the proposed programme of work has largely been secured. A business case is currently being prepared for CEPN transformation funding to support the training activity.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board (TB) welcomed the proposal and stressed how important it is to embed MECC principles. TB further discussed whether wider cultural change can be achieved through an organisational development programme.

Recommendations

The City Integrated Commissioning Board is asked:

- To **NOTE** the content of the report
- To **APPROVE** the proposed approach to embedding MECC principles across all health and care services.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the content of the report
- To **APPROVE** the proposed approach to embedding MECC principles across all health and care services.

Links to key priorities

MECC is a big ticket item for the Prevention workstream, and supports delivery of a number of other workstream priorities – for example, outpatient transformation (Planned Care), reducing A&E repeat attendances (Unplanned Care), transforming the community health services workforce (CYPM).

MECC is a key enabler in achieving the ambitions of the City and Hackney Integrated Commissioning Boards to achieve a shift in focus and resource towards prevention and self-care (as set out in the Strategic Framework).

Specific implications for the City

Embedding MECC will help to support delivery of the City Health and Wellbeing Strategy, including improving the health of City workers.

Specific implications for Hackney

Embedding MECC will help to support delivery of the Hackney Health and Wellbeing Strategy – improving outcomes for 0-5s (including child obesity), reducing the harms from tobacco, improving the mental wellbeing of working age adults.

Patient and public involvement and impact

This proposal has been developed with the input of one of the Prevention workstream resident representatives, who also helped organised a Healthwatch workshop to test out City and Hackney resident views of MECC to inform our plans. Residents will continue to be involved throughout the programme, especially during the proposed scoping and testing phase.

Clinical/practitioner input and engagement

This proposal has been co-produced with a wide range of clinicians and practitioners (through an initial scoping workshop and subsequent planning meetings) – including GPs, Homerton clinical and workforce staff, ELFT, pharmacist, LB Hackney adult and children's services, CoL adult and children's services, VCS, commissioners, Public Health, Hackney community library service, as well as the Healthy London Partnership MECC lead.

Impact on/overlap with existing services

The proposed approach will build on existing good practice, building a movement for change across all health and care services in the City and Hackney to embed prevention into routine practice of all frontline staff.

Summary of proposal

What is this proposal about?

The proposal document appended to this paper outlines a two-year programme of work to scope, co-design, test and embed a local approach to 'making every contact count' (MECC) across Hackney and the City.

This proposed approach has been developed in full partnership with a wide range of local stakeholders (including clinicians and practitioners, commissioners, residents and provider workforce leads). A multi-disciplinary planning group has led the process, and early testing of the principles underlying the MECC approach has been undertaken with residents through a workshop facilitated by City and Hackney Healthwatch.

Why MECC?

The fundamental idea underpinning the MECC approach is simple. It recognises that staff across health, local authority and voluntary sectors have thousands of contacts every day with individuals and are ideally placed to promote health and healthy lifestyles.

Our ambition is to empower the entire local health and care workforce to have conversations with patients and the public about their health and wellbeing, to help embed prevention and support culture change across the health and care system for lasting and sustainable population health benefits. MECC is thus a key mechanism for achieving the aspirations of the City and Hackney Integrated Commissioning system to shift focus and resources towards prevention.

What is MECC?

MECC is about using the vast human resources across NHS, local authorities, voluntary and community sectors to give people consistent, simple messages and signpost them to services that help improve their health and wellbeing. It involves the use of behaviour change techniques to opportunistically engage people in conversations about their health and wellbeing at scale, across organisations and populations. A MECC intervention takes a matter of minutes and is not intended to add to the busy workloads of frontline staff – it is structured to fit into and complement usual practice. As such, MECC is embedded in the principles of very brief advice.

Very brief advice is an evidence-based approach recommended by NICE to support positive behaviour change. At a population level, very brief advice has been shown to be effective in improving uptake of preventative services and modifying health harming behaviours. Modelled estimates show that system savings can be released as a result of these types of interventions. However, it is important to acknowledge that, for many people, a single MECC conversation is unlikely on its own to result in positive behaviour change - but it can influence people's intention and attempts to change their behaviour, particularly if consistent messages are given wherever people come into contact with them.

The proposal

The focus of the proposal outlined in this document is on:

a) designing, testing and rolling out a tailored MECC training programme for frontline staff

b) taking action to stimulate a movement for change across the health and care system so that MECC becomes 'the way we do things around here'.

Training is key to effective delivery of MECC, but must take place within a supportive organisational culture and enabling environment, with appropriate systems for (quickly and simply) recording activity and making onward referrals. All four of these 'building blocks' need to be in place in order to achieve our ambitions, and this has been taken into account in developing our plans.

We recognise that there is a good deal of existing local practice that we can learn from and build on in designing and embedding MECC across the local system. Our proposals therefore include a detailed scoping phase, to identify opportunities for targeting resources in a way that will bring the greatest added value for effectively implementing MECC into usual practice.

As part of the development of this proposal, the planning group has co-produced a draft vision for the City and Hackney MECC programme - see below. This would need to be further tested and refined during the scoping phase to ensure that it has universal resonance.

Draft co-produced vision for MECC in City and Hackney

A …	whole system approach to prevention …
for …	everyone in the City and Hackney …
that …	gives people the skills and confidence to start conversations with others about things that might be affecting their health and wellbeing …
so that …	they receive consistent and timely information, and access to support where needed, to enable them to live longer and happier lives.

In order to realise this vision, a dedicated resource is required to lead the development and implementation of this transformation programme. The appended paper outlines a proposed approach to programme delivery and the resources needed to achieve this. Most of the required resources have been secured; the remainder will be sought via CEPN transformation funding (a business case is currently in development).

Sign-off:

Workstream SRO _____Anne Canning

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

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

City & Hackney CCG _____ David Maher, Managing Director

FULL PROPOSAL

Building a movement to '**make every contact count**' in Hackney and the City

PROPOSED APPROACH

Workstream: Prevention

Workstream lead: Jayne Taylor

Clinical lead: Clare Highton

Patient/Public lead: Natascha Turner-Dyer

Document Information

Status: Final

Date created: 14 June 2018

Contents

1 What is MECC?

Very brief advice, or 'making every contact count', is grounded in theoretical and therapeutic approaches – including the *Stages of Change* behaviour change model. The *Stages of Change* model posits that by identifying an individual's position in the change process, health and care professionals can tailor interventions and help people move along the stages of behaviour change.[1]

MECC is about using the vast human resources across NHS, local authorities, voluntary and community sectors to give people consistent, simple messages and signposting them to services that may help improve their health and wellbeing. It recognises the potential of the wider workforce in promoting health and wellbeing and supports staff to think about their own health and wellbeing, and that of their friends and families, as well as the people they come into contact with through their work.

MECC is a scalable behaviour change approach that encourages positive health and wellbeing choices through individual, organisational and environmental interactions. It involves enhancing, identifying and acting on the opportunities to engage people in conversations about their health in a respectful way, to help them take action for their own health and wellbeing.

(Healthy London Partnership definition)

A MECC intervention takes a matter of minutes and is not intended to add to the busy workloads of frontline staff – it is structured to fit into and complement usual practice.

✓ MECC is about…

- focusing on prevention and improving access to support to live healthier lives
- having 'unexpected' conversations
- spotting the chance & taking the opportunity
- raising issues sensitively & appropriately
- having existing conversations 'slightly differently' using new skills
- incorporating these conversations as 'business as usual'

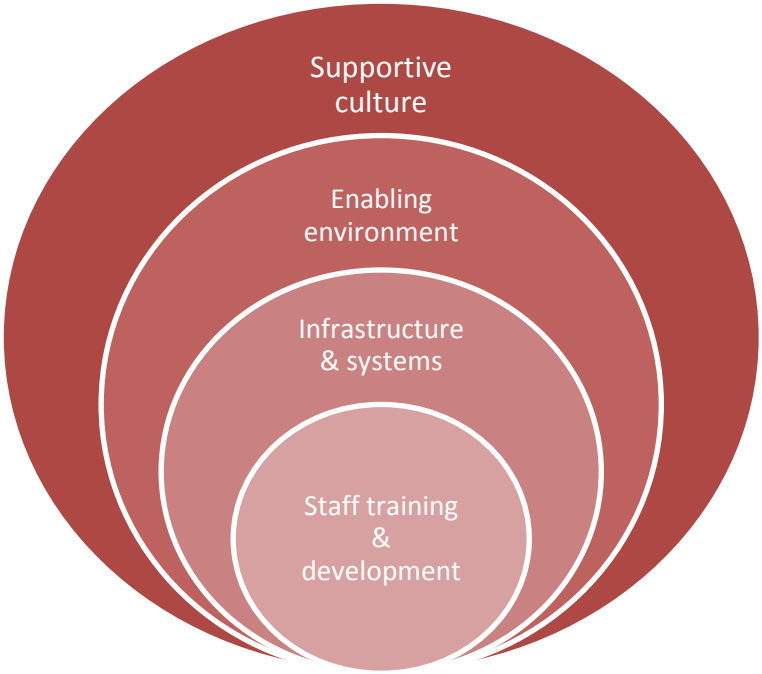
✗ MECC is not about…

- adding to workloads
- all frontline staff becoming experts, advisors or councillors
- telling people how to live their lives

There are **four key 'building blocks'** to a successful and sustainable MECC approach. A comprehensive staff training and development programme is a necessary, but not sufficient, condition. Also required is a supportive organisational culture for staff to change the way they work, an enabling environment in which MECC interactions can take place (e.g. smokefree spaces, healthy food and drink offer, easy access to stairs not lifts), and the right infrastructure to facilitate these interactions (e.g. effective and easy-to-use recording and

[1] Prochaska & DiClemente (1983). Stages and processes of self-change in smoking: towards an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51;390-395.

referral systems, information on local services, contractual levers and incentives). Importantly, appropriate support services must be in place locally for the identified health behaviours.



2 Strategic context

2.1 Local context

MECC offers a huge opportunity to contribute to the ambitions of City and Hackney's Integrated Commissioning programme to achieve a whole system shift towards prevention and self-management. Specifically, MECC is key enabler to support achievement of three of the stated aims of Integrated Commissioning (as outlined in the strategic framework), as follows.

- **Improve the health and wellbeing of local people with a focus on prevention and public health**, providing care closer to home, outside institutional settings where appropriate, and meeting the aspirations and priorities of the two Health and Wellbeing strategies.
- 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.

MECC is a 'big ticket item' for the Prevention workstream. It is of central importance in helping us deliver on all three of our broad (and related) ambitions:

- reducing exposure to the major preventable risk factors for poor health (such as smoking, physical inactivity, obesity, alcohol, substance misuse)
- early intervention to prevent/limit the impact of unhealthy behaviours or poor health on quality of life (helping people to access support as early as possible)

- supporting personal resilience and people's capacity to look after their own health (raising awareness of healthy behaviours and facilitating access to relevant resources and services).

The new Neighbourhoods model provides a valuable opportunity to align ambitions for and delivery of MECC across City and Hackney, as both have a focus on prevention and empowering people to live healthy lives.

MECC also aligns with, and could potentially support progress with, other workstream priorities - including reducing A&E repeat attendances (Unplanned Care), outpatient transformation (Planned Care) and transforming the community services workforce (Children, Young People & Maternity).

Building on existing local good practice

There are various well-established initiatives ongoing locally which aim to embed MECC-like approaches into interactions with local residents and service users. These include smoking very brief advice, alcohol identification and brief advice, '5 to Thrive', Mental Health First Aid, Healthy Living Pharmacy Health Champions, as well as various signposting and navigation projects. A number of small pilot projects have also been developed to test out the potential for using MECC in 'non-traditional' settings (including JobCentre Plus and within Hackney Council's Private Sector Housing team). And an online MECC learning module has recently been made available to City of London Corporation staff.

The learning from these initiatives will be used to build a comprehensive local programme to equip and motivate all frontline staff to have healthy conversations as part of their everyday interactions with local people. We do not want to duplicate or compromise successful approaches that are proving effective locally.

2.2 Regional context

The East London Health and Care Partnership Workforce Delivery Plan articulates a vision for "A NEL-wide workforce which can work across integrated health and social care systems, support the growth of out of hospital care / community based care, shift focus from treatment to prevention and manage whole pathways of care." A key enabler to achieve this is enhancing training programmes to include prevention – specifically, to 'make every contact count' across all interactions with the public.

Making every contact count is one the key prevention priorities of the Healthy London Partnership (HLP). HLP have supported the development of our proposals, attending our scoping workshop and various planning meetings.

2.3 National context

A MECC consensus statement was published in 2016 by Public Health England, NHS England, the Local Government Association, Health Education England, NICE, and others.[2] The statement underlines the signatories' support for all health and care organisations to adopt the MECC approach.

[2] http://mecc.yas.nhs.uk/media/1014/making_every_contact_count_consensus_statement.pdf

The NHS Five Year Forward View calls for a radical upgrade in prevention and public health by:

- increasing support available to help people to manage and improve their health and wellbeing
- ensuring behavioural interventions are available
- understanding impact on health of smoking, alcohol, weight, diet and physical activity
- recognising the need to change behaviour.

This is supported by a national CQUIN to incentivise screening, brief advice and referral for alcohol and tobacco – the 'Preventing ill health by risky behaviours – alcohol and tobacco' CQUIN applies to all mental health, community and acute trusts in 2018/19.

Reflecting the key role of MECC in delivering the prevention agenda, the NHS Standard Contract includes the following requirement:

"8.6 The provider must develop and maintain an organisational plan to ensure that staff use every contact that they have with service users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count guidance."

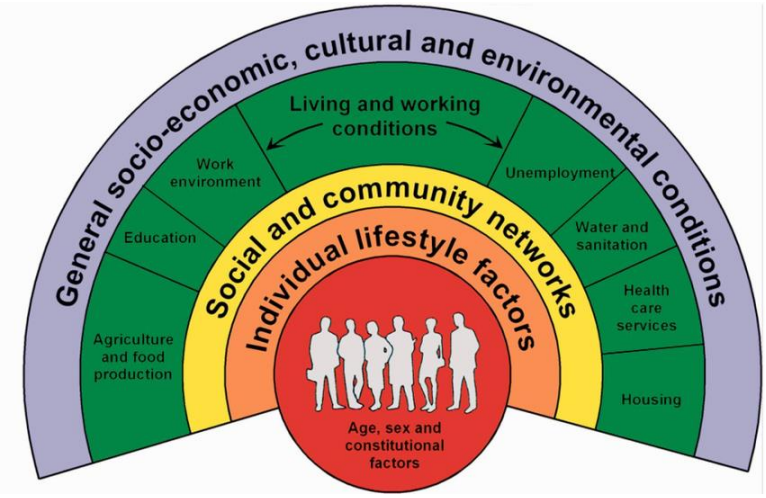
The Local Government Association has similarly identified MECC as a vehicle not only for health improvement, but also supporting the wider determinants of health.[3]

MECC also complements the 'wellbeing principle' and strengths-based approaches that are enshrined in the Care Act 2014, which focuses strongly on prevention and person-centred care.

3 Strategic objectives and drivers for change

3.1 The challenge

Population health and wellbeing is influenced by a complex interaction of personal, social and environmental circumstances.[4]



[3] https://www.local.gov.uk/sites/default/files/documents/making-every-contact-coun-e23.pdf
[4] http://www.esrc.ac.uk/about-us/50-years-of-esrc/50-achievements/the-dahlgren-whitehead-rainbow/

In Hackney, rates of premature mortality from causes considered to be preventable (including cardiovascular disease, respiratory disease and cancer) remain stubbornly above the London average.[5]

Many long-term conditions are closely linked to known behavioural risk factors. Around 40% of the UK's 'disability adjusted life years lost' are attributable to tobacco, hypertension, alcohol, being overweight or being physically inactive.

	In City and Hackney…	**London**	**Trend**
 SMOKING CONTRIBUTES TO 20% OF ALL DEATHS	19.6% of adults smoke (Hackney)	15.2%	
 OBESITY CONTRIBUTES TO 10% OF ALL DEATHS	41.5% of 10-11 year old are overweight/obese	38.5%	
 INACTIVITY CONTRIBUTES TO 5% OF ALL DEATHS	16.8% of adults are inactive*	22.9%	?
 ALCOHOL CONTRIBUTES TO 6% OF ALL DEATHS	33.9% of adults drink above the recommended limit + Among City workers, rates of higher risk drinking are double the national average	21.6%	?

*<30 minutes of moderate exercise (including walking) per week

The cost of 'lifestyle'-related preventable disease to the NHS and wider system is significant. Every year, **almost one fifth of the total NHS budget is spent on treating preventable diseases and conditions**. These diseases have a strong social gradient, disproportionately affecting some of our most deprived communities. We also know that people who smoke or who are obese are at significantly increased risk of needing adult social care (twice as likely in the case of smoking and three times in the case of severe obesity), and to need this support at a younger age than average (nine years earlier for smokers). The annual costs to Hackney Council and City of London Corporation of providing social care to people with smoking-related support needs is estimated at £2.7m.

