Health in Hackney Scrutiny Commission – 8th April 2018

Integrated Commissioning: Report of the Planned Care Workstream

1. Introduction

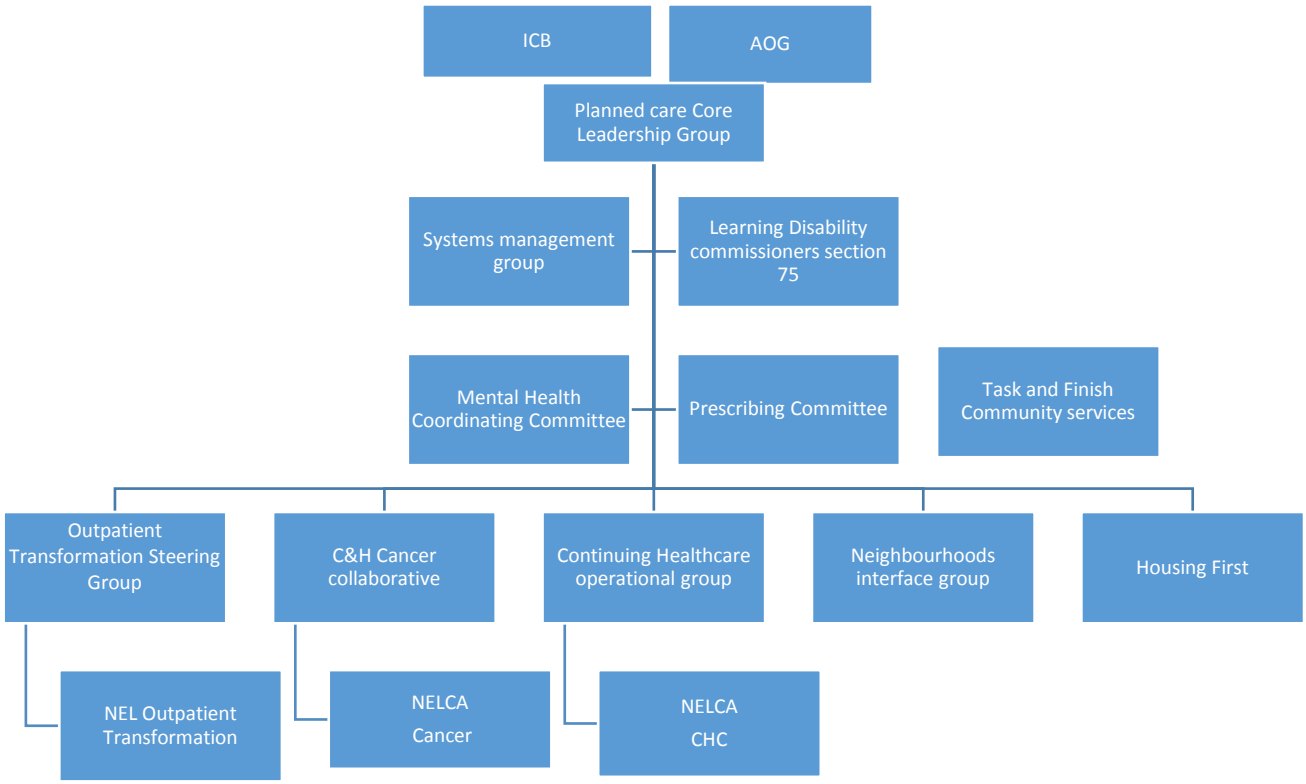
The purpose of this paper is to provide a comprehensive briefing on the progress, achievements and issues that are the current focus of the Planned Care workstream.

2. Membership

The Planned Care workstream has a governance structure of a core leadership group (CLG) which oversees a sub-structure of projects.