In addition, poor mental wellbeing has significant personal, social and economic consequences. Stress and anxiety are one of the major causes of absence from work, and we know that depression is significantly underdiagnosed and undertreated (especially in more socially deprived populations).[6]

The so-called 'MECC plus' approach incorporates the wider determinants of health and wellbeing (including social networks, support to manage debt, find employment or tackle housing issues). Addressing these social determinants of health, and engaging more socially deprived people in healthy conversations or signposting them to specialised local support services, can play a key role in reducing health inequalities. Locally:

- one in four Hackney residents know fewer people locally than they once did; social

[5] Public Health Outcomes Framework

[6] See relevant chapters of the City & Hackney JSNA ('Society and environment' and 'Mental health and substance misuse') - https://hackneyjsna.org.uk/

isolation among older residents is a major priority in the City

- Hackney is the 2nd most deprived area in London and has witnessed the 4th biggest loss of income from recent welfare reforms
- Hackney has a significantly higher rate than average of both homeless acceptances and households in temporary accommodation, and these numbers are growing; and despite its small resident population, the City faces major challenges in terms of homelessness, especially rough sleeping.

3.2 The opportunity

Brief interventions are very adaptable and low cost methods, and can be applied in a wide range of settings and used to target whole communities (Werch et al, 2006).[7]

Locally, on a daily basis, frontline public service and VCS staff have thousands of interactions with people who are at risk of poor health because of the circumstances in which they live and/or the lifestyles they adopt. Every year, there are at least 740,000 adult face-to-face appointments with a GP or practice nurse in City and Hackney and over 100,000 A&E attendances at Homerton Hospital, not to mention all of the social care assessments/visits and VCS contacts with the public. We know from the 2017/18 ELFT CQUIN report that over 250 mental health inpatients were given brief advice about smoking and over 100 about alcohol – there is a significant opportunity to scale up this activity across the local system.

Research has shown that people welcome the opportunity to talk to staff about lifestyle issues, but don't start this conversation themselves as they think staff are too busy to talk.

As described in 2.1, it is important to recognise that we are not starting from scratch, and in developing our proposals we have been mindful of not wanting to 'reinvent the wheel'. There are a various separate 'MECC-like' initiatives and activities currently being delivered, or planned, in Hackney and the City that we can build on and learn from.

3.3 Our ambition

This proposal aims to build a movement for change across City and Hackney, where *all* frontline staff are enabled and motivated to start positive conversations about health and wellbeing with people they meet every day.

If we are successful, MECC will achieve the following for the local system.

- All frontline staff will have the skills and confidence to have very brief conversations with people about a range of health and wellbeing issues, and know where to refer them for specialist support.
- Conversations about health and wellbeing are routinely built in to all patient and service user encounters.
- There is a step change in the number of local people who are able to take action to lead happy, healthy lives.
- Over the longer term, health inequalities are reduced.

[7] http://journals.sagepub.com/doi/10.1177/0163278705284444

4 Evidence base

MECC is a low cost, evidence-based approach to positive behaviour change that is recommended by the National Institute of Health and Care Excellence (NICE).

NICE Public Health Guidance 49 - *Behaviour Change: individual approaches*
Recommendation 9: • Encourage health, wellbeing and social care staff in direct contact with the general public to use a very brief interventions (30 seconds to a couple of minutes) to motivate people to change behaviours that may damage their health. The interventions should also be used to inform people about services or interventions that can help them improve their general health and wellbeing. • Encourage staff who regularly come into contact with people whose health and wellbeing could be at risk to provide them with a brief intervention. (The risk could be due to current behaviours, sociodemographic characteristics or family history.)

Most of the available evidence on very brief advice is based on local evaluations, but some limited clinical and economic evidence is available to support the case for MECC. For example:

- the BWEL trial tested a very brief (30 second) intervention by GPs to refer overweight/obese patients to a weight management programme during a consultation unrelated to their weight - 40% attended the programme and four out of five patients agreed that the prior conversation with GPs was appropriate and helpful[8]
- opportunistic brief interventions on smoking provided by physicians as part of routine practice is estimated to increase quit attempts and quit rates significantly[9,10]
- delivering alcohol IBA to every patient at GP registration is estimated to significantly reduce alcohol-related deaths and hospital admissions - with the greatest absolute reduction in health harms estimated for the lowest socio-economic groups.[11]

Examples of findings from local evaluations of MECC programmes are provided below.

[8] http://www.makingeverycontactcount.co.uk/media/1131/lancet-bis-for-obesity-in-primary-care-randomised-trial-oct-2016.pdf

[9] Aveyard et al (2011), *Brief opportunistic smoking cessation interventions: a systematic review and meta-analysis to compare advice to quit and offer of assistance*, Addiction, 107(6).

[10] Stead et al (2013), *Physician advice for smoking cessation*, Cochrane Database of Systematic Reviews

[11] Public Health England (20160, *The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies: an evidence review.*

Examples of MECC impacts in other areas (source: HLP plus others as referenced)

Impact on patients and the public

- Training a small number of people can result in a large number receiving health advice. For example, in Telford, 16 staff members trained resulted in 480 people receiving opportunistic advice and 170 referred to other services.
- In Camden and Islington, case studies are starting to show very positive outcomes for service users:
  "*I had gone to visit a young mum who I'd recently placed in temporary accommodation. She told me how she felt powerless to get a job because of having young children and no qualifications. I told her about Camden's Employment team and gave her their contact details. The next time I visited she had received information about a local college and the crèche facilities available, which led to her enrolling on a course."*

Impact on staff

- Increased knowledge and confidence to deliver prevention as part of usual role is commonly reported in local evaluations, for example:
  "I feel equipped to promote health services within 20 seconds to service users. The training group exercises were really useful to drive home the points being taught."
- A qualitative retrospective evaluation of NHS Yorkshire and Humber's MECC programme (2013) found that this approach has considerable potential for changing staff behaviour in promoting healthy lifestyles as part of day-to-day interactions with the public.[12]
- Staff often frequently report improvements to their own (and their family's) health through increased awareness of healthy lifestyle behaviours.

System impact

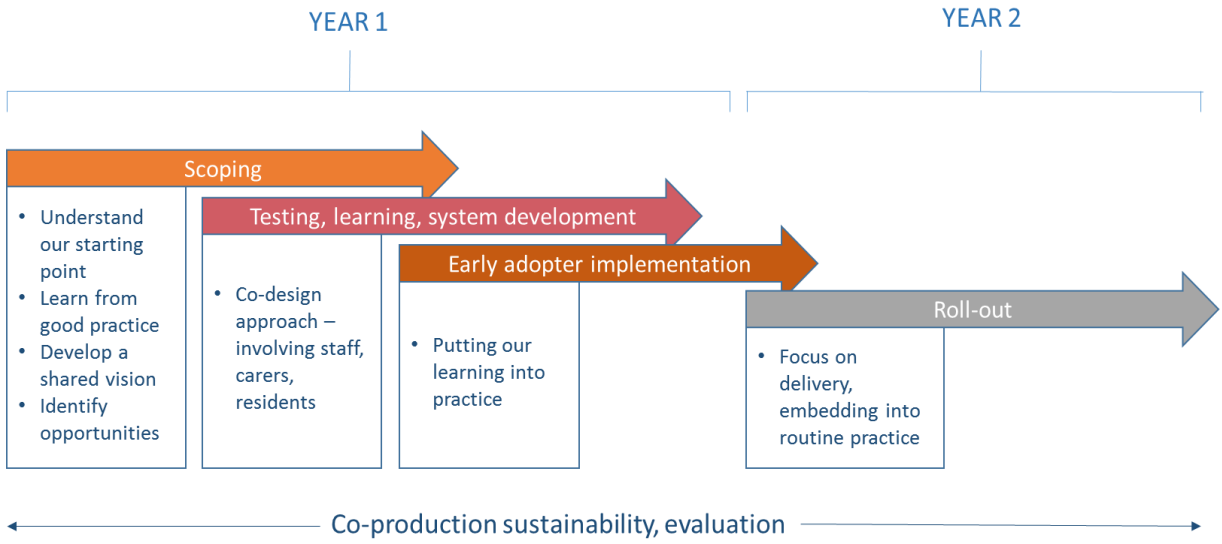
- One hospital had a 70% increase in uptake of their stop smoking service following the introduction of MECC.
- Over a seven month period, the Contact Centre team in Islington Council made 672 MECC referrals into relevant services such as employment and benefits advice.
- In Croydon, 40 out of 80 people that made use of the service they were signposted to had stopped going to their GP for their (mental health) condition as a direct result of joining the peer-to-peer support group:
  "People need to know that you don't have to go to the GP. Lots of people don't have that confidence. The connectors [having MECC conversations] were giving people this confidence."

[12] http://www.publichealthjrnl.com/article/S0033-3506(13)00128-5/pdf

5 Project plan

The diagram below summarises a proposed **phased approach** to the development and implementation of the City and Hackney MECC programme. The core principles underpinning this approach are:

- **co-design** with the target audiences (staff, carers and residents)
- a commitment to **ongoing testing and learning**
- embedding considerations around **sustainability** from the outset.



The proposed approach to scoping, co-designing, rolling out and evaluating a MECC programme for Hackney and the City would be led by a dedicated MECC implementation lead. They would be supported by a steering group and a network of visible MECC champions identified early on in the programme (starting with the existing network of local partners who have supported the development of our proposals).

The table below outlines the main activities and outputs for each phase of the proposed MECC programme. A detailed project plan will be developed following appointment of the MECC implementation lead, at the start of the scoping phase.

A key early action will be to develop a logic model and monitoring and evaluation framework, and to define the key metrics to be used for measuring progress and outcomes. Qualitative information will also be collected throughout to enable an assessment to be made about the acceptability, perceived value, scalability and sustainability of the programme.

	YEAR 1			YEAR 2
	Scoping	**Testing, learning & system development**	**Early adopter implementation**	**Roll-out**
ACTIVITIES	• Review of evidence, guidance & good practice • Map current MECC-like activity and learning from local pilots • Neighbourhood programme – alignment & opportunities • Baseline assessment – 'readiness' of local system for MECC • Engagement programme – senior leaders, staff, carers, residents • Develop a shared vision • Define scope – topics, target audience, settings, professional/carer groups • Identify 'early adopters' • Identify system champions • Brand development (including meaningful name for programme)	**Co-design approach…** Examples of things to test (to be informed by scoping phase): • multi-professional training • 'train the trainer'/cascade training model • face-to-face vs. online training • face-to-face vs. telephone vs. electronic 'conversations' and signposting • acceptability of MECC conversations to different target audiences • appropriate settings for MECC • recording and referral systems • methods for supporting community of practice	**Putting it into practice…** Activity to be informed by scoping and testing phase, but in general terms will include: • continued engagement • marketing & communications • delivery of training sessions • organisation and system development	**Consolidation of learning…** Focus on delivery: • embedding and scaling up successful practice • outcomes measurement
OUTPUTS	• Action plan to address gaps and build on current strengths within local system • Logic model – define programme activities, expected outputs, immediate impact and long-term term outcomes • Monitoring and evaluation plan – milestones & metrics	• Results of early testing documented • Practical recommendations for design of local programme • Required system changes begin • Agree MECC delivery models for 'early adopter' staff groups/sites • Detailed budget for Year 2 roll-out of programme	• Demonstrable progress towards establishing MECC as 'the way we do things around here' • Year 1 progress report • Practical tools to support implementation • Up to 10 training sessions delivered; up to 200 staff trained • Delivery plan for Year 2 roll-out • Sustainability plan agreed	• Final programme report and recommendations • Up to 20 training sessions delivered; up to 400 staff trained • Demonstrable progress made towards sustainability of the programme

6 Expected benefits

A summary of the expected benefits for patients/residents/workers, staff, providers and the wider system is provided below, based on evidence from other programmes (see section 4) and input from stakeholders involved in developing the plans set out in this document.

Patients and the public:	Better informed about actions they can take to improve their health and wellbeing – and motivated to take action. Greater awareness and uptake of local preventative services and support to address social and environmental determinants of health.
Staff:	Upskilled, motivated and confident to have conversations with the public about health and wellbeing, support them to take action to improve their health, and know where to signpost people to for further help. Improved job satisfaction for staff not 'traditionally' involved in giving advice.
Providers:	Create a culture of prevention where staff look at improving their own health as well as helping service users/residents to improve theirs – positive impact on staff wellbeing and absenteeism rates. Reputational benefits from investing in staff development and wellbeing – positive impact on recruitment and retention.
The system:	Supports shift in focus of integrated commissioning towards prevention. • Short-term – increase in uptake of wellbeing and advice services, greater interconnectivity between services. • Medium term – reduced demand for, and more efficient use of, health and care services. • Longer term - reduced health inequalities, reduction in premature mortality and preventable morbidity

Return on investment

It is not possible to provide a reliable estimate of the total return on investment (RoI) that could be achieved if we were to achieve our ambition to implement a whole system approach to making every contact count in City and Hackney. Much will depend on the model that emerges following the scoping and testing phase, but anyway attaching reliable RoI estimates to this type of preventative activity is notoriously difficult.

Based on a very narrow definition of RoI, indicative net savings to the NHS have been published by Public Health England in relation to specific priority risk factors (alcohol, smoking and physical activity).[13] Applying these estimates to local activity data produces the following examples of potential net savings to the local health system over a five year period:

- alcohol IBA in primary care - £100,000[14]

[13] Public Health England (2016), *Local health and care planning: menu of preventative interventions*.

[14] Based on an assumption of IBA in 5% of 742,000 adult face-to-face GP/nurse appointments p.a. (2016/17 data)

- smoking VBA in acute hospital setting - £90,000[15]
- physical activity brief advice delivered by healthcare professionals - £300,000[16]

While all of these interventions are predicted to be cost saving to the NHS within five years, the real benefits from these types of preventative interventions will accrue over a much longer time period. Moreover, as alluded to above, these estimates are based on a very narrow definition of RoI resulting from MECC activity in specific healthcare settings. The scope for wider system savings, and importantly population health gains, through the scaling up of MECC across the entire health and care sector is significant.

As such, these **projected short to medium-term net savings to the NHS significantly underestimate the wider potential system benefits over the longer-term** (including reduced demand for social care), as well as the full social value of achieving a system shift in prevention. As an illustration, the total annual cost of tobacco to society in Hackney and the City is £78.8m (including costs to the NHS, local authorities, local businesses and the wider economy).[17]

7 Resources required

7.1 Programme costs

This section provides estimates of **detailed Year 1 costs** (for scoping, testing and early implementation) and **Year 2 ballpark costs** (for ongoing evaluation, roll-out and sustainability planning).

Funding is being sought from three different sources.

1. Year 1 ICT enabler funding has already been secured (subject to final ICB approval) for the proposed digital and communications lead, with a further business case planned when ICT requirements to support the programme become clearer during the scoping phase.
2. Resources for the training co-design and delivery element will be sought from CEPN transformation funds – a proposal is in development; this is not yet agreed.
3. Year 1 funding for the MECC implementation lead, who will have overall responsibility for programme delivery, is confirmed from the LB Hackney Public Health budget; a further business case will be required to secure Year 2 funding.

[15] Assuming 10% of all local quitters are referred from Homerton (based on 1,500 quitters p.a.)
[16] Based on one clinical champion carrying out 1x training session per week to other healthcare professionals
[17] Action on Smoking and Health 'ready reckoner', 2018 edition

Year 1 costs

Cost item/resource	Purpose/role	Proposed source	£
MECC implementation lead (1xFTE)	Overall responsibility for scoping, testing, implementing and embedding MECC activity across the system Design and conduct of baseline assessment (as part of scoping) and outcomes monitoring/evaluation	LBH Public Health	67k[a]
Digital and communications lead (0.5 FTE)	Lead on development and prototyping of digital solutions Support development of community of practice	ICT enabler – awaiting ICB approval	25k
System prototyping fund	Rapid development and testing of ICT/digital solutions identified during scoping and testing phase	ICT enabler – TBC	TBC
Training resource/partner	Co-design & delivery of training sessions	CEPN – proposal in development	15k[b]
Engagement, comms & marketing	Support scoping and co-design, raise awareness and build movement for change	LBH Public Health	5k[c]

[a] Based on LBH PO8 (spine point 53) / NHS Agenda for Change Band 8A (inner London) – mid range. Exact salary cost TBC when final 2018/19 payscales published.
[b] Includes design, delivery and evaluation costs, 10 face-to-face training sessions (up to 200 people), training materials and venue hire. Backfill costs assumed to be provided in-kind.
[c] Includes materials, expenses, transcription and translation costs for engagement events.

Detailed **Year 2** costs will be finalised at the end of the scoping and testing phase, but ballpark estimates are set out below.

Year 2 (ballpark) costs

Cost item/resource	Purpose/role	Proposed source	£
MECC implementation lead (1xFTE)	Oversight of programme roll-out Develop sustainability plans Final evaluation report and recommendations	LBH Public Health - TBC	67k[a]
Digital system support	TBC during scoping phase	ICT enabler - TBC	TBC
Training delivery partner	Training delivery and evaluation	CEPN – proposal in development	20k[b]
Engagement, comms & marketing	Support community of practice Promote MECC across the local workforce Continue to build movement for change	LBH Public Health - TBC	5k[c]

[a] Based on LBH PO8 (spine point 53) / NHS Agenda for Change Band 8A (inner London) – mid range. Exact salary cost TBC when 2019/2020 payscales published.
[b] Includes training delivery and evaluation costs, 20 face-to-face training sessions (up to 400 people), training materials and venue hire. Backfill costs assumed to be provided in-kind.
[c] Includes materials, event expenses and translation costs.

7.2 Infrastructure requirement – estates and support services

Corporate service	Description of impact
Legal	None
Estates & Facilities	Possible adjustments to service settings where MECC conversations take place, to ensure the environment is supportive to the message being given. These will be confirmed during the scoping phase, but might include extension of smokefree spaces, signage and/or changes to contracts with on-site food retailers.
ICT	ICT/digital solutions may be identified as part of the scoping and testing phase to support delivery of the local MECC programme (e.g. system enhancements to facilitate recording of conversations and/or onward referral or signposting, e-learning resources, networking environment to support system-wide community of practice). A nominal Year 1 budget for this has been included in the estimated programme costs in 7.1.
Workforce & Education	Training is a key component of the programme. Frontline staff will need to be competent and confident to identify opportunities for MECC conversations, be able to assess a persons' readiness for change, and be well informed about local support services for onward referral and signposting. Staff will need to be freed up to be able to attend training, and supported to engage in ongoing CPD (e.g. through the proposed 'community of practice'). If a 'train the trainer approach' is successfully tested and rolled out, this will need to incorporated into people's workplans and job roles.
Finance	Some limited support will likely be required to procure a MECC training provider.

8 Stakeholder engagement

The proposed approach set out in this document has been co-produced with a range of stakeholders - including clinicians, practitioners, patients/residents, commissioners and others (including HCVS and Healthy London Partnership) - as summarised below. The planning group identified a number of key priorities that the programme must address (see appendix) – these have been incorporated into this proposal.

The proposed programme will continue to build on these foundations, taking a fully collaborative approach to designing, testing and implementing MECC across the City and Hackney.

Engagement activity	Date(s)	Participants	Purpose
Scoping workshop	5.12.07	35 people in total attended the workshop, including: GPs, Homerton, ELFT, pharmacist, commissioners, VCS, Public Health, community library service, Healthy London Partnership	To start the conversation about our local ambitions for MECC. Early testing of potential challenges and opportunities. Recruit volunteers to join planning task and finish group for local MECC programme.
Planning group meetings	21.02.18 29.03.18	22 volunteers recruited via the scoping workshop, including: GP, pharmacist, commissioners, CEPN, local authority children and adult services, provider workforce and quality improvement leads, community libraries, ELFT practitioner, VCS, Public Health, Healthy London Partnership	Build on learning from the scoping workshop to develop plans through collaboration.
Healthwatch workshop	17.04.18	19 local residents/service users	Early testing of resident/service user views of MECC to inform our plans.

9 Risk assessment

The key risks associated with this proposed programme of work are outlined below. **The phased approach** to programme development and implementation, following co-production principles and with a commitment to ongoing testing and learning, **should help to mitigate against most of the risks described**.

A detailed risk log will be developed at the start of the programme and monitored via the MECC steering group, with reporting by exception to the Prevention workstream.

No.	Description	Proposed mitigation
1	Inadequate resourcing made available for programme development	Year 1 funding secured from LBH Public Health. Business case presented to CEPN Board and ICT Enabler Board to optimise use of local resources to fund programme.
2	Lack of senior strategic buy-in to vision – MECC not regarded as a priority	Engagement initiated during planning phase will continue throughout scoping and beyond. Programme co-designed to ensure addresses needs of key local stakeholders. Recruitment of senior MECC champions within provider organisations.

No.	Description	Proposed mitigation
3	Lack of staff engagement with MECC agenda – MECC not regarded as a priority	Engagement with staff initiated during planning phase will continue throughout scoping and beyond. Programme co-designed to ensure addresses needs of staff. Senior sponsorship of programme within provider organisations; role for senior MECC champions to lead required organisation development. Recruitment of clinical and practitioner MECC champions during scoping phase, to support a movement for change. Establish community of practice to promote MECC and build movement for change.
4	MECC conversations not acceptable to target audience(s)	Resident engagement initiated during planning phase will continue throughout scoping and beyond, to ensure programme is tailored to the needs of local people.
5	Inappropriate MECC conversations initiated	Careful design of training spec and commissioning of appropriate training delivery partner – to ensure staff are able to establish clear boundaries. Community of practice supports ongoing learning and adoption of good practice.
6	Service areas with high staff turnover unable to retain core skills	Implement MECC as part of induction training. Pilot use of cascade training/train the trainer approach. Advocacy role of implementation lead - work with CEPN to lobby staff colleges to embed MECC in core NHS and social care training programmes.
7	Environment(s) unsupportive of MECC and positive behaviour change	Baseline audit will identify priority areas for action – organisational support to be provided by MECC implementation lead.
8	Infrastructure not fit for purpose (for recording MECC activity, signposting/referral, etc.)	Baseline audit will identify areas for improvement/ investment – ICT resource will help address.
9	Lack of capacity in local support services that people are signposted/referred to	ICT enabler funding will facilitate development of effective systems for monitoring uptake – feedback loop to ensure intelligence informs service planning.
10	MECC activity not sustained beyond end of programme	A key focus (and success measure) for Year 2 of the programme is embedding plans for sustainability.
11	Challenge in 'proving' value of MECC	Monitoring and evaluation planning to begin on day 1 – define what is 'good enough' evidence for decision-makers at the start. Design, test and implement infrastructure changes to facilitate collection of information on outcomes.

APPENDIX: Priority actions identified by planning group

Programme resource

- Adequately resource programme to shape and implement MECC programme
- Appoint dedicated programme lead

Baseline assessment

- Get a good understand of where we are starting from - staff skills/training, environmental audits of key sites where MECC may be delivered, resources, capacity/quality of relevant local services for onward referrals
- Build on what we already know works well/don't reinvent the wheel - learning from local MECC-type activity, learning from other areas

Define our ambition and what success looks like

- Cross-sector senior leadership buy-in is key - setting an example, modelling behaviours
- Develop a shared vision of what we are trying to achieve

Evaluation

- Build in from the outset
- Articulate clear outcomes and metrics for measuring success

Consultation/co-production

- With professionals - involve staff in design from the start, what are the barriers and facilitators to MECC conversations? What is the most effective approach to MECC training for different professional groups?
- With residents - what sort of messages would be well received, in what context, from what sort of people?

Training

- Co-design curriculum and format
- Test and learn

Staff communications and information sharing

- Early adopters as MECC champions
- Staff comms campaign about the power of MECC conversations - with friends and family, not just patients/service users
- Awareness raising about how MECC can support more effective interactions with patients/service users/residents, rather than seen as an extra burden for staff
- Consistent Hackney and City wide message and branding (language/name is key)
- Establish and facilitate a MECC network and platform for sharing good practice

Wider comms so no surprises when conversations started during service interactions

Supportive infrastructure

- Efficient and effective referral process/systems
- Up-to-date, accurate and easily accessible information about local support services
- Organisational systems to monitor MECC training, conversations, outcomes/referrals

Sustainability

- Sustainability built in from the start
- Test and learn from 'train the trainer' / 'cascade training' models
- Ongoing support/ownership of the local MECC programme to maintain momentum
- System incentives for MECC

Title:	Transforming Hackney's Integrated Learning Disabilities Service (ILDS) update
Date:	12 July 2018
Lead Officer(s):	Simon Galczynski, Director of Adult Social Care (LBH) Simon Cribbens SRO, Planned Care (CoLC) Siobhan Harper, Director – Planned Care Workstream – Integrated Commissioning (CHCCG)
Author:	Tessa Cole, Head of Strategic Programmes and Governance (LBH)
Committee(s):	Planned Care Core Leadership Group for information – 19 June 2018 Transformation Board for information – 27 June 2018
Public / Non-public	Public

Executive Summary:

This report provides an update on progress with the implementation of the review of the Integrated Learning Disabilities Service (ILDS), which is jointly commissioned by City and Hackney Clinical Commissioning Group (CHCCG) and the London Borough of Hackney (LBH). The whole service went through a review in 2017/18 to look at improving the quality of health and social care provision and in doing so achieve a greater degree of integration and multi-disciplinary working between the various professionals involved and contribute to a financially sustainable operating model moving forwards. The scope of the review covered ILDS only and the outcome will be a more integrated service model and new service specification.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board endorsed the approach and the progress being made and would like to develop a more ambitious approach to supporting people with learning disabilities in the medium term.

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:

The plan to transform the Integrated Learning Disabilities Service aligns strongly with the local Sustainability and Transformation Plan's ambition "*to develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care*".

The expected outcomes will support delivery of the Joint Health & Wellbeing Strategic priority no. 3 because improved outcomes will enhance the quality of life for vulnerable people with care and support needs.

They also support the Planned Care Workstream's ambition to ensure that commissioned services "*are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy*." And the Integrated Commissioning Board's and Transformation Board's collective ambition to *"promote the integration of health and social care through our local delivery system"* to *"build partnerships between health and social care for the benefit of the population"* to *"deliver a shift in focus and resource to prevention and proactive community based care"* and to *"ensure we maintain financial balance as a system and achieve our financial plans."*

It is anticipated that ILDS service improvements will positively enable CHCCG to deliver the Better Care Together programme, the 5 year Forward Plan and contribute to the IAF indicator around reducing the number of people with LD receiving inpatient care, because it will transform the way local services are structured and provided. We are planning to consolidate the best of what already exists across the whole system and design in further improvements.

The redesign of ILDS is also underpinned by the nine principles captured in the 2015 paper 'Building the right support' which is a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

Specific implications for City:

ILDS health services are delivered within the operating boundary of CHCCG. Therefore a key implementation consideration for the new arrangement for the ILDS health provision is to ensure clear pathways are mapped with the City of London

Adult Social Care and Children's Social Care services to ensure continued support for C&H registered patients from City of London for the health component of the service.

Specific implications for Hackney:

The social care element of ILDS operate within the confines of Hackney borough only. As such, the vision for Learning Disabilities going forward is vertically aligned to the Mayor's strategic priorities and horizontally aligned with wider departmental priorities.

Patient and Public Involvement and Impact:

A summary of the user and carer involvement and engagement into this work forms a core component of the main body of this report. Ongoing user and carer engagement will be delivered through the newly established LD Partnership Forum which seeks to co-produce any change related to support for people with learning disabilities.

Clinical/practitioner input and engagement:

During phase 1 of the review, both health and social care staff within ILDS have been actively involved in a series of co-production events, the purpose of which was to review service provision, identify opportunities for improvement and develop options for a new service model. Since the Integrated Commissioning Board approved the new ILDS operating model in February 2018 this work has been on-going to develop the four core care pathways further. The bulk of this work was conducted as part of a whole service away-day in February 2018 when we set up four multidisciplinary groups to map out how each of the four core new pathways could operate in practice. Since then we have held regular sessions with the lead clinicians and social care managers to refine the detail further and negotiate potential issues e.g. definitions and protocols.

Impact on / Overlap with Existing Services:

The changes around the future commissioning of ILDS health services will impact directly on the current LB Hackney section 75 agreement with Homerton University Hospital and East London Foundation Trust (ELFT). Under the new partnership arrangements, LBH will remain the service host and lead social care provider. ELFT

will be the lead Health provider and Homerton will no longer be a partner in the delivery of ILDS.

Sign-off:

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

Main Report

1. Background and Current Position

Hackney's Integrated Learning Disability Service (ILDS) is an integrated multi-agency, multi-disciplinary team, providing specialist health and social care support to adults with Learning Disabilities (LD), who are residents of the London Borough of Hackney and the City of London, and have a GP in the area. The service is jointly-commissioned by the Council and the CCG and the service plays an important role in delivering the objectives agreed by the INEL Transforming Care Partnership (TCP) as part of NHS England's Transforming Care Programme.

ILDS is a highly specialist service and is currently delivered through a section 75 partnership agreement between LB Hackney, Homerton University Hospital and East London Foundation Trust. The council provides specialist social workers while ELFT provide Psychiatrists and Homerton supply Psychologists, Physiotherapists, Occupational Therapists, Speech and Language Therapists and specialist Community Nurses.

The following data provides a summary of performance for ILDS in 2017/18:

Measures	2016/17	2017/18	Most recent Comparator Average
Total number of adults with a learning disability in receipt of long term services during the year	**493**	**529 (251 per 100K)**	**283 per 100K**
Of which were in a care home	**139**	**139 (26.3%)**	**25.8%**
Of which were in the community	**354**	**390 (73.7%)**	**74.2%**
Proportion of those that received a community based service via a direct payment.	**30.2%**	**31.2% (122)**	**40.30%**
Number of working age service users with a learning disability	**455**	**490 (232 per 100K)**	**254 per 100K**
Proportion of working age adults with learning disabilities in paid employment	**4.2%**	**3.7% (18)**	**5.4%**

Proportion of working age adults with learning disabilities who live in their own home or with their family	**74.6%**	**77.7% (378)**	**74.1%**
Percentage of service users in receipt of long term services for more than 12 months received an annual review.	**58.3%**	**80.4%**	**NA**
New service users entering adult services via the transitions pathway	**22**	**22 (10.4 per 100K)**	**9.9 per 100K**
Proportion of service users with a learning disability that responded to being very happy with the way staff helped them (annual survey)	**74.7%**	**77.6%**	**NA**
Measures	**2016/17**	**2017/18**	**Most recent Comparator Average**
Proportion of service users with a learning disability that felt their life was really great (annual survey)	**43.2%**	**45.5%**	**NA**
New client assessments	**69**	**45**	**NA**
of which lead to a support plan	**46**	**35**	**NA**
Carer assessments completed	**110**	**108**	**NA**
Safeguarding concerns raised	**136**	**150**	**NA**
Section 42 Enquiries conducted as a result of a safeguarding concern being raised	**NA**	**62**	**NA**

An options paper went to the Integrated Commissioning Board in February 2018 and the board approved the implementation of a new operating model with four core pathways. This report provides an update on progress since then.

2. Service changes update

Our on-going co-production work with health and social care staff has led to further refinement of the 4 core care pathways as follows:

Transitions: This multi-disciplinary team will initially focus on age group 16-25 years who are in education, but as the team matures they will get involved from age 14. The Transitions social workers will adopt an advisory role between the ages of 14 and 15, they will jointly plan between the ages of 16 and 17 and formally take over responsibility from age 18. The Transitions social workers will lead the process and liaise with health colleagues as appropriate. Depending on the level of individual needs and capabilities, young people may move out of the Transitions team before the age of 25 years either (a) because they have finished their education, in which case Transitions will ensure they are settled beforehand OR (b) because they are not in education, but they are settled within their situation and merely require annual review. However, the decision to move on will be risk-based and will be the result of a multi-disciplinary team discussion.

Review and Move On: The purpose of this multi-disciplinary team is to identify people with a social care package who have the potential to live a more independent life and to enable them to do so. The objective is to break the culture of on-going service dependency by supporting people to do more for themselves through targeted time-limited interventions. The team will take a risk-based approach to put plans in place to provide the right level of support to enable skills development and appropriate accommodation placements. People in this pathway will include the 'care funding calculator' cohort, people whose situation is stable or who have the potential to be safely moved or stepped down to a more independent care setting.

Long-term Care: The purpose of this multi-disciplinary team is to provide regular (but not frequent) on-going support to help people manage their long-term conditions. In other words, 'case working' for people with a variety of needs who require continuous intervention and/or monitoring beyond a period of 3 to 4 months. This group will not be deemed capable of stepping down or 'moving on' because of the complexities surrounding their needs. Cohorts will include continuing healthcare cases, long-term complex work involving Court of Protection (COP) and/or other legal work, people with complex family situations, people who do not tend to remain stable for long periods.

Intensive Support Team: The purpose of this multi-disciplinary team is to support people aged 18+ with a learning disability, with co-morbid mental illness and / or behaviours which challenge. This is likely to include the following clients:

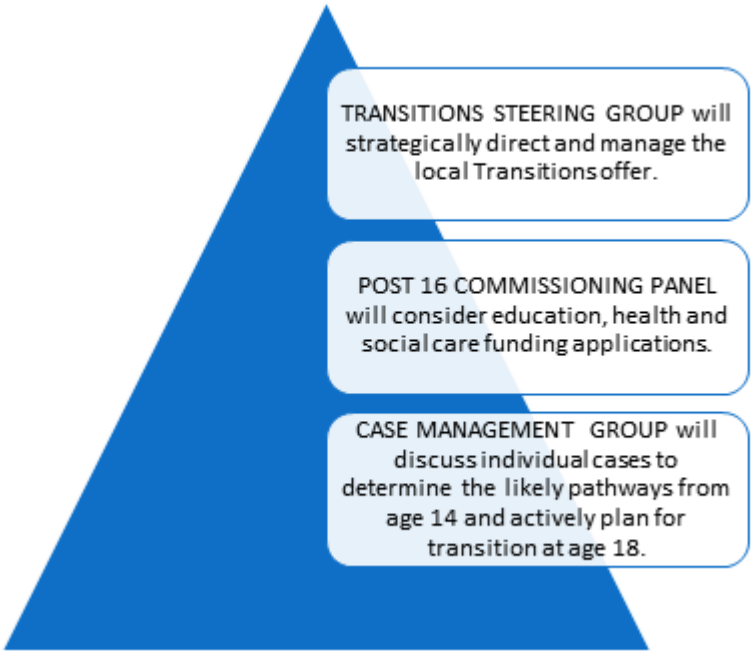
- Those with a chronic mental illness who are subject to the Care Programme Approach (CPA). This will include those clients who currently receive input from the Assertive Outreach Team.
- Those who have had a recent mental health admission either via mainstream or specialist services.
- Those who have had recent contact with Forensic Psychiatry services or who are currently in-patients detained under the Mental Health Act (1983).