The Planned Care workstream Core Leadership Group membership comprises the following:

- Andrew Carter - SRO - Director of Commissioning and Partnerships, Department of Community and Children's Services, City of London Corporation
- Siobhan Harper - Director, Planned Care Workstream
- Gary Marlowe - Clinical lead, Planned Care Workstream
- Tessa Cole - Head of Programmes, London Borough of Hackney
- Elspeth Williams – Patient and public representative
- Michael Vidal - Patient and public representative
- Angshu Bhowmik - Consultant Respiratory and General Physician, Homerton University Hospital NHS Foundation Trust
- Mark Logan - Head of Contracting, Homerton University Hospital NHS Foundation Trust
- Sarah Williams -NE Quadrant GP Lead Director, GP Confederation
- Sheraz Ahmad - Consultant Psychiatrist and Associate Medical Director East London Foundation Trust
- Haren Patel – GP clinical lead Prescribing Committee
- Hana Villar – MIND and HCVS representative



The current scope of the workstream is depicted in the diagram above. Since the last report from the workstream in May 2018 there has been an increase in working with partners at a North East London level. This paper will provide a detailed update on the following:

- Outpatient Transformation
- Learning Disability service Transformation
- Pooling budgets for continuing healthcare and adult social care, creating a single system of commissioning and integrated delivery
- Cancer – early diagnosis, delivery of NHS constitution standards and survivorship support
- Community services and neighbourhoods
- Housing First

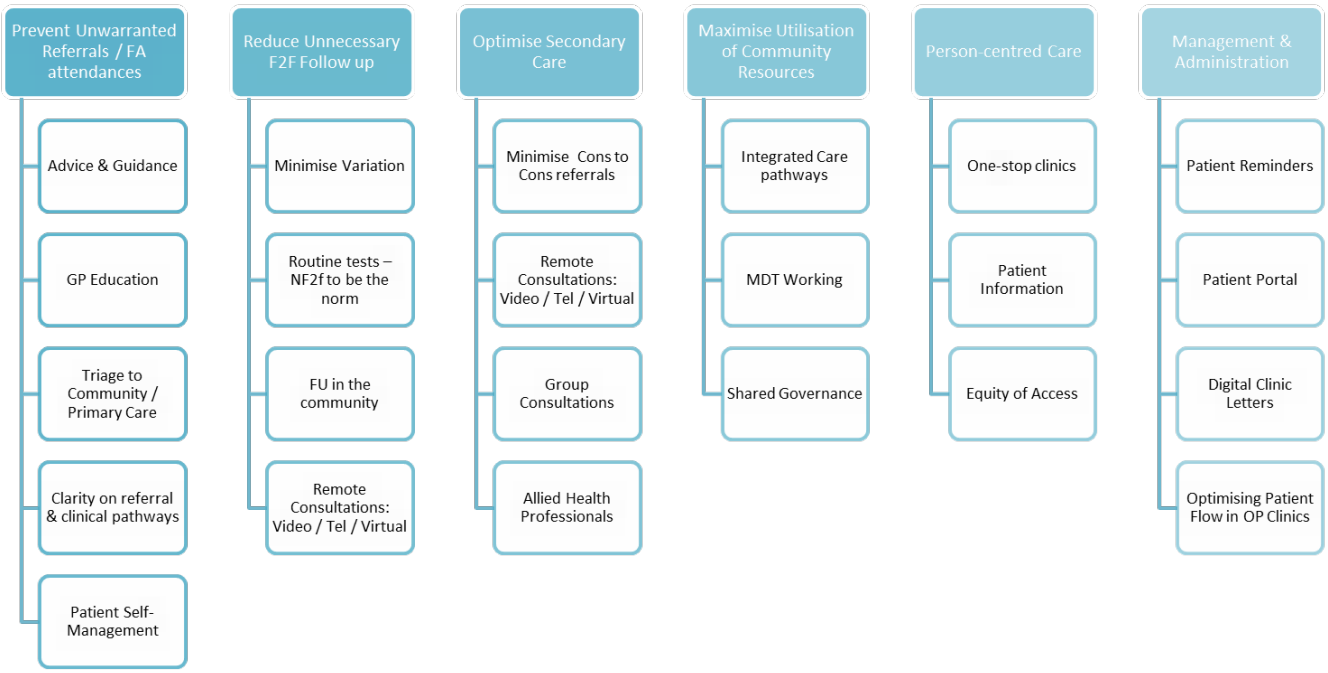
Other aligned programmes include and these are subject to their own reporting requirements to the CCG and ICB.