- People who urgently require assessment, diagnosis and intensive treatment for an acute presentation of mental ill health or a behaviour which challenges.

Acceptance onto the pathway will be based upon the current risk profile of the person. This will include consideration of risk of harm to self, others, self-neglecting behaviours and risk of placement breakdown. Where possible this pathway will be provided in the community but if the level of risk is such that hospital admission is required, the Intensive Support Team will assist in minimising inpatient stays by helping with early discharge and supporting people to resume their daily life.

Transitions Care Pathway

In the wider context, we have collaborated with LBH Children's Services to develop and agree a new Transitions pathway and governance structure as follows:



The social care elements of this pathway went live in May 2018 and we have begun collaborating with CAMHS and Mental Health colleagues to explore opportunities to join up the health pathways e.g. through joint Transitions Clinics in order to improve outcomes and support strategic initiatives like the Transforming Care agenda.

TUPE Staff Transfer

As well as seeking agreement to structure the ILDS service into these four new pathways, the proposal that came to the Transformation Board and the Integrated Commissioning Board in February 2018 secured agreement to a model whereby all

ILDS health provision is provided by ELFT and that existing clinical staff at the Homerton are TUPE transferred to ELFT following consultation.

Homerton and ELFT began a 30 day TUPE staff **consultation exercise** on 1st May. Unfortunately staff illness and the Easter break delayed the mobilisation process, and as a consequence our planned timelines have been delayed. Overall though, this process has gone well and we anticipate the official transfer to take place on the 1st July 2018.

In the meantime, Homerton have provided verbal assurance that the ILDS clinicians can continue to use St. Leonard's facilities and the current section 75 partners are working collaboratively to finalise and agree the budget to be transferred from Homerton. At this juncture we are planning to put in place an interim arrangement to maintain business continuity until a new section 75 agreement is developed.

Introducing new ways of working

On the 8th June LBH and ELFT will begin a joint 30 day staff **engagement and consultation exercise** in line with each partner organisations' change policies. The purpose of this exercise is to communicate the proposed changes to the service structure and expectations in relation to new ways of working going forward. This will give health and social care staff time to reflect on the detail of proposals and provide opportunities for them to feed back their comments and recommendations. As part of this process they will also be invited to state their preferred team within the new structure and we will make every effort to accommodate their requests. It was originally planned to conduct this exercise during April but felt it would be more appropriate to wait until the TUPE consultation was concluded first.

Once this engagement exercise is complete, we plan to carry out a recruitment campaign in July to appoint to the new Team Manager posts. Following this process, and anticipating maximum notice periods, we anticipate the 'go live' date to be end of September/early October. In the interim period, the plan is to continue with co-production as is in order to ensure that we will hit the ground running when the new service goes live and that business continuity is preserved and risk management is appropriately maintained.

3. Development of service outcomes and service specification

In line with the redesign of ILDS a new service specification is being developed. The service specification is being underpinned by the development of core service outcomes that are being co-produced with users and carers through the newly established Learning Disability partnership forum which includes carers and service users, and with health and social care staff within ILDS itself.

Work to date has included engaging with service users and carers at the 'Big Do' event and through the newly established LD Partnership forum and through discussions with health and social care staff at team meetings and finally at a provider forum which included supported living providers, carers and voluntary organisations in the borough. The discussions have centred on what users would like to achieve in their lives and as members of the wider community and what good would look like to them in terms of ILDS service delivery. This includes engaging with young people who fall into the transition cohort who will be moving from Children's Services support to Adult Services support.

The outcomes are expected to be finalised at the end of June and the service specification will be ready to go-live in September. This will include a robust performance management framework underpinned by the outcomes and local authority and NHS statutory reporting requirements.

Other commissioning activity for the service includes a placement mapping exercise to feed into a wider accommodation review for people with learning disabilities. This will inform future commissioning decisions in relation to residential, supported living and shared lives provision in and out of the borough so that people with learning disabilities can be supported in the most appropriate living situation for them that promotes their independence.

4. Improving health outcomes and links with primary care

Nationally people with learning disabilities have poorer physical and mental health than other people and die prematurely. Some of these deaths are avoidable. Clinical evidence shows that LD annual health checks can identify health conditions, ensure the appropriateness of ongoing treatments, promote health (e.g. through screening and early immunisation) and establish trust and continuity of care. In Hackney the overall uptake of health checks for people with LD who are under the care of the integrated learning disabilities service is around 55%,, which is in line with the London average, however this is below the 75% target and is lower than in previous years. It is also currently unclear how many adults have health action plans and more importantly how to measure and evaluate actions from them. This suggests there is room for improvement.

General practice and primary care have the much needed generalist skills to help people with a learning disability navigate through a complex health and social care system. All patients with an LD should be on a LD register in their general practice and once aged 14 and over should have an annual health check and be referred/supported to receive appropriate actions, such as screening, immunisation, lifestyle advice and sexual health. Local City and Hackney data (extracted by the Clinical Effectiveness Group from primary care records) shows that 81% GP registers have had a full annual health check and 84 % have had a health action plan. It is imperative that practices

are helped to make reasonable adjustments and provide appropriate support materials.

In Hackney, comparing actual GP registers with predictive modelling suggests that there is current under-recording of LD however, issues with data capture and recording are being explored locally. There is significant variation in the recording of LD between GP practices which is probably beyond variations in local prevalence.

In terms of mortality there have been at least 8 premature deaths amongst people with LD with potentially preventable causes. Progress to investigate these deaths under the LeDeR programme to date has been slow and there is a recovery plan underway to get this back on track.

To address all of this locally we are delivering a programme of work that is aimed at strengthening links with primary care in relationship to learning disabilities and improving health check performance. This work has been discussed and is being supported by the GP Clinical Lead for Prevention and Long Term Conditions, Dr Clare Highton. The outputs from this work are expected to be:

- Areview of coding of LD registers in primary care , in particular what degree of disability should lead to which coding
- An increase in the number of health checks undertaken using the EMIS LD health check template to collect data if feasible
- An increase in referrals and actions from the health checks e.g. numbers having immunisations, cervical cytology, bowel screening, mammography and eyes, teeth and feet where patient consent or can be aided to attend
- An increase in self-reported confidence by general practices and primary care staff to meet LD service user needs e.g. use of health passport and reasonable adjustments
- A defined link between LD health checks and social prescribing
- A defined link to positive behaviour support
- Better links with the LD team, and possibly joint reviews between primary care and the team

The proposed approach to delivering this is through the emerging neighbourhood model. For each neighbourhood an ILDS team member will be assigned to act as a link person. It is expected that they will act as a link between primary care and specialist ILDS support and provide each practice or cluster of practices or neighbourhood with a supportive learning event to assist in their confidence in completing LD health checks (it is anticipated that this will be practical and informal within one of the surgeries lasting one hour).

As well as this an LD liaison nurse has been appointed to Homerton Hospital which provides a new opportunity to improving support for people with an LD who are admitted to hospital or come in for a blood test. This role is to support the client and support the ward staff to ensure reasonable adjustments are made.

5. Transforming Care Programme

The national Transforming Care programme aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition. The programme has three key aims:

a) To improve quality of care for people with a learning disability and/or autism
b) To improve quality of life for people with a learning disability and/or autism
c) To enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay

In terms of people in the TCP cohort in Hackney there are zero patients as inpatients funded by the CCG. Inner North East London is doing well but we are skewed by performance in Waltham Forest. There are 4 patients under restrictions in secure settings and it is anticipated that 2 will be discharged in 2019. It should be noted that our progress is one of the best in London, but these are very complex, expensive discharges and there is a tension between individual rights and the wider safety of the community. There is considerable lack of expertise amongst providers to support these clients Of the remaining 2 clients will probably never meet a threshold for discharge and the other requires at least 2 years of treatment.

6. Joint funding arrangements

Although the CHCCG and LBH already have an integrated commissioning arrangement for the Learning Disability Service, there has been an additional agreement to progress joint funding arrangements within this service to meet health needs beneath the threshold of a Continuing Health Care. Existing joint funding arrangements between the CHCCG and LBH 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 review, CHCCG commissioned a report in 2017 which identified the lack of joint funding mechanisms with the Local Authority, especially in comparison to neighbouring boroughs. Furthermore, since the integrated service was set up 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.

For 2017/18 there has been an agreement to increase the health funding into the Learning Disability service in line with benchmarks. This will be resourced from the £1.9m drawdown and subject to a business case agreed by NHS England. During 2018/19 the Planned Care workstream will oversee the trial of a new panel process for assessing health and social care needs and calculating the associated joint funding

split for Learning Disability cases. This will verify the health contribution for future years and it is expected this will report by August 2018. Similarly, in 2018/19, a joint funding policy and procedure will be agreed and implemented in the Learning Disability service for all new cases.

It is expected that joint funding of care packages will start for the integrated learning disability client group first and arrangements will then be implemented for other client groups such as older people within the development of the further pooled budget programme of work.

7. User engagement

Hackney Informed Voices Enterprise (a community interest company whose membership is made up of people with learning disabilities) was consulted in July 2017 in order to better understand the lived experience of ILDS from the end user's perspective. Feedback confirms that joined up services and continuity of care are perceived as being most important. A further service user engagement session was held in January 2018 where there was unanimous support for the proposed option for the new operating model as outlined in this paper.

User and carer engagement continues to be central to the development of the new service and the service specification as detailed earlier. This has been delivered through a number of ways including the 'Big Do' event in March 2018, an annual service user and carer event which was used to get user and carer input into shaping services and improving health outcomes. At the event there was service user and carer input into the new service design and the development of outcomes for the service. The event was also used as an opportunity to recruit interested users and carers to the newly established LD partnership forum.

The first LD partnership forum meeting was held in May 2018 with interested carers and users and these will run quarterly going forward. The first session was used to plan how the forum will work going forward and key areas of focus. This will include ongoing input into the implementation of the new ILDS service and the development of a LD charter in Hackney to make LBH more learning disability friendly. Contact has also been made with the Carers Centre and Health watch to discuss having more specific carer engagement moving forward.

8. Conclusion

In summary, there are a number of significant work streams being delivered to support the transformation of services and outcomes for people with Learning Disabilities in City and Hackney. This includes the development of a new service model, a change in the provider of health clinical input into the service and the development of a new

service specification. Staff, service user and carer input into the design and delivery of this is seen as key to delivering the improvements required to deliver a financially sustainable and integrated offer of support going forward. The Transformation Board is asked to note progress to date and is invited to provide feedback on the work streams outlined.

Supporting Papers and Evidence

APPENDIX 1:

ILDS Review Revised Project Timelines

Critical milestones	Deliver by	Status
Staff consultation about the proposal to transfer ILDS clinical staff from Homerton to ELFT via TUPE.	30.05.2018	Completed
Joint staff engagement exercise (LBH + ELFT) about the proposed restructure and change to working practices in line with each organisation's organisational change procedures.	30.06.2018	In progress and on track
ILDS recruitment campaign for Team Manager posts and other vacant posts	31.07.2018	Planned
Interim arrangement developed to bridge the gap until the section 75 agreement is signed off	31.07.2018	Planned
Operational refinements to internal workflows and processes.	31.08.2018	In progress and on track
New service specification and structure approvals	14.09.2018	In progress
Draft new section 75 agreement	31.10.2018	To be initiated
New model 'go live' date	31.10.2018	In progress
First review of the new service	31.01.2019	To be initiated

Title:	Neighbourhood Development Programme Update Report
Date:	12 July 2018
Lead Officer:	Tracey Fletcher, Unplanned Care Workstream SRO Nina Griffith, Unplanned Care Workstream Director Dr Stephanie Coughlin, Clinical Lead, Neighbourhoods Programme
Author:	Jennifer Walker, Project Manager
Committees:	Neighbourhood Steering Group, 19 June 2018 Unplanned Care Programme Board, 22 June 2018 Transformation Board, 27 June 2018 Integrated Commissioning Board, 12 July 2018
Public / Non-public	Public

Executive Summary:

This paper provides an update six months after the approval of a business case to secure Better Care Fund money to support the planning, design and initial delivery of Neighbourhoods in City and Hackney.

The paper summarises the approach being taken to develop new ways of delivering care across neighbourhoods. This approach concentrates on facilitating “bottom up”/co-produced models of care using agreed quality improvement methodology and within a robust governance structure. The over-arching governance structure will prevent silo-working and also prioritise work based on system need, maintain pace and ensure that learning is formally collated so that local models can be scaled. It is envisaged that neighbourhoods will help drive improvements to existing processes and communication, nurture innovation and shape the strategic direction of future service delivery.

The vision and goals for the neighbourhood programme are detailed. With the critical feature of the model being that it delivers person centred, local care by bringing together teams around the patient. The vision is likely to change over the next 4-6 weeks as we add further detail to be clear about the link to social care and incorporate a Women’s, Children’s, Young People and Maternity perspective.

The report recognises that there are likely to be strategic implications for some services once new models of care have been tested with respect to how future commissioning and contracts are drawn up.

It is critical that although the Neighbourhood programme reports formally into the Unplanned Care Programme Board, that it represents the overall system. Significant

progress has been made in developing relationships with the care workstreams, identifying how neighbourhoods might support the delivery of work stream priorities and the beginning of a way of operationalising these shared priorities.
There has been considerable progress since the approval of funding in late December 2017. Further details on this are contained within the report. The most significant progress has been made in the development of an early shared understanding of the potential of neighbourhood working and the benefits it might bring to City and Hackney residents. There is a palpable sense of the opportunity and potential that neighbourhood working might offer to teams and residents. A communications plan has been developed to continue this work and to further enhance a shared sense of understanding of what neighbourhoods are and what they might do.

There is an ongoing commitment to ensuring that neighbourhoods deliver sustainable/cost effective models of care. The focus of work is using neighbourhoods and the structure to help existing teams to work in different ways rather than investing in new staff/roles. Equally there is a commitment to not increase meetings for staff and add additional layers of bureaucracy and complexity. The programme is working out what this looks like in practice as neighbourhoods develop.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board noted the update paying particular attention to the deliverables over the next six months of the programme.

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:

Delivery of the neighbourhood programme is a key strategic priority for City and Hackney

Specific implications for City

We recognise that the neighbourhood model for the City will need to be adapted to reflect the characteristics of the City population and the different health and care services that they access.

We are developing a City specific version of the neighbourhood data set to understand this better.

We have a City representative on the neighbourhood patient panel.

We are running a pilot of how mental health could work in the neighbourhood in South-west and the City.

Specific implications for Hackney

The neighbourhood model will also focus on the diverse needs of Hackney residents.

Patient and Public Involvement and Impact:

We are fully committed to the principles of co-production in the development of the neighbourhood model.

We have convened a patient panel who consist of six user representatives who meet monthly to hold the programme to account for involving users, they also send one or two reps to the steering group each month. Users have been part of the project team that attended the UCLP/Dartmouth Place Based Care Network events over the past six months. A user sat on the panel for the recent appointment of the project manager.

Users have helped us shape our vision and objectives for neighbourhoods, and have really challenged to think about neighbourhoods as central to our local communities. The patient panel are also helping us to develop a plan to better engage more widely with our communities around neighbourhoods.

Users were well represented at the neighbourhoods mental health workshop and their input is shaping the form of the pilot.

Clinical/practitioner input and engagement:

The programme is strongly clinically led:

- There is an over-arching clinical lead who is overseeing the whole programme
- Each provider organisation has sent clinical / practitioner representation to the steering group
- We have recently appointed 7 primary care clinical leads across 7 of the 8 neighbourhood areas
- We are utilising the practitioner forum in July to discuss neighbourhoods
- We have representation from a range of clinical/practitioner professions at the steering group including hospital consultant, primary care physician, psychiatry, community nursing, AHPs, social care, psychology.

This has ensured that the people designing neighbourhoods have direct, front line experience of care delivery and so understand the challenges and what could work.

Impact on / Overlap with Existing Services:

There is significant overlap with a wide range of existing services, and with the work of all four workstreams. This is described in more detail in the main paper.

Main Report

1. Background

A business case to develop a neighbourhood model in City and Hackney was approved by the Transformation and Integrated Commissioning Partnership Boards in December 2017. This secured just over £800,000 for one year from the Hackney and City Better Care Funds to provide programme management (clinical and managerial) and clinical/project management resources across a number of providers. This one year funding provided capacity for providers to design and test new ways of working within a neighbourhood model alongside the initial set up of a neighbourhood structure in Hackney and City.

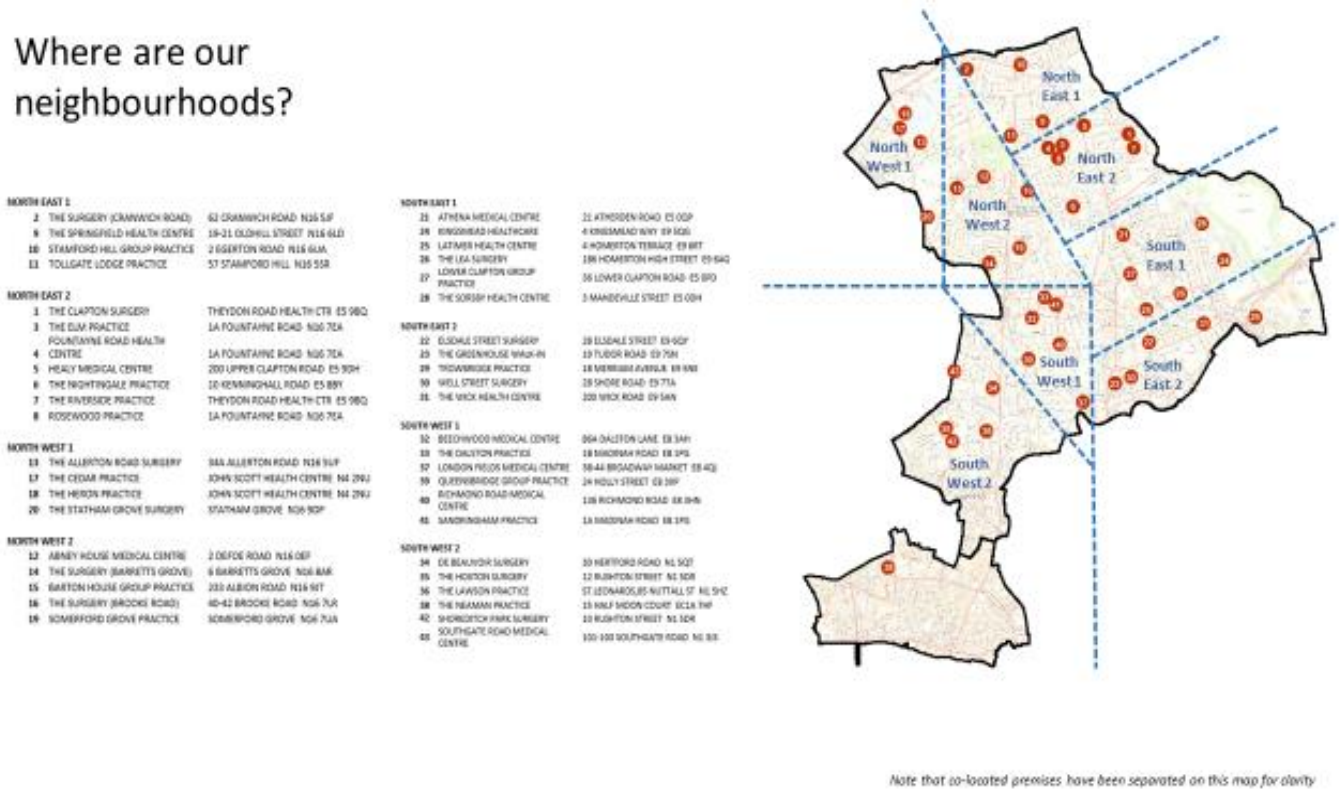
The Transformation Board requested that a formal update on progress be bought back in six months. This report provides an overview of progress to date across the City and Neighbourhood development programme.

2. A recap of the Neighbourhood Model

2.1 <u>An overview of the Neighbourhood Model</u>

GP Practice populations form the building blocks of the geographical neighbourhood community in population groups that are between 30,000 and 50,000. This equates to eight neighbourhood areas in City and Hackney.

<u>Figure 1:</u>



The neighbourhood will build on existing networks and assets across providers, residents and community groups already in place to create a geographical neighbourhood community.

Neighbourhoods will focus on prevention, as well as the wider social and economic determinants of health. The neighbourhood model will organise services around the resident. This approach should lead to real and meaningful integration of health and social care.

The neighbourhood builds on the concept of mutual patient/resident support and peer learning to empower patients/residents to better manage their wellbeing. Residents will be supported to use existing services through informed navigation and an accessible structure that makes sense to them.

2.2 What is the vision for Neighbourhoods?

The neighbourhoods steering group have spent some time developing a clear vision for neighbourhoods. Though not yet finalised, the current working vision for Neighbourhoods is that they will:

- improve the overall health and wellbeing for the City and Hackney population
- reduce inequality of access to services and reduce inequalities in health and social outcomes for the City and Hackney population
- focus on the wider social and economic determinants of health for the whole population enhancing early intervention & prevention models
- coordinate and plan services with residents around their individual needs
- create empowered communities who are better able to support themselves,
- prevent ill-health and increase their ability to sustainably manage their own wellbeing
- listen to and act on what matters to residents and patients
- will improve the quality of care received and patient experience in a sustainable way

2.3 What are the goals for the Neighbourhood Development Programme?

The Neighbourhood Development programme goals are:

- To be transformational and innovative with the integration of care
- To be outcomes focused with robust, measurable and reproducible high quality outcomes
- To be whole population focused as well as at the individual neighbourhood level; serving natural recognised communities;
- To truly understand the needs of the population; with a particular focus on prevention and a reduction in health inequalities
- To work collaboratively across the system so that strategic planning and measures of success, both with commissioners and providers, are aligned and conducted in partnership where appropriate
- To be a driver of co-production of patient outcomes with residents and patients

- To utilise existing community assets, harness the capacity of the non-registered workforce, and include community groups and local people
- To support and enable the development of a high quality, enthusiastic, and sustainable workforce making City and Hackney the place where people choose to work
- To identify the totality of resources available, and commit to focusing them on the interventions that will have the greatest sustainable impact on population health

3. The approach

The Neighbourhood Development programme has committed to a way of working where changes to the delivery of care are co-produced by staff involved in the delivery of care and residents at a local level. There was an agreement not to direct change from a central top down position with pre-prescribed models of care. The programme has put in place a robust governance structure to maintain an overview of the changes being tested across the entirety of the programme, ensure that these are in-keeping with the neighbourhood vision and goals and ensure that these local bottom up changes are appropriately tested and able to be spread sustainably.

The programme has undertaken to use quality improvement methodology to support the testing of new models of care. This will be underpinned by the triangulation of robust information, provider and resident views.

The intention is to test changes with one neighbourhood where there is either a particular interest/need. This enables changes to be tested on a controlled scale with an enthusiastic and committed team. The learning from these smaller scale pilots can then be extracted and amendments made before the model is rolled out further. This is the Discovery phase of the programme. It will formally feed into Phase 4 where the results of this work will be reviewed, an assessment will be made as to whether the models can be scaled including “when” and “how”. Section 5 includes further detail on these phases. There is a delicate balance between bottom up design and delivering where there is good evidence to inform change at scale and pace. This will be managed via the Neighbourhood governance structure. There are a series of underpinning/cross-cutting work streams which will provide a foundation to the neighbourhood specific work. These will look at how to improve underlying processes and communication to support change and further detail is included in Appendix 1 and in Section 5 below.

Once the system wide implications for services are understood following completion of the pilots and assessment of scalability, these will be formally linked into the contracting arrangements and commissioning of services where these are affected by the changes made. The intention is for Neighbourhoods to shape and drive change for future service delivery based on local need/evidence linked to what is known to work elsewhere and application of evidence.

All Neighbourhoods will provide core services with agreed performance outcomes (as is currently the case) although these core services may be reconfigured to better support the neighbourhood model if this is indicated. This will enable the existing out of hospital blueprint to be re-shaped. Additionally where local need indicates that enhanced local service provision/changes to care might be required, this will be developed and tested for sustainability. It is important to note that all patients will be able to access the services they need regardless of their neighbourhood of residence.

4. Delivery Phases

The neighbourhood programme had three distinct developmental phases which are summarised below in the initial business case.

- **Phase 1 – Neighbourhood Identities and Primary Care**
    - Development of neighbourhood identities and collaboration across primary care
- **Phase 2 – Neighbourhood Governance**
    - Development of a structure to support neighbourhood governance
- **Phase 3 - Discovery Phase (Previously phased readiness)**
    - Development of ways of working to deliver change across providers to deliver the neighbourhood vision/aims (The re-worked vision is attached in Appendix 1. This will be amended to better reflect social care and include a specific reference to Children, Women, Young People and Maternity
- **Phase 4 – Formal review, scaling and implementation of new ways of working**

Phase 3 has developed a strong co-production/bottom up approach to design. This allows focused work between primary care and providers, both strengthening working relationships and trust but allowing new models of care to be tested in a controlled way before wider roll. A strong over-arching governance model has been developed to ensure that there is good understanding of the different work across the neighbourhood areas, appropriate service integration and input into the different work streams, strong communication across neighbourhoods and providers and no silo-working.

This discovery phase will formally link into Phase 4 where pilots from across the neighbourhoods will be drawn together so that they can be scaled up and rolled out across the system.

In Phase 3 there is also system wide enabler work ongoing to support neighbourhood development through a number of cross cutting work streams (a number of these are listed below):

- Strengthening MDT working and communication
- Using neighbourhoods to strengthen safeguarding processes
- Management of the multi-morbid/complex patient

- Understanding the population through risk stratification/population segmentation

It is recognised that system wider enabler work particularly around processes and communication to support other potential changes to service delivery.

5. Progress to date

There are four stages for the development of the Neighbourhood model during the first year and beyond of funding. These stages are underpinned by support from the central programme team, a strong over-arching governance structure and a robust co-production model. This is summarised below:

5.1 Governance

- Overall clinical lead in place and chairing Steering Group
- Formal work stream structure in place and reporting into Steering Group
    - Patient Panel
    - Information and Evaluation
    - Provider Design Group
- Formal monthly programme reporting into the Unplanned Care Programme Board
- Appropriate programme management infrastructure in place

5.2 Co-production

- Established over-arching patient panel with six enthusiastic and committed patient representatives to provide overview, challenge and scrutiny for co-production plans across the programme
- The Patient Panel will take a lead on developing an initial engagement model for neighbourhood residents and testing this in an agreed neighbourhood
- Panel meets monthly and work programme is in place

5.3 Central Programme Team

- The neighbourhood development programme is supported currently by 0.8 WTE programme lead and a 0.2 clinical lead. There will be an additional project manager and some ring-fenced information and analytical resources in place by the end of July.
- The central programme team ensures that the programme is managed to budget and to the timescales/milestones agreed.
- The neighbourhood programme is complex with many different strands of work in place happening concurrently. The central programme team maintains an overview of these and provides support both in terms of infrastructure and logistics to enable the delivery of these work streams

Progress across the main programme stages is set out below:

5.4 Phase 1 – Neighbourhood Identity and Primary Care Development

- A configuration of eight neighbourhoods based around co-located GP practices has been agreed

- Primary Care Leads have been appointed for seven of the eight neighbourhoods with expectations that the one remaining vacancy will be filled within the next four – six weeks
    - A Primary Care Development Manager to support the clinical leads and help design/deliver changes within primary care has been appointed by the City and Hackney GP Confederation
    - Initial support model in place for clinical leads with intention to bid for formal development programme to reflect complexities of system leadership to Community Education Provider Network (CEPN)

- Potential neighbourhood test and learn projects being agreed across neighbourhoods
    - See Table 2

- Neighbourhood primary care identity being established to create environment for culture of collaboration across practices
    - Achieved by:
        - Quadrant MDT meetings have been split into neighbourhood grouping for >12 months
        - Primary Care Neighbourhood Training afternoons set up for each neighbourhood in July
        - Local neighbourhood practice meetings/communication

5.5 Phase 2 - Neighbourhood Governance

- Configuration of neighbourhoods agreed and widely communicated
- Primary Care leadership model in place
- Approach to testing new ways of working agreed using quality improvement methodology
- Integrated information profile developed using public health, primary care, social care, mental health and secondary care data for each neighbourhood
- CEPN bids to be submitted to support:
    - Training and skills required for neighbourhood/MDT leadership to support existing primary care leads to develop longer term model of support for other potential MDT leadership roles
    - Development of MDT working/communication in neighbourhoods across a number of settings and levels

5.6 Phase 3 – Discovery Provider and Work Stream Planning and Design

- Additional resources to support planning, design and initial delivery phase identified across all providers
- Providers have identified linked neighbourhoods to work with to look at ways in which working differently within a neighbourhood model might improve the quality of care and outcomes for residents
- Table 1 sets out the potential test and learn pilots and areas of interest across the neighbourhoods and providers
- Formal reports are provided to the Steering Group on a regular basis by provider

- The Provider Design group (a sub group of the Steering Group) will provide a space for the providers to talk through their scoping for future work, project plans, risks/issues and interface with other providers to avoid a silo-ed approach

Phase 4 has not yet commenced.

6. Interface with the System/Other Work Streams

Although the Neighbourhood Development programme reports formally via the Unplanned Care workstream, in order for the vision for neighbourhoods to be realised it needs to effectively support and work across the system.

This has been achieved by working directly with all four integrated commissioning work streams and identifying how the development of a neighbourhood model might support the integrated commissioning workstreams in delivering their work stream priorities. Significant progress has been made in the last two months in scoping the potential shared priority areas across neighbourhoods and the work streams. A suggested model for taking this forward has also been agreed.

Additionally the neighbourhood programme team regularly reports into the respective work stream boards on general progress across the neighbourhood programmes and specific shared priorities.

Table 1 sets out a summary of work to date:

Table 1: Interface between Neighbourhoods and Work Streams

Work Stream	Potential Shared Priorities	Delivery model
Planned Care	- Management of complex/vulnerable patients with multi-specialty team involvement - Outpatient transformation - Housing	Working group to scope and plan how to work together on share priorities
Unplanned Care	- Extended Access Hubs - Urgent Care Model - Discharge - Falls	Via weekly team meeting and clinical leads
Prevention	- Making every contact count (connection/navigation model) - Asset Mapping	Using existing social prescribing community forum Specific task and finish group for asset mapping
Children, Women, Young People and Maternity	- Childhood Mental Health - School Nursing - Interface with adult services - Maternity	Working group to scope and plan how to work together on share priorities

7. Going forward

The next steps for the Neighbourhood programme can be divided into two main areas:

- Delivering 18/19 objectives using agreed funding
- Building on 18/19 into 19/20 (and beyond)

The significant deliverables over the next six months of 2018/2019 are summarised below:

- Creation of recognisable neighbourhood areas with established identities and collaborative primary care underpinned by an integrated neighbourhood dataset
- Test and learn projects delivered across neighbourhoods for provider funded projects with collation of early implications for system wide delivery
- Formal Review of test and learn to assess and develop future service configuration model for 2019/2020
- Development of a Memorandum of Understanding/Governance model for ongoing/sustainable operation of neighbourhoods
- Creation of an agreed outcomes framework for the overarching neighbourhood programme to assess impact and local measurement and outcome models for specific test and learn projects
- Specification and provider identified for evaluation of the neighbourhood development programme
- Identification of priorities to continue neighbourhood development programme into 2019/2020
- Completion of a business case to support Year Two (19/20) of the neighbourhood development programme based on agreed priorities and learning from Year One
- Early work on identifying a longer term 3/5 year work programme for the neighbourhood development programme

8. Recommendations and conclusion

The Transformation Board is asked to note and endorse the contents of this report. It is specifically asked to note:

- The overall programme approach
- The proposed test and learn projects and focus areas for each neighbourhood
- The structure and approach to working across the system specifically via the workstreams
- The deliverables for the remainder of 2018/2019

Supporting papers
Appendix 1

Sign-off:

Workstream SRO _____Tracey Fletcher

London Borough of Hackney _____Anne Canning, Group Director of Children, Adults & Community Health City of London Corporation _____Simon Cribbens, Assistant Director of Commissioning & Partnerships City & Hackney CCG _____ David Maher, Managing Director

Appendix 1

Cross Cutting/System Enabling Work	Neighbourhood	Clinical Lead	Provider Linked Test and Learn (Please note these are detailed by host provider but will have input from all other relevant providers)	Potential Later Focus Area/Areas of Interest	Governance
Development of an integrated dataset for each neighbourhood Collaborative working and neighbourhood identity across primary care Model to manage multi-morbid/complex and vulnerable patients LINKED TO Exploring how the neighbourhood model might support frailty pathways and management Reviewing MDT communication and formal structures and strengthening Risk Stratification/population segmentation model Neighbourhood Governance and working structure Developing and supporting MDT/neighbourhood leadership Interface between existing formal structures e.g. consortia and neighbourhoods	NE1	Dr Tehseen Khan	Voluntary Sector – Community Navigation/Connection Model	Childhood Immunisations Managing boundary patients	Over-arching provider design group reporting into the Steering Group
	NE2	Job Share Dr Denyse Hoseyin Dr Rajiv Goel		Childhood Immunisations	
	NW1	Vacant			
	NW2	Dr Moyra McAllister	Social Care/London Borough of Hackney – looking at how adult social care interfaces with neighbourhoods		
	SE1	Marina Macey			
	SE2	Dr Kathleen Wenadeen	Mental Health		
	SW1	Dr Gopal Mehta	Mental Health Co-production – developing a resident engagement model		
	SW2 and City City	Dr Jenny Darkwah	Community Nursing		
	Other areas being explored without linked neighbourhood pilots or agreed approach currently: - Asset Mapping - Linking school nursing and neighbourhoods - Childhood mental health/prevention - Maternity services - Linked Work Stream Priorities				

Title:	Integrated Commissioning Evaluation – first update paper
Date:	12 July 2018
Lead Officers:	David Maher, City & Hackney CCG Anne Canning, London Borough of Hackney Simon Cribbens, City of London Corporation
Author:	Anna Garner, Head of Performance, City & Hackney CCG
Committee(s):	Evaluation Steering Group Transformation Board, 27 June 2018 Integrated Commissioning Board, 12 July 2018
Public / Non-public	Public

Executive Summary:

This report provides a summary of evaluation activities conducted so far and those in train included in this paper.