- Mental Health
- Prescribing

3. Progress on current plans

3.1 Outpatient Transformation

As part of the Outpatient Transformation programme, the following key transformation areas were identified:



Task and Finish groups manage the discussion on transformation opportunity at specialty level. We are currently working on transformation plans in the following specialties:

- Trauma & Orthopaedics

- Dermatology
- Hypertension
- Gynaecology
- Diabetes
- Cardiology

Specific developments are now taking shape with a proposal for a virtual fracture clinic now agreed and plans for a new tele-dermatology service in train as well as an agreement to scope an integrated women's health service.

3.2 Overperformance in elective care

Significant progress on outpatient transformation has been limited in 18/19 by the impact of an unexpected and considerable increase against the CCG plans for elective activity at the Homerton – in outpatient attendances, day case and elective operations.

In July 2018 City & Hackney CCG issued the Homerton with an Activity Query Notice querying this over performance in Day Case, Elective, and Outpatient activity. A Joint Demand Capacity Recovery Action Plan was agreed in response to this AQN. One of the components of this plan was to carry out four internal audits. The results of these have been reviewed and a considerable element of the activity has been found to be counted or coded incorrectly. The ICB has also maintained an overview of these issues.

Because of the lack of consensus on the drivers behind the overperformance the CCG has now decided to commission an independent audit to concentrate on establishing the source of referrals and understanding the standard operating procedures that underlie the counting and coding of activity. As required under General Condition 15 of the contract, the methodology and focus of these audits will now be agreed between the two organisations. The aim is to conclude this piece of work by the end of Q1 2019/20. The contract negotiations for 2019/20 must be concluded in line with the national timetable by 21st March 2019 and therefore this activity adjustment will need to be reflected in the agreed baseline. The contract value may be amended following the external audit conclusions at the end of Q1.

4. Learning Disability Service Transformation

This project is subject to an earlier report to members of the committees and therefore will not be repeated here. However the following points are highlighted as priorities for the workstream.

- Developing a service specification to support the new model with a comprehensive set of health and social care outcomes with a clear service offer to individual service users. The specification will drive genuine integration and increased multidisciplinary working within the service along with better transition planning and proactive support to service users and families in crisis and who are receiving long term care.
- Development of a strategy for all people with learning disabilities which will aim to strengthen our approach to personalised services promoting independence, maximising opportunities to meaningful activities, employment and access to mainstream services. The Integrated commissioning team for learning disabilities recently undertook a visit to services in Thurrock to explore new models of day opportunities which deliver highly personalised care for people with learning disabilities including people with profound and complex disabilities.
- A focus on maximising accommodation and supported living options for people with learning disabilities in Hackney
- Increased focus on the Transforming care programme locally and in particular to strengthen our planning for young people with possible learning disabilities and/or autism from the age of 14 who might be at risk of admission to a specialist NHS facility. This intervention is designed from a prevention perspective and will be intended to provide a personalised approach to support families and young people into adulthood.
- Both the specification and the strategy are planned for discussion at the Planned care Core Leadership Group in April followed by the ICB in May.

5. Implementation of the joint funding pilot process

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 such an agreement was made between partners to test the level of health funding into the Learning Disability service in line with neighbouring benchmarks. This led to the implementation of a pilot joint funding process with new criteria and a joint panel led by the workstream. The pilot was applied to approximately 48 current care packages and the findings then extrapolated across the current LD care package cohort to establish a potential level of health need to be funded. An independent body reviewed the findings of the pilot and recommended a level of health funding was legitimately identified. The CCG has agreed to fund an additional £1.9m for 18/19. Discussions are now ongoing between the CCG and LBH to embed a new joint funding policy within the ILDS team and operationalise the approach as business as usual and to plan for the financial implications.