Future direction and plans: programme not as advanced as previously thought (unsurprising given the little time the Integrated Commissioning programme has been in place) and findings from the stakeholder interviews suggest that people feel there is a lack of coherence and clarity regarding the rationale, theory of change/logic model for the programme and how the workstreams are enabled to achieve any changes. More support to programme overall and workstreams needed to develop plans.

The next steps for the programme are:

- Development of outcomes framework for programme overall (using existing plans to use Healthwatch 'I' statements to draft outcomes framework via stakeholder workshop, but offering evaluation team's additional expertise and support) – end August
- Following this, development of outcomes frameworks for each workstream, based on the overall programme framework developed above, and support on how to use these outcomes frameworks, action planning with workstreams in order to:
    - Link planned activities to their impact on outcomes in framework
    - Quantify impact and timelines for this
    - Identify gaps and how to fill them
    - Draft theory of change including all of the above: linking activities and outputs of workstreams to impact and improvement in patient outcomes

- Identify economic elements of the above impacts: economic/financial case for workstream

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board noted the progress made and next steps.

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

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

PPI lay member apart of evaluation steering group (along with voluntary sector rep and governance lay member)

Clinical/practitioner input and engagement:

Clinicians part of TB and ICB – initial approval of the evaluation specification and receive regular update reports

Impact on / Overlap with Existing Services:

N/A

Evaluation of Integrated Commissioning System – first update paper

The evaluation is being conducted by partnership of COBIC, Cordis Bright and PPL Consulting. Evaluation started at beginning of February 2018.

Evaluation activities conducted so far

- Completion of 21 interviews with programme stakeholders
- A review of programme and workstream documentation, finance and budget data, and existing performance management data provided by City and Hackney colleagues.
- Five rapid evidence reviews of "what works" in delivering similar integrated commissioning programmes, and what works/good practice in integrated commissioning in the specific areas of each workstream.
- Development of draft value proposition documents for the overall programme and for each of the workstreams, based on the review of programme and workstream documentation and data, including logic model templates.

Evaluation activities in train

- Meeting observations, including attending Transformation Board and Integrated Commissioning Board meetings
- Drafting a baseline evaluation report, presenting findings from the review of programme and workstream documentation and data, analysis of the interviews with programme stakeholders, benchmarking of the programme against good practice as identified by the rapid evidence assessments, and outlining next steps for the development of the programme.

Findings so far

Whilst the evaluation is still in its early stages (and the below does not include findings from the evidence review and the document review), some emerging themes from interviews with programme stakeholders can be highlighted:

- **Governance:** Stakeholders reported concerns that current programme governance structures require reviewing as it is overburdened and inefficient due to a lack of agreement between partners regarding delegated authority and where decisions can be made. It is understood that the programme is in the process of commissioning a governance review with a view to addressing these issues.
- **Workstream and programme structure:** Stakeholders were positive regarding the progress of workstreams to date, with regular workstream meetings reported. However, the structure of workstreams was highlighted by

some as potentially problematic as it does not given enough emphasis to mental health or to specific cohorts of patients and service users:

  - Mental health was reported to feature as a sub-set of other workstreams, and a cross-cutting feature across the programme, however stakeholders reported concerns that in this form, it is not given enough prominence.
  - Stakeholders also reported that there was a lack of clarity regarding how workstreams would work together on services focused on particular groups of patients and service users, such as the frail elderly.

- **Co-design:** This was highlighted as a key strength of the programme to date, with public engagement reported to be strong, particularly from the CCG. However, it was also highlighted that patient and service user input is currently centred on board-level engagement, with suggestions that it would be more beneficial for all to have greater engagement instead in co-design processes. Stakeholders also suggested that there is a challenge with ensuring that input is received from a wide range of individuals, who will be able to represent the range of different views which may be held by local people, and that ongoing work, particularly with partners from Healthwatch Hackney, is hoped to work toward improving this in future.
- **Programme maturity:** From both stakeholder interview and programme documentation, there is evidence that the programme is less developed at this point in time than stakeholders had initially envisaged. Whilst workstreams are meeting and beginning to be involved in decision making processes, it was reported that more work was required to develop specific work plans and performance monitoring systems for both the individual workstreams, and the programme as a whole.

<u>Future direction and plans</u>

- Programme not as advanced as previously thought (unsurprising given the little time the Integrated Commissioning programme has been in place) and findings from the stakeholder interviews suggest that people feel there is a lack of coherence and clarity regarding the rationale, theory of change/logic model for the programme and how the workstreams are enabled to achieve any changes
- The specification had originally set out a ‘formative’ phase for the evaluation (allowing the results of the research/findings to drive the development of the programme) and this needs more focus than originally thought.
- This would include providing more support to the programme as a whole and the workstreams to:
  - Delineate aims alongside how these might be achieved and the impact/timescales for this
  - Ensure workstream plans are in line with the aims of the programme as a whole

- Incorporation of evidence from models elsewhere and the literature, on both process of implementing integrated commissioning (enablers, behaviours, activities etc) and expected impact

Next steps

- Full summary of findings from stakeholder interviews, document review and evidence review, as part of the baseline evaluation report – mid/end July
- Presentation to TB (beginning of August): baseline evaluation report findings, what this might mean for programme overall, gaps/barriers/challenges in our current programme and how we might fill these, enablers/successes of programme and how to use this to improve chances of impact, and use/success of co-production in the programme – this will be process/implementation focussed as outcomes/impact factors will be covered in outcomes framework (more detail below)
- Development of outcomes framework for programme overall (using existing plans to use Healthwatch 'I' statements to draft outcomes framework via stakeholder workshop, but offering evaluation team's additional expertise and support) – end August
- Following this, development of outcomes frameworks for each workstream, based on the overall programme framework developed above, and support on how to use these outcomes frameworks, action planning with workstreams in order to:
  - Link planned activities to their impact on outcomes in framework
  - Quantify impact and timelines for this
  - Identify gaps and how to fill them
  - Draft theory of change including all of the above: linking activities and outputs of workstreams to impact and improvement in patient outcomes
  - Identify economic elements of the above impacts: economic/financial case for workstream

Sign-off:

London Borough of Hackney _____Anne Canning, Group Director of Children, Adults & Community Health City of London Corporation _____Simon Cribbens, Assistant Director of Commissioning & Partnerships City & Hackney CCG _____ David Maher, Managing Director

Title:	IT Enabler programme – IT project leads proposal
Date:	12 July 2018
Lead Officer:	Tracey Fletcher, SRO, IT Enabler Group
Author:	Anita Ghosh
Committee(s):	Transformation Board - 15 May 2018 Integrated Commissioning Board – 12 July 2018
Public / Non-public	Public

Executive Summary:

The care workstream directors have outlined digital solutions to support new models of care. These solutions will collectively help to streamline the patient journey, empower patients, facilitate care closer to the patient's home and better collaboration across health and social care providers

This proposal is for City ICB to **ENDORSE** and Hackney ICB to **RATIFY** the decision of the senior sponsors and Chief Financial Officers to release £280k to fund four IT project managers to meet the immediate ICT detailed planning requirement for each of the four care workstreams as part of the IT Enabler programme. This money will be released from the Section 256 agreement between the CCG and the London Borough of Hackney.

The project managers will be responsible for working up detailed IT specifications and recommendations aligned with new models of care and our emerging integrated care system.

The project managers will work collectively as a team to ensure shared learning and reduce any duplication. This will help ensure all future investment in digital solutions is optimised and systems are cohesive across the sector.

This early investment is deemed essential to guard against the procurement of IT systems that do not offer maximum levels of integration and/or delays in implementation.

Issues from Transformation Board for the Integrated Commissioning Board

The IT enabler proposal for release of the funding was endorsed by the Transformation Board.

Recommendations:

The Hackney Integrated Commissioning Board is asked to

- **RATIFY** the release of £280k to fund four IT project managers to meet the immediate ICT detailed planning requirement for each of the four care workstreams.

The City Integrated Commissioning Board is asked to

- **ENDORSE** the release of £280k to fund four IT project managers to meet the immediate ICT detailed planning requirement for each of the four care workstreams.

Links to Key Priorities:

This proposal will facilitate the delivery of workstream priorities including:

- Integrated Urgent Care service
- Neighbourhood development
- Outpatient transformation
- Making Every Contact Count (MECC)
- Self-management
- Supported employment
- Improving emotional health and wellbeing
- Support for vulnerable groups
- Improving care in maternity and early years

Specific implications for City

The interface for healthcare staff and patients/service users in the City will change when new digital solutions are introduced. Strong change management will be required to ensure these solutions are accepted and adopted in full.

Specific implications for Hackney

The interface for healthcare staff and patients/service users in Hackney will change when new digital solutions are introduced. Strong change management will be required to ensure these solutions are accepted and adopted in full.

Patient and Public Involvement and Impact:

The IT Enabler programme board includes patient and public representation who fully support this proposal.

Clinical/practitioner input and engagement:

The IT Enabler programme board includes clinical and practitioner representation who fully support this proposal. Each care workstream director has also engaged with clinicians and practitioners in forming their outline proposals.

Impact on / Overlap with Existing Services:

Digital solutions will introduce new ways of working and delivering services.

Supporting Papers and Evidence:

Attached: IT Enabler programme – IT Project Leads proposal

Sign-off:

Workstream SRO _____Tracey Fletcher London Borough of Hackney _____Anne Canning, Group Director of Children, Adults & Community Health City of London Corporation _____Simon Cribbens, Assistant Director of Commissioning & Partnerships City & Hackney CCG _____ David Maher, Managing Director

Main Report

1. Proposal:

The care workstream directors have started to formulate digital requirements to support their respective workstreams to deliver the Hackney and City Transformation programme.

Digital solutions identified to date include:

Virtual consultations, shared care records, integrated care record system to support neighbourhoods, electronic referrals and bookings, electronic ordering and prescribing, mobile apps, “signposting” applications, interoperability across provider systems including social prescribing to the voluntary sector, citizen held records and audit tools to measure and manage outcomes.

These solutions support key initiatives around integrated urgent care, neighbourhoods, outpatient transformation, continuing healthcare (CHC), making every contact count (MECC), supporting vulnerable groups and improving care in maternity and early years.

Collectively the proposed digital solutions will help streamline the patient journey, empower patients, facilitate care closer to the patient’s home and better collaboration across health and social care providers.

This proposal, previously agreed by the Transformation Board, is to invest £280,000 for the recruitment of IT project managers.

Securing these resources will also provide assurance to the east London heath and care partnership (ELHCP, north east London STP) that the City and Hackney digital programme is resourced and underway.

The project managers will be responsible for working up detailed IT specifications and recommendations aligned with new models of care and our emerging integrated care system.

The project managers will work collectively as a team to ensure shared learning and reduce any duplication. This will help ensure all future investment in digital solutions is optimised and systems are cohesive across the sector.

This early investment is deemed essential to guard against the procurement of IT systems that do not offer maximum levels of integration and/or delays in implementation.

2. Brief Options appraisal

The workstream directors have presented initial outline proposals for IT systems at the March and May 2018 IT Enabler programme board meetings, and highlighted the need for project managers to take the work forward.

IT project managers recruited to support the IT enabler programme will have specific workstream projects to deliver against over the forthcoming months. However they will all have common deliverables in the form of requirements specifications and options appraisals of IT systems from a range of possible suppliers, including systems that need to be delivered across workstreams.

The model will adopt a team approach that will provide the transformation programme with a rich source of subject matter expertise and a team that can expertly analyse workflow and identify opportunities where IT can support new models of care for both care professionals and patients/service users alike.

The appointment of dedicated resources will expedite overall delivery of IT systems in line with implementation of new models of care rather than afterwards.

3. Evidence base

The City and Hackney IT Enabler programme to date has a proven track record of delivering digital solutions that have transformed the way care professionals work across organisational boundaries. Some of these solutions are now being recognised London-wide.

The solutions have been delivered with the support of dedicated project managers who first and foremost understood the needs of the care model and worked closely with IT system suppliers to ensure the IT solutions satisfy the need.

Success achieved to date would not have been achieved without dedicated “people” resources.

4. Anticipated benefits

The benefit of an IT Enabler team approach and appointment of dedicated resources are set out in the sections above.

Dedicated resources will secure delivery of IT to support new models of care without delay while providing a strong pool of subject matter expertise.

It is essential that the IT project managers work as a unit to ensure the most appropriate IT systems are procured and support the care workstreams in a way that is both joined up and economical.

It can also be noted that digital solutions identified to date will strengthen levels of integration across health and social care and will also support patients and service users in better access to health and care services including the provision of care closer to their homes.

Ultimately, it is the patient who will benefit the most from the deployment of IT systems at the earliest opportunity to support new models of care.

Without dedicated IT project management resources to take these solutions forward, the transformation programme will inevitably suffer a delay in identifying and subsequently adopting IT to support new ways of working.

5. Project risks

Delays in recruitment: the process to recruit can be lengthy. Flexibility will be applied to ensure resources are secured as quickly as possible.

6. Project timeline

- Appointment of project leads – Q2 2018/19
- Project leads deliver initial proposals for IT Enabler Phase 3 (Hackney and City Transformation): Q3 2018/19

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

The City Integrated Commissioning Board is asked to endorse and the Hackney Integrated Commissioning Board is asked to approve funding of £280,000 to be allocated as follows:

			2018/19	2019/20	
Workstream	**Project**	**Resource**	**Total**	**Balance**	**Grand Total**
Unplanned	Integrated Urgent Care	(Snr) IT Project Manager	£21,750	£7,250	**£29,000**
Unplanned	Neighbourhoods	(Snr) IT Project Manager	£54,375	£15,125	**£69,500**
Unplanned	Dementia	Carer support tool - PM	£31,159	£0	**£31,159**
Prevention	Making Every Contact Count	MECC IT PM	£25,000	£25,000	**£50,000**
Planned	CHC/Old People's Transition	IT Project Manager	£50,000	£0	**£50,000**
CYP		IT Project Manager	£50,000	£0	**£50,000**
			£232,284		**£279,659**

The variation in allocation across the workstreams is due to the varying levels of maturity; also, the planned workstream for example has already secured some transformation resource.

The team will be managed by the senior IT project manager to ensure all members deliver against common objectives with an IT focus. It is expected that project managers will support one another during the course of working.

Regular progress reports will be made available to the IT Enabler programme board.

Title:	City and Hackney System - Assessment of ICS Readiness
Date:	12 July 2018
Lead Officers:	David Maher, Managing Director, City & Hackney CCG Anne Canning, Group Director, Children, Adults and Community Health, London Borough of Hackney Simon Cribbens, Assistant Director, Commissioning & Partnerships, Community and Children's Services
Author:	Devora Wolfson, Integrated Commissioning Programme Director/Jonathan McShane, ICS (Integrated Care System) Covenor
Committee(s):	Transformation Board, 15 May 2018 Integrated Commissioning Boards, 12 July 2018
Public / Non-public	Public

Executive Summary:

In order to check our progress towards becoming a mature Integrated Care System, an assessment was made based on a combination of the criteria set out in the national NHS ICS development programme and the criteria proposed by North East London STP for their system.

This report provides a desktop assessment of our position and what we may need to do next to develop into a more mature ICS.

The assessment identifies that we need to establish a short-term independent leadership role to progress the ICS and this was endorsed by the Transformation Board. The CCG has approved funding for a short term ICS convenor role to facilitate this work. The focus of this role is to:

- Support our work with local clinical leaders to implement service improvements that require a system-wide effort; for example, implementing new primary care networks or increasing system-wide resilience ahead of next winter;
- Facilitate the identification of system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions;
- Support the ongoing strategic review of our estates, developing a plan that supports investment in integrated care models in City and Hackney and

across NEL maximises the sharing of assets, and the disposal of unused or underutilised estate;
- Help all partners to take further steps to enhance the capability of the system including stronger governance and collective decision-making
- Convene an Executive Forum of provider chairs, non-executive directors and elected members, to help drive integration across partners and finalise our efforts to set a local 'system control total' from within which our workstreams will manage demand and mitigate growth.
- Represent the City and Hackney system at a regional and national level to ensure our unique design and delivery model is recognised and that we continue the momentum we have gained in integrating our services.

It was agreed at the Transformation Board on 15 May 2018, that this methodology was a useful approach to assessing our readiness to become an ICS. The Board also agreed that further actions required in order to become a mature ICS should be set out in a workplan with timescales and performance metrics for approval by the ICB. We will also consider the best way to develop a gateway/assurance process to formally assess our progress as a system and how this dovetails with the workstream assurance. Progress with the plan will be overseen by the Transformation Board and reported to the ICB.

This more detailed plan will brought to a future Integrated Commissioning Board meeting.

Issues from Transformation Board for the Integrated Commissioning Board

The overall approach was endorsed by the Transformation Board.

Recommendations:

The Hackney ICB is asked:

- **NOTE** the report and **COMMENT** on the initial assessment of our position (Appendix 1)
- **AGREE** that a further more detailed report will be brought to a future meeting.

The City ICB is asked:

- **NOTE** the report and **COMMENT** on the initial assessment of our position (Appendix 1)
- **AGREE** that a further more detailed report will be brought to a future meeting.

Links to Key Priorities:

N/A

Specific implications for City

The assessment will consider whether the needs of City residents and workers are being addressed through our process.

Specific implications for Hackney

The assessment will consider whether the needs of Hackney residents are being addressed through our process.

Patient and Public Involvement and Impact:

The involvement of patients, residents and service users is being assessed through the criteria.

Clinical/practitioner input and engagement:

Clinical and practitioner involvement is being assessed through the criteria.

Impact on / Overlap with Existing Services:

N/A

Supporting Papers and Evidence:

Attached report

Sign-off:

London Borough of Hackney _____Anne Canning, Group Director, Children, Adults and Community Health City of London Corporation _____Simon Cribbens, Assistant Director of Commissioning and Partnerships City & Hackney CCG_____ David Maher, Managing Director

Assessment of Position against ICS Criteria

Area	Current Position in City and Hackney	What we need to do
A clear proposal of what we are trying to achieve	• Strategic document in place for integrated commissioning • Vision currently being developed	Need to finalise our vision/proposal and ensure its sets out what and how things will change Develop our IC clinical strategy and commissioning strategy.
Coherent and defined population that reflects patient flows and broadly co-terminus /Scope. Good understanding of the needs of the population	• Population coverage (all residents in City and Hackney) • All services in scope • Working on patient flows outside the system • Some data available. More detailed local data will become available through neighbourhood work	Produce a narrative that sets this out Further mapping of patient/service user flows outside and back into the system and quality assuring the effectiveness of these flows More detailed local data will become available through neighbourhood development work. We need to access other sources of analytics and pull together.
Partnership Form	We have had a number of workshops about this including facilitated workshops by Kings Fund and Beachcroft. Some agreement that we would use alliance contracts at least in the medium-term. Agreement that our work should not be held up whilst we agree the partnership model.	We need further discussions about this at different levels, Board/Councillor/level, ICB and TB etc. The ICS convenor role will facilitate this. Further discussions about this at TB and ICB in June/July

Strong leadership with mature relationships involving wider stakeholders and patients. Strong Governance	• Wide range **of** health and care partners including voluntary sector, parts of education and pharmacy already involved in the proposal – *set out in devolution business case and strategic framework* • Strong patient and user engagement through our planning and governance • Our neighbourhood model will lead to more engagement of smaller, local providers and community groups and the development of local partnerships and bring further opportunities to pull in wider determinants of health – e.g. housing and schools – *already considered in the workstreams* • Housing becoming involved through planned care • Developing strong leadership teams at different levels, e.g. non exec, Members etc. • Clinical leads on all the workstreams (both health and social care) and establishment of wider Systems clinicians and practitioner forum • Role descriptions developed for some leadership roles, e.g. clinical leads and ICB members • Established governance structure and framework - *this will be refined through the governance review* • MOUs being developed between workstreams and for workstreams etc. – *although not legally binding* • Need to streamline our reporting and governance process to reduce duplication and reporting in different places – *Governance review specification is being finalised*	Set out our current and future partnership plans in a single document We have agreed that we need to commission independent leadership to progress the ICS: – The CCG is hosting a short term ICS convenor role to facilitate the discussions on behalf of the system Our partnership and leadership arrangements are well established but the accountability between the different levels of governance need further development and strengthening Implement recommendations from the governance review
Track record of delivery with evidence of progress towards Five year Forward View (5YFV)	• We are delivering on many of the 5YFV although not others, for example, cancer measures, childhood obesity, use of e-referrals, some CHC targets, childhood immunisations • The CCG and partners are assuring itself of workstream plans to achieve all requirements not being met	Further development, review and evaluation detailed improvement plans

priorities and NHS constitution standards.	currently and are working across system to improve outcomes where performing poorly	
Compelling plans /Outcomes and Objectives	• Workstream plans for 18-19 onwards and in the longer-term • IC Programme Plan in place • Our neighbourhood model will integrate primary care, social care, mental health and hospital services based on populations. • Prevention and self-care are well embedded; we have a specific prevention workstream and prevention is embedded in the other three workstreams too • Seven-day working in place	Pull together outcomes document once this work is complete Produce a single document covering all workstream plans for 18/19 onwards including outline plans to achieve our vision including neighbourhood plans Implementation of plans to deliver our current 'Big Ticket' items and other priorities
Workforce	• Pieces of work being carried out around workforce shortages locally especially primary care and community nurses • Have looked at models such as Buurtszorg and combining practice and community nurse roles but waiting in development of neighbourhood model to consider workforce models locally • Our CEPN (Community Education Provider Network) Enabler Group provides leadership on this. They have appointed an inter professional educator (currently for 1 year) to develop training for the multi-disciplinary workforce	Overall workforce approach needs further development and may need additional resourcing.
Culture of quality improvement	• We have appointed a team of evaluators to work with us over the coming three years to test our approach and the impact of the change working closely with patients and users and staff. • We are looking at developing a common QI approach for system) including reporting of progress and recording of learning	Developing our systems QI approach

IT systems / connected data	• IT Enabler Group well established with resources to support transformation • HIE in place for limited data sharing • LDR work around East London Health and care Plan	Further implementation of digital solutions and shared platforms
Engagement and communications	• Co-production is key underlying principle in local system work • Health and social care co-production charter • Patient and service user reps on each workstream • Involvement alliance being developed • Two enabler groups – one for communications and one for engagement • Dedicated integration communication resource (ET) • Communications and Engagement plans in place	Further embedding of co-production in all our work Clear and regular information to residents about how services are changing through IC Implementing the neighbourhood model in way that increases local resident participation and engagement
Strong financial management Payment models, risk sharing and resources	• The CCG and the local authorities are delivering their operation plans within budget • Working in a challenging financial climate • Working towards develop a systems financial control total • Assurance processes in place that new model operates within financial budget • PIC model for transformation investment / disinvestment decisions • How budgets are aligned / pooled in relation to workstreams • Responsibilities of workstreams to stay in financial balance and to achieve QIPP and local authority savings • Estates strategy agreed and being refreshed by Autumn 2018 • Working together / the 'rules' of the proposal would be set out in MOUs. S75 for any pooled budget is stronger in terms of conflicts of interests etc but covers less about how we work together	Comprehensive mapping of all contracts across workstreams – in place for some workstreams Further work towards systems financial control total planned for 2018-2019. This is a significant piece of work and will affect all levels of governance. Move to further pooling of budgets Review current financial risk share arrangement in relation to Section 75 agreements

	• OD work important in terms of how we shape working together • Risk share process in place for Section 75 agreements	

Title:	Consolidated Finance (income & expenditure) report as at May 2018 - Month 02
Date:	12 July 2018
Lead Officers:	Anne Canning, London Borough of Hackney (LBH) Jane Milligan, City & Hackney Clinical Commissioning Group (CCG) Neal Hounsell, City of London Corporation (CoLC)
Authors:	Integrated Finance Task & Finish Group CCG: Sunil Thakker, 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 City Integrated Commissioning Board, 12 July 2018 Hackney Integrated Commissioning Board, 12 July 2018
Public / Non-public	Public

Executive Summary:

This reports on finance (income & expenditure) performance for the period from April 2018 to May 2018 across the CoLC, LBH and CCG Integrated Commissioning Funds.

The Month 2 forecast position for the Integrated Commissioning Fund as at Month 02 is £4.4m adverse. The adverse position is driven by Learning Disabilities commissioned care packages within the London Borough of Hackney.

Issues from Transformation Board for the Integrated Commissioning Boards

The report has not yet been presented to TB.

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

Main Report

Background and Current Position
N/A

Options
N/A

Equalities and other Implications:
N/A

Proposals
N/A

Conclusion
N/A

Supporting Papers and Evidence:
Report attached

Sign-off:

London Borough of Hackney _____Ian Williams
City of London Corporation _____Mark Jarvis
City & Hackney CCG ____Sunil Thakker

NHS
City and Hackney
Clinical Commissioning Group

Hackney

CITY OF LONDON

City of London Corporation
London Borough of Hackney
City and Hackney CCG

Integrated Commissioning Fund
Financial Performance Report

Month 02 (May) 2018 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 Outturn	Forecast Variance £000's	Prior Mth Variance £000's
Pooled Budgets	City and Hackney CCG	25,621	4,270	4,270	-	25,621	-	-
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	210	-	7	(7)	210	-	-
Total		25,831	4,270	4,277	(7)	25,831	-	-
Aligned	City and Hackney CCG	377,954	60,350	60,350	-	377,954	-	-
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	7,436	980	933	47	7,437	(1)	-
Total		385,390	61,330	61,283	47	385,391	(1)	-
ICF	City and Hackney CCG	403,575	64,620	64,620	-	403,575	-	-
	London Borough of Hackney Council	102,502	17,084	8,673	8,411	106,865	(4,364)	-
	City of London Corporation	7,646	980	940	39	7,647	(1)	-
Total ICF Budgets		**513,723**	**82,684**	**74,233**	**8,451**	**518,087**	**(4,364)**	**-**
CCG Primary Care co-commissioning		45,898	7,156	7,156	-	45,898	-	-
Total		**45,898**	**7,156**	**7,156**	**-**	**45,898**	**-**	**-**

Notes:

- Unfavourable variances are shown as negative. They are denoted in brackets & red font
- ICF = Integrated Commissioning Fund – comprises of Pooled and Aligned budgets

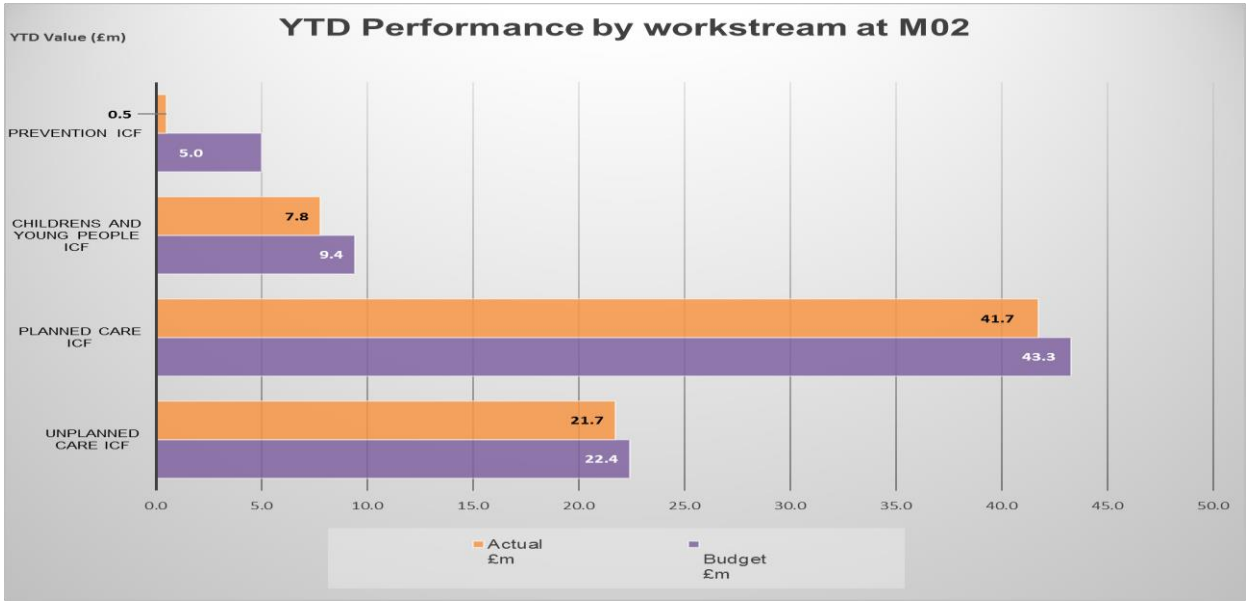
Summary Position at Month 02

- At Month 02 (May) the Integrated Commissioning Fund forecasts on overall adverse position of £4.4m
- The London Borough of Hackney reports a forecast position of £4.4m adverse for the year against its annual budget. The adverse position is driven by Learning Disabilities commissioned care packages.
- The City of London forecasts a small year end adverse position of £0.01m, driven by the Prevention workstream.
- At month 02 City & Hackney CCG reports a year end break even position .
- **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (BCF) including the Integrated Independence Team (IIT) and Learning Disabilities.
- The CCG took on Primary Care Co- commissioning on 1 April 2017. At M02 these budgets are forecast to break even.

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 £000's Forecast Outturn £000's	Forecast £000's Forecast Variance £000's	Forecast £000's Prior Mth Variance £000's
Unplanned Care ICF	134.9	22.4	21.7	0.7	134.1	0.8	0.0
Planned Care ICF	265.2	43.3	41.7	1.5	270.4	(5.2)	0.0
Childrens and Young People ICF	56.6	9.4	7.8	1.6	56.6	0.0	0.0
Prevention ICF	30.7	5.0	0.5	4.5	30.7	0.0	0.0
All workstreams	**487.3**	**80.1**	**71.8**	**8.3**	**491.6**	**(4.4)**	**0.0**
Corporate services	25.2	2.4	2.4	0.0	25.2	0.0	0.0
L ocal Authorities (DFG Capital and CoL income)	1.2	0.2	0.1	0.1	1.2	0.0	0.0
Not attributed to Workstreams	**26.4**	**2.6**	**2.5**	**0.1**	**26.4**	**0.0**	**0.0**
Grand Total	**513.7**	**82.7**	**74.2**	**8.5**	**518.1**	**(4.4)**	**0.0**



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, corporate running costs and non recurrent funding to offset over spends.
- The forecast combined workstream position is an adverse position of £4.4m by the year end. This is being driven by Planned and Unplanned Care:
- Position Summary:
  - The Planned Care workstream is reporting a forecast overspend of £5.2m driven by London Borough of Hackney Learning disabilities (£3.2m) due to increase in demand (in terms of numbers and complexity of care for clients) resulting in higher costs packages.
  - Staffing pressures of £1.3m across the service to manage demands within the service and improve annual review performance.
  - £0.9m due to delays in delivering Housing Related Support (HRS) savings.
  - The Unplanned Care workstream is forecasting an year end under spend of £0.8m. The majority of the forecast under spend relates to Interim Care £0.64m within LBH and is offset by overspends on care packages expenditure which sit in the Planned Care workstream (as above).

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 02, 2018

				YTD Performance			Forecast		
	ORG	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Commissioned	Unplanned Care	19,094	3,182	3,182	0	19,094	0	0
		Planned Care	6,476	1,079	1,079	0	6,476	0	0
		Prevention	50	8	8	0	50	0	0
		Childrens and Young People	0	0	0	0	0	0	0
	Pooled Budgets Grand total		25,621	4,270	4,270	0	25,621	0	0

	ORG	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Variance £000's	Prior Mth Variance £000's
Aligned	Commissioned	Unplanned Care	109,820	18,303	18,303	0	109,820	0	0
		Planned Care	192,619	31,275	31,275	0	192,619	0	0
		Prevention	3,790	632	632	0	3,790	0	0
		Childrens and Young People	46,522	7,754	7,754	0	46,522	0	0
		Corporate and Reserves	25,202	2,386	2,386	0	25,202	0	0
	Aligned Budgets Grand total		377,954	60,350	60,350	0	377,954	0	0
Subtotal of Pooled and Aligned			**403,575**	**64,620**	**64,620**	**0**	**403,575**	**0**	**0**

In Collab	Primary Care Co-commissioning		45,898	7,156	7,156	0	45,898	0	0
Grand Total			**449,473**	**71,776**	**71,776**	**0**	**449,473**	**0**	**0**
CCG Total Resource Limit			**479,888**						
SURPLUS			**30,415**						

- *Continuing Health Care , FNC = Funded Nursing Care
- London Ambulance Service (LAS)

- At Month 02 the CCG reports a break even position. Whilst it is still early stages to map out trends in finance and activity, the acute portfolio was reviewed and risk assessed using month 1 flex data to declare a breakeven position
- A large number of prior year disputes were resolved in 2017/18 and the residual disputes are expected to be concluded in 2018/19. These were known risks identified with adequate provision made ensuring compliance with the year-end audit.
- **Pooled budgets** The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF) ,Integrated Independence Team (IIT) and Learning Disabilities. These budgets are forecast to break even at year end.
- **Aligned budgets**: At month 2 these budgets are forecast to break even.
- Primary Care Co- commissioning services passed on to the CCG on 1 April 2017 with a budget of £43.9m. There has been a 4% increase on these budgets for 2018/19. At Month 02 of this financial year, the YTD position including all GP Medical Service budgets have been reported as break even
- The £30.4m surplus forecast outturn has been risk assessed and delivery expected to be on target. The surplus represents the cumulative brought forward surplus of £32.4m less £1.9m drawdown which has been approved by NHSE. This non recurrent drawdown was badged to support London Borough of Hackney Learning Disabilities packages (subject to review) by the Governing Body in April 2018.