6. Further pooling

The Planned Care workstream continues to develop plans for integration of health and social care budgets for care home and nursing home placements, Continuing Healthcare (CHC) budgets and care packages in the home. The ambition is to create an integrated system to deliver:

- Better patient experience through a single consistent commissioning/funding process
- Joint funding of care packages
- Joint/single brokerage function
- Joint/single commissioning function appropriate to care groups
- Greater efficiency and better utilisation of resources with increased flexibility to share funding of care packages across care groups particularly to prevent an escalation of care needs
- Greater market influence, control and development opportunities
- Improved planning and commissioning of care

Progress has been made on the development of a joint brokerage function with additional capacity to support health based placements and to scope how a joint function would work in practice. We are currently recruiting to this role as a short term role to help specify this before substantive recruitment takes place.

Further opportunities for joint commissioning of accommodation based services are also emerging with a project exploring the mental health pathway in line with Mental health Housing related support tender and the introduction of Housing First.

We are working together regularly on contract pricing for placements and home care - matching inflationary uplift where possible across residential and free nursing care placements and home care providers.

Further work is also taking place within the Task and Finish finance group to design the supporting framework to the pooled budget proposal - including the contract details and risk share. A further update on progress is due to ICB in July 2019.

7. Continuing Healthcare

This has been a major improvement project for the workstream – to gain better financial control and to improve delivery on the ground by ensuring the national quality premium standards are met as well as ensuring reviews are up to date and fast track well managed. Our initial plans for Continuing Healthcare were to bring the administrative function in house from the Commissioning Support Unit; however, this has now been superseded by the establishment of NELCA and the likely NHSE mandated model for delivery of CHC at scale.

City and Hackney along with the rest of NEL are also now in an escalated assurance process with NHSE regarding the delivery of the national quality premium standards. Our quarterly performance is shown in the tables below. We have significantly improved in delivery of the location of assessment, which has been achieved through good joint working particularly with the CHC team and LBH. For 28 days to completion of assessment the picture is not so robust and this requires our focused oversight

of the CHC team and the CSU interface as data quality and collection issues continue to impact on consistent performance against the standard. It is also expected that the additional brokerage support will improve this further.

% CHC assessments in an acute setting

CCG	QUARTERLY & MONTHLY ACTUALS								MONTHLY TRAJECTORY	
	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Jan-19	*Feb-19*	*Mar-19*
Barking and Dagenham	31.0%	40.0%	6.3%	2.2%	3.4%	12.2%	12.5%	9.7%	*9.7%*	***10.3%***
Havering	18.9%	34.0%	6.7%	3.9%	1.8%	20.0%	15.0%	5.6%	*12.8%*	***10.4%***
Redbridge	17.9%	22.2%	10.7%	4.1%	4.2%	10.3%	14.0%	3.0%	*12.6%*	***12.1%***
City and Hackney	51.4%	73.7%	48.3%	60.5%	54.3%	71.0%	26.3%	7.1%	*15.4%*	***14.3%***
Newham	57.1%	33.3%	46.4%	37.2%	43.8%	47.1%	17.6%	42.9%	*19.0%*	***14.0%***
Tower Hamlets	98.8%	42.4%	42.9%	29.4%	38.2%	42.4%	22.2%	7.7%	*20.0%*	***14.0%***
Waltham Forest	76.3%	54.7%	38.8%	29.5%	15.6%	18.1%	14.3%	14.3%	*13.1%*	***12.8%***
North East London STP	47.4%	43.2%	24.8%	20.6%	17.7%	25.9%	16.0%	8.4%	*13.7%*	***11.9%***
Tolerance level	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*