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 02, 2018 - City and Hackney CCG

Summary and Progress Report on Financial Risks and Opportunities to Month 2 - 31 May 2018

Ref:		Description	Risks/ (Opps) £'000	Prob. %	Adj. Recurrent £'000	Adj. Non Recurrent £'000	Narrative
1	Risk	Homerton Acute performance	1,270	47%	600	0	Risk based on over-performance and claims.
2		Bart's Acute performance	1,430	28%	400	0	Risk for QIPP non delivery, over-performance and claims.
3		Outer sector - Acute performance	1,000	0%	0	0	Risk for out of area over-performance.
4		NCA performance	500	0%	0	0	Risk based on uncertainty of costs.
5		Continuing Healthcare, LD & EOL	650	0%	0	0	Risk relating to activity increase above plan, high cost patients packages and service provision.
6		Non Acute performance	450	0%	0	0	Risk of over-performance across the portfolio.
7		Programme Costs	650	0%	0	0	Risk represents in-year non-recurrent costs in support of the integrated commissioning programme.
8		Property Costs	500	0%	0	0	Risk related to the Homerton CHS estates rebasing.
9		Non Recurrent Investment Cost Pressure	2,000	0%	0	0	NR investment programme.
10		Primary Care - Rent Revaluation	500	0%	0	0	Retrospective rent increases.
11		Primary Care - Rates	250	0%	0	0	Increased rateable value on estate.
12		QIPP Under Delivery	750	0%	0	0	Under-delivery for schemes within the Operating Plan.
Total Risks			**9,950**	**10%**	**1,000**	**0**	
1	Opps	Acute Claims and Challenges	(1,500)	67%	(1,000)	0	Based on historic trend, revised to reflect current probability.
2		Acute Reserves	(1,076)	0%	0	0	Release of reserve to contain acute cost pressures.
3		Contingency	(2,995)	0%	0	0	Contingency release subject to risk review and assessment.
4		Prescribing	(700)	0%	0	0	Possible underspend across the portfolio.
5		Running Costs	(850)	0%	0	0	Headroom to support and contain acute/non acute pressures.
6		Prior year Items	(2,500)	0%	0	0	Opportunities arising from settlement of disputed items, accruals etc. invoices provided for in prior year resulting in an in-year benefit.
7		Non Recurrent Investment slippage	(1,000)	0%	0	0	Reviewed and risk assessed each month and managed accordingly.
8		QIPP Over Delivery	(500)	0%	0	0	Possible pipeline opportunities.
Total Opportunities			**(11,121)**	**9%**	**(1,000)**	**0**	
					0	**0**	
				Headline brought forward surplus		**(30,415)**	
				Drawdown for LD business case		**1,965**	
				Underlying brought forward surplus		**(32,380)**	

Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

City of London Corporation – Position Summary at Month 02, 2018

	ORG Split	WORKSTREAM	Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Outturn £000's	Forecast Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Comm'ned & *DD	Unplanned Care	65	-	7	(7)	65	-	-
		Planned Care	145	-	-	-	145	-	-
		Prevention	-	-	-	-	-	-	-
Pooled Budgets Grand total			210	-	7	(7)	210	-	-

	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Variance £000's	Prior Mth Variance £000's
Aligned Budgets	Comm'ned & *DD	Unplanned Care	346	-	-	-	346	-	-
		Planned Care	3,864	571	554	17	3,864	-	-
		Prevention	2,327	276	249	27	2,328	(1)	-
		Childrens and Young People	1,076	147	164	(17)	1,076	-	-
		Non - exercisable social care services (income)	(177)	(15)	(34)	20	(177)	-	-
Aligned Budgets Grand total			7,436	980	933	47	7,437	(1)	-
Grand total			**7,646**	**980**	**940**	**39**	**7,647**	**(1)**	**-**

* DD denotes services which are Directly delivered .

* Aligned Unplanned Care budgets include iBCF funding - £317k

* Comm'ned = Commissioned

- At Month 02 the City of London forecasts a small year end adverse position of £0.01m against its full year plan.
- **Pooled budgets** The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF) ,Integrated Independence Team (IIT) and Learning Disabilities. These budgets are forecast to break even at year end.
- **Aligned budgets** are forecast to be over spent by £0.01m at year end in the Prevention workstream
- No additional savings targets were set against City budgets for 2018/19.

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 2

						YTD Performance			Forecast		
	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
Pooled and Aligned Budgets	Commissioned & Directly Delivered	LBH Capital BCF (Disabled Facilities Grant)	1,414	1,414	-	236	113	122	1,414	-	-
		LBH Capital subtotal	1,414	1,414	-	236	113	122	1,414	-	-
		Unplanned Care (including income)	5,529	1,139	4,390	922	236	685	4,731	798	-
		Planned Care (including income)	62,082	26,002	36,080	10,347	8,833	1,514	67,246	(5,164)	-
		CYPM	8,986	-	8,986	1,498	(131)	1,629	8,986	-	-
		Prevention	24,491	-	24,491	4,082	(378)	4,460	24,489	2	-
		LBH Revenue subtotal	101,088	27,140	73,948	16,848	8,560	8,288	105,452	(4,364)	-
Grand total			**102,502**	**28,554**	**73,948**	**17,084**	**8,673**	**8,411**	106,865	(4,364)	-

102,502

- There is a delay in achieving Housing Related Support (HRS) savings that is resulting in a £891k overspend. The service is working in collaboration with existing providers to develop a sustainable service model pending wider re-commissioning exercise in 2019/20. The target for 2018/19 is £2.505m and this has been revised to incorporate the undelivered savings from the implementation of telecare charging. Progress remains ongoing in HRS to meet the overall savings targets over the three year period, and ongoing scrutiny is taking place via the monthly CACH Budget Board.
- **Unplanned Care:**
- The majority of the Unplanned care forecast under spend relates to Interim Care £0.635m and is offset by overspends on care packages expenditure which sit in the Planned Care workstream.
- There is a favourable forecast underspend in Substance Misuse £67k due to declining activity levels.
- There is a favourable staffing forecast of £94k due to a combination of vacant posts, pension opt out and staff not at the top of their grades.
- The Planned Care overspend is partially offset by forecast underspends in Unplanned Care reducing the overall revenue overspend to £4.4m
- **CYPM & Prevention Budgets:** Public Health constitutes vast majority of LBH CYPM & Prevention budgets which is forecasting a very small underspend.

- At Month 2 LBH reports a forecast over spend of £4.4m
- **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 £3.2m pressure after contribution of £1.9m from the CCG for joint funded LD packages and one off ASC grant of £878k. Ongoing discussions are occurring with the CCG and this could increase or decrease the contribution for the current financial year.
- The overall budget pressure within LD represents increase in demand in terms of numbers and complexity.
- The Care Management & Adults Divisional Support is forecasting a £948k overspend. The overall budget pressure breakdown is made up of staffing pressures of £727k 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 £221k within the Adult Social Care Management Team which is due to the high premium for consultancy/locum staff and this includes £159k regrading of ASC Social Workers.
- Provided Services position is a £399k overspend. This is attributed to:
  - Housing with Care staffing pressure of £367k. The service is currently under strategic review to seek efficiencies and reduce costs without impacting negatively on service provision.
  - Day Services and transport is overspend by £61k, which reflects delays with Oswald Street day centre delay in opening to September 2018.
  - Meals on Wheels is underspending by £29k 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.

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 02, 2018- 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).	4,364	100%	4,364	100%
LD joint Funding	1,900		1,900	
TOTAL RISKS	**6,264**	**100%**	**6,264**	**100%**

Mitigations	Full Mitigation Value £'000	Probability of success of mitigating action %	Expected Mitigation Value £'000	Proportion of Total %
Work with CCG to determine ongoing contributions for LD joint packages	TBC	TBC	TBC	TBC
Review one off funding	4,364	100%	4,364	100%
Uncommitted Funds Sub-Total	**4,364**	**100%**	**4,364**	**100%**
Actions to Implement				
Actions to Implement Sub-Total	**0**	**0**	**0**	**0**
TOTAL MITIGATION	**0**	**0**	**0**	**0**

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 02, 2018

City and Hackney CCG

The recurrent QIPP target for the year as per the Operating Plan is £5.1m. At month 2, the delivery of this target is on plan

London Borough of Hackney

LBH has agreed savings of £2.7m for 2018/19 (this includes delayed telecare charging implementation of £0.36m), of this we are on course to deliver £1.8m (£300k one off income) for 2018/19. The shortfall in savings relates to delays in achieving Housing Related Support (HRS) savings that is resulting in a £891k overspend. The service is working in collaboration with existing providers to develop a sustainable service model pending wider re-commissioning exercise in 2019/20.

City of London Corporation

The CoLC have not identified a saving target to date for the 2018/19 financial year

Title:	Integrated Commissioning Register of Escalated Risks
Date:	12 July 2018
Lead Officer:	Devora Wolfson, Integrated Commissioning Programme Director
Author:	Devora Wolfson, Integrated Commissioning Governance Director
Committee(s):	Transformation Board, 27 June 2018 Integrated Commissioning Boards, 12 July 2018
Public / Non-public	Public

Executive Summary:

This report presents a summary of risks escalated from the four care workstreams and from the Integrated Commissioning programme as a whole.

The Children, Young People and Maternity Service Care Workstream (CYPM) has now reviewed its Risk Register and escalated a risk to the IC risk register relating to childhood immunisations.

The threshold for escalation of risks is for the inherent risk score (before mitigating action) to be 15 or higher (and therefore RAG-rated as red). Whilst in a number of cases, mitigating action has reduced the score by a significant margin, escalated risks will continue to be reported to the TB and ICB regardless of the residual risk score, until the ICB is satisfied that further reporting is not necessary.

Each of the four Care Workstreams has responsibility for the identification and management of risks within its remit.

All risks identified are associated with a particular area of work, be it a care workstream, a cross-cutting area such as mental health, or the overall Integrated Commissioning Programme.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board noted the report.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the Integrated Commissioning Escalated Risk Register.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the Integrated Commissioning Escalated Risk Register.

Links to Key Priorities:

The risk register is a mechanism for ensuring the continued delivery of priorities in the City Joint Health & Wellbeing Strategy including:

- Good mental health for all
- Effective health and social care integration
- All children have the best start in life
- Promoting healthy behaviours

and the continued delivery of the priorities in the Hackney Joint Health & Wellbeing Strategy including::

- Improving the health of children and young people
- Controlling the use of tobacco
- Promoting mental health
- Caring for people with dementia

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Impact on / Overlap with Existing Services:

As part of the transfer of responsibilities from the CCG Programme Boards to the Integrated Commissioning Care Workstreams, certain risks have been transferred, or are in the process of being transferred. The 'safe' transfer of risk from programme board to workstream will be managed by the CCG Programme Director and the workstream director.

Supporting Papers and Evidence:

Appendix 1 - Integrated Commissioning Escalated Risk Register

Sign-off:

London Borough of Hackney _____Anne Canning, Group Director, Children, Adults and Community Health City of London Corporation _____Simon Cribbens, Assistant Director of Commissioning and Partnerships City & Hackney CCG_____David Maher, Managing Director

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. ICS Convenor appointed who will support the SROs.	3	4	**12**	⟷	2	4	**8**
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. ICS Convenor appointed to support building relationships between partners in health and social care organisations and their commitment to collaboration and integrated service delivery.	3	4	**12**	⟷	2	4	**8**
UC1	Unplanned Care	Tracey Fletcher/ Dylan Jones	Risk that Homerton A&E will not maintain delivery against four hour standard for 18/19.	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 the Case Notes Review action plan.	3	4	**12**	↓	2	4	**8**

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	4	**16**	Ongoing work to develop a new model which better utilises and integrates all Primary Care services – expectation that this will protect GP resource GP OOH contract budget has been modelled to accommodate increased hourly rates required for interim, face to face, OoHs GPs Consider how partners can work together to make an attractive offer to GPs Explore ways to address challenges recruiting GPs through CPEN	The providers have met together a number of times through the integrated urgnet care referene group and are considering options for how to work together to bettter attract GPs into the range olf services. We have benchmarked with neighbouring boroughs to borrow ideas	4	4	**16**	⟷	3	4	**12**
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	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 March 2019. CHUHSE are supporting the workstream to find a sustainable solution. Urgent care reference group established to agree the sustainable solution. The 111 contract includes a range of reporting requirements and KPIs that will allow us to monitor the impact of the service and manage 111 closely against their outcomes.	3	4	**12**	↓	2	4	**8**
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 Implement actions from Multi Disciplinary Case Notes Review relating to DToCs 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. 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 Capacity to deliver plans and culture shift required [re High Impact Change Model]	4	2	**8**	⟷	4	2	**8**
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**	↓	2	3	**6**

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**	↓	2	4	**8**
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. Went through assurance gateway 3 successfully.	3	4	**12**	↓	2	4	**8**
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 approved at UPCPB in February	4	3	**12**	↔	2	4	**8**
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. A quarterly report showing the totality of all involvement activities is taken to the UPCPB to give assurance that we are involving users.	3	4	**12**	↓	1	4	**4**

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 Unplaned Care Acute 'Menu of Opportunities' Longer term, larger, system transformations will be required to deliver savings	Savings have been identified for 2018/19 up to the 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. Working with CCG QUIPP team to develop effective monitoring reports to track progress and quickly identify slippage	4	4	16	⟷	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)	Scheduled for discussion at Transformation Board on 27 June 2018 when a comprehensive update on the shared transformation and recovery plan will be provided.	5	4	20	⟷	3	3	9
PC2	Planned Care	Simon Galczynski / Siobhan Harper	IAF Targets: Cancer 62 day targets at the Homerton have been missed for a number of months. 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)	WD has escalated performance to the CCG FPC and has written formally to the provider. The 62 day cancer target continues not to be met and thus the score remains 16.	4	4	16	⟷	3	3	9
Pv4	Prevention	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	Funding for the proposed programme of work has largely been secured. A business case is currently being prepared for CEPN transformation funding to support the training activity element of the service. A report on MECC will be considered by TB in June 2018.	5	2	10	↓	5	1	5
CY8	CYPM	Pauline Frost	Risk that low levels of childhood immunisations in the brought may lead to outbreaks of preventable disease that can severely impact large numbers of the population	5	3	15	1. CYPMs Workstream closely involved in NHSE quarterly steering group 2. CCG NR investment in childhood immunisations in 2017/18 and 20181/9 to create capacity and enhanced access	1. Risk falls within CYPM Workstream Transformation Priority: 0 -5 2. Childhood Imms Domiciliary Service will be available from June 2018 3. Reviewing joint work between primary care and community paeds	5	3	15	**NEW**	TBC	TBC	TBC

Integrated Commissioning Boards Forward Plan, 2018-19		
Title	**Summary of Decision**	**Reporting Lead**
14-Sep-18		
IC evaluation - outcomes framework	For discussion and noting	Anna Garner / Cordis Bright
Integrated Commissioning Strategic Vision and Objectives	For discussion and approval	Devora Wolfson
CYPM APR3	For approval	Angela Scattergood/ Amy Wilkinson
Intermediate Care Service	For discussion and approval	Tracey Fletcher / Simon Galczynski
Draft systems Commissioning Intentions 2019/20	For endorsement	David Maher / Anne Canning / Simon Cribbens / Devora Wolfson
Recommendations for funding of proposals for workstreams from the prioritisation committee	For discussion and approval	David Maher / Anna Garner
Integrated Finance Report	For noting	Sunil Thakker / Ian Williams / Mark Jarvis
IC Risk Report	For discussion and approval	Devora Wolfson
11-Oct-18		
Reprocurement of Carers Services	For approval	Anne Canning / Jayne Taylor / Simon Galczynski
IC Governance review - draft report	For discussion and approval	Devora Wolfson
Integrated Care Partnership Framework		David Maher
Mental Health Strategy including crises intervention, suicide and veterans and Early Intervention in Psychosis		David Maher
Primary Care at scale		David Maher
Developing our financial system control total	To approve refined approach	Sunil Thakker / Ian Williams / Mark Jarvis
Integrated Finance Report	For noting	Sunil Thakker / Ian Williams / Mark Jarvis
IC Risk Report	For discussion and approval	Devora Wolfson
15-Nov-18		
ICS readiness update	For endorsing direction of travel	Devora Wolfson
Integrated Finance Report	For noting	Sunil Thakker / Ian Williams / Mark Jarvis
IC Risk Report	For discussion and approval	Devora Wolfson
06-Dec-18		
Mainstreaming co-production within the Integrated Commisisoning Programme		Jon Williams / Catherine Macadam

IC Evaluation Report	For discussion and noting	Anna Garner / Cordis Bright
Integrated Urgent Care delivery		David Maher
Integrated Finance Report	For noting	Sunil Thakker / Ian Williams / Mark Jarvis
IC Risk Report	For discussion and approval	Devora Wolfson
17-Jan-19		
IC Evaluation Report	For discussion and noting	Anna Garner / Cordis Bright
Integrated Finance Report	For noting	Sunil Thakker / Ian Williams / Mark Jarvis
IC Risk Report	For discussion and approval	Devora Wolfson
07-Feb-19		
Integrated Finance Report	For noting	Sunil Thakker / Ian Williams / Mark Jarvis
IC Risk Report	For discussion and approval	Devora Wolfson
14-Mar-19		
IC Evaluation Report	For discussion and noting	Anna Garner / Cordis Bright
Integrated Finance Report	For noting	Sunil Thakker / Ian Williams / Mark Jarvis
IC Risk Report	For discussion and approval	Devora Wolfson
Unscheduled Items		
Local Account (Integrated Report) - TBC	For discussion and endorsement	Simon Galczynski / Ellie Ward