% CHC referrals completed within 28 days

CCG	QUARTERLY & MONTHLY ACTUALS								MONTHLY TRAJECTORY	
	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Jan-19	*Feb-19*	*Mar-19*
Barking and Dagenham	64.8%	64.7%	62.0%	93.9%	70.4%	72.0%	51.3%	64.7%	*75.1%*	***80.0%***
Havering	73.4%	75.3%	66.3%	88.4%	81.6%	60.3%	60.3%	60.6%	*74.9%*	***80.0%***
Redbridge	67.3%	47.9%	48.9%	87.0%	66.0%	53.2%	54.9%	53.3%	*76.2%*	***80.0%***
City and Hackney	75.7%	67.7%	76.7%	75.0%	81.6%	64.9%	73.8%	61.5%	*78.0%*	***80.0%***
Newham	75.0%	67.3%	55.3%	45.7%	73.2%	75.7%	88.6%	36.4%	*81.0%*	***81.5%***
Tower Hamlets	88.5%	95.7%	48.0%	51.0%	71.9%	45.7%	54.8%	15.8%	*76.0%*	***80.0%***
Waltham Forest	55.9%	81.7%	82.8%	91.9%	76.7%	88.9%	92.0%	85.7%	*85.9%*	***85.3%***
North East London STP	69.3%	73.5%	61.9%	80.7%	74.9%	65.4%	60.6%	55.7%	*76.9%*	***80.6%***
Tolerance level	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*

8. Cancer

The commissioning and provider arrangements for cancer are complex and require close working with our partners in North East London. Much of the agenda for cancer services is set by the National strategy and the requirement to improve the assessment of City and Hackney CCG against the Integrated Assessment Framework where we are currently assessed as 'inadequate'

Indicator (latest time period used)	Benchmark	City and Hackney CCG performance
Cancers diagnosed at early stage (2016)	National trajectory to national ambition (53.5%)	48.60%
People with urgent GP referral having definitive treatment for cancer within 62 days of treatment (2017/18)	National Standard (85%)	77.90%
One-year survival from all cancers (2015)	National trajectory to national ambition (72.4)*	71.3
Cancer patient experience (2016)	2015 National mean (8.74)	8.4

It should be noted that the data used for the IAF rating is now out of date and we are preforming better particularly on the 62-day waiting time standard - please see tables below

Cancer Waiting Times - Initial Report

January 2019

Description	Two-Week Wait		31-Day Wait				62-Day Wait		
	All Cancers	Symptomatic Breast Pts	1st Treat	2nd/Sub (Surgery)	2nd/Sub (Chemo)	2nd/Sub (RT)	Urgent Referral	Screening	Cons Upgrade
Operational Standard	93%	93%	96%	94%	98%	94%	85%	90%	N/A
Trust Name									
BARKING, HAVERING & REDBRIDGE UNIV HOSPITALS	89.7	98.0	98.0	100.0	100.0	99.0	85.3	94.7	93.8%
BARTS HEALTH	96.1	98.1	98.6	100.0	100.0	99.4	86.7	90.5	86.0%
HOMERTON UNIVERSITY HOSPITAL	96.4	97.2	100.0	100.0	100.0		89.1	0.0	91.2%
NEL STP Area (Providers)	93.8						86.2		
ROYAL FREE LONDON	90.0	85.1	99.2	100.0	96.0	100.0	77.7	72.1	80.7%
UNIVERSITY COLLEGE LONDON HOSPITALS	89.1	55.2	96.1	97.8	100.0	94.9	73.6	100.0	72.9%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	97.4	97.4	97.0	100.0	100.0		84.3	69.6	83.8%
CCG Name									
NHS BARKING AND DAGENHAM CCG	92.7	97.4	98.3	100.0	100.0	100.0	78.8	100.0	92.3%
NHS HAVERING CCG	89.8	97.4	97.6	96.0	100.0	100.0	81.2	83.3	94.1%
NHS REDBRIDGE CCG	90.7	96.4	96.9	100.0	100.0	97.5	84.0	100.0	93.8%
NHS CITY AND HACKNEY CCG	94.9	97.1	100.0	93.3	100.0	96.7	87.1	100.0	91.4%
NHS NEWHAM CCG	97.1	95.5	95.5	100.0	100.0	100.0	82.8	80.0	85.7%
NHS TOWER HAMLETS CCG	96.2	98.1	100.0	100.0	100.0	100.0	95.0	100.0	100.0%
NHS WALTHAM FOREST CCG	95.3	90.2	97.8	100.0	100.0	97.6	86.8	75.0	86.7%
NEL STP Area (Commissioners)	93.7						83.9		
NHS WEST ESSEX CCG	95.4	96.6	95.8	85.7	100.0	95.2	78.6	66.7	81.5%
Regional and National Performance									
National *(England)*									
UCLH Cancer Collaborative Area *(Trusts: NC&EL+PAH)*	92.0	88.7	97.8	98.7	99.6	97.9	81.2	80.0	83.0%
RM Partners/SEL Area *(Trusts: NW, SE & SW London)*	94.2	95.6	96.4	94.7	99.1	95.0	84.3	83.8	90.2%
London Area Performance *(Trusts: London)*	93.0	92.2	97.0	96.3	99.1	96.5	79.4	82.8	84.3%

Source: National Cancer Waiting Times Database / CADEAS via Transforming Cancers Services Team for London

East London Health and Care Partnership:

Cancers diagnosed at Stages I and II

CCG	Stage 1 or 2 (FY2012-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2013-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2014-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2015-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q1) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q2) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q3) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2017-Q1) 1 yr rolling ave.
Barking & Dagenham	43.5%	45.0%	47.0%	41.0%	41.0%	44.0%	45.0%	47.0%	52.0%
City & Hackney	44.9%	50.0%	49.0%	52.0%	50.0%	48.0%	49.0%	52.0%	55.0%
Havering	52.0%	49.0%	39.0%	46.0%	46.0%	47.0%	49.0%	51.0%	51.0%
Newham	40.3%	41.0%	40.0%	48.0%	47.0%	49.0%	50.0%	50.0%	52.0%
Redbridge	46.1%	47.0%	46.0%	51.0%	50.0%	50.0%	49.0%	50.0%	52.0%
Tower Hamlets	34.1%	44.0%	43.0%	47.0%	45.0%	51.0%	54.0%	55.0%	57.0%
Waltham Forest	34.9%	51.0%	45.0%	56.0%	55.0%	54.0%	56.0%	57.0%	60.0%
WELC	38.8%	47.3%	44.6%	51.3%	49.7%	50.5%	52.2%	53.5%	56.2%
BHR	48.1%	47.5%	43.3%	46.7%	46.2%	47.7%	48.4%	49.7%	51.4%
NEL	43.5%	47.4%	43.9%	49.0%	47.9%	49.1%	50.3%	51.6%	53.8%
National Average (England)	43.6%	48.0%	51.0%	52.0%	52.0%	52.0%	52.0%	53.0%	52.0%

Source: National Cancer Dashboard

* NB It should be noted that there are several different approaches to calculating the proportion of patients with tumours diagnosed at stage 1 or stage 2, according to whether 'all cancers' or only 10 defined 'stageable cancers' are included in the total and whether cases with missing stage are included or excluded from the denominator. The figures given above, used in the National Cancer Dashboard and the CCG Outcome Indicator Set, are for 10 specified stageable cancer types (breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphoma and invasive melanomas of skin) and include unstaged cases in the denominator. Using the alternative approach (all cancer types, excluding unstaged cases from the denominator), our baseline in 2014 was 54.2% stage 1&2 compared to an England average of 54.4% (data source: pan-vanguard cancer intelligence analysis of NCRAS data, updated January 2017). It is this approach that is used to define the ambition of reaching 62% of all cancers with recorded stage being diagnosed at stage 1 or 2 by 2020 in the national cancer taskforce strategy. The gap to be closed is therefore 7.8% and our interventions focus on the common cancers where our current early stage proportion is below the England average using this calculation method (particularly colorectal and lung)and will also benefit patients with less common cancers where are our current proportions are beneath the England average (NHL, oesophageal) and in improvement in early stage detection more generally.

We are now in the process of refreshing our local action plan to improve our performance. Our current local actions include:

- Achieve a median time to first Outpatient appointment of 7 days – locally The Homerton can offer 7 day appointment for fast track referrals in a number of pathways and straight to test pathways in colorectal
- Implement the national optimal pathway for lung cancer, national colorectal and prostate cancers
- Commission outpatient activity and diagnostics to deliver the new NICE referral guidelines, including direct access tests and one stop model (NG12). In Hackney GPs have direct access to MRI tests and CT for abdominal pain and access
- Move performance to compliance and on to sustainability – this has improved considerably in the last six months at the Homerton and there is a Recovery planning in process at Chief Officer level between NEL and NCL
- Reducing those who present as an emergency to increase 1 year survival – as above and is further supported by our commissioning of direct access diagnostics which we have fully implemented
- Recognise living with cancer as LTC – we commission the GP Confederation to offer extended consultation time for cancer survivors and support their recovery. We aim to go further with this and to work with Prevention colleagues on greater access to exercise and lifestyle support for cancer survivors in Hackney. We will be working with the GP confederation to commission a stratified follow up service in primary care for prostate patients which we aim to have in place by April 2019

However, screening uptake for Hackney resident's remains low and in particular for bowel screening. Existing and new local initiatives to support early diagnosis and detection include:

- FIT implementation – a simpler bowel screening test will be implemented - the screening programme is expected to introduce the quantitative faecal immunochemical test (FIT)in 2019 and has committed to lowering the younger age for screening to 50.
- Early diagnosis –City and Hackney GPs are supported by a dedicated GP to promote practice level improvements and education for cancer detection and early diagnosis
- NEL Early Diagnosis Centre for all NEL patients - "cold site" facility, run separately to main provider diagnostic services and dedicated to cancer diagnostics

Proposals within the NHS Long Term Plan have committed to 3 in 4 cancers being diagnosed at an early stage by 2028. Cancer screening programmes are coordinated nationally for cervical, breast and colorectal cancers; however, these are implemented and monitored locally. The colorectal cancer-screening programme invites individuals every two years between the ages of 60 and 74 by post to provide a self-sample for faecal occult blood test.

Colorectal cancer screening uptake in Hackney and the City remains significantly below the national rate (annually 43% compared with 59%). Notably, one-year colorectal cancer survival is significantly below national rates as well as a number of Hackney's statistical peers.

Evidence from across London suggests that Black men are significantly more likely to develop colorectal cancer than men from other ethnic groups.[i] Migrant communities are less likely to attend screening programmes, and recent local evidence has highlighted one reason for this include a lack of information in general and a specific lack of information in an appropriate language.

A number of campaigns have sought to engage individuals to participate in colorectal screening including regional campaigns conducted in partnership by Department of Health, NHS England, Public Health England and McMillan among other cancer charities under the campaign brand Be Clear on Cancer. Literature suggests the following activities may increase uptake of colorectal cancer screening:

- Advertising campaigns combined with personalised invitation and reminder letters[ii]
- GP endorsement and primary care engagement in screening
- Community champion models and targeted community engagement[iii]
- Use of the quantitative faecal immunochemical test for screening[iv]

To address this we are working with partners to extend an ongoing pilot project which commenced in 2018. The project aimed to increase the uptake of colorectal cancer screening among individuals from Black African ethnic groups in Hackney. The pilot was originally funded through the Healthier City and Hackney Fund and provided by Community African Network (CAN), a voluntary sector organisation, and Hackney CVS and included the following components:

- Recruitment of volunteer community health champions
- Targeted face to face community outreach
- Targeted engagement through a GP practice
- Production and distribution of promotional materials

The following outcomes have been achieved:

- 10 community champions trained and 1 GP practice engaged
- 1,254 individuals reached through targeted outreach
- 215 telephone contacts through GP with 15 returned screening kits and 40 replacement kits

Although this project has been able to engage individuals from the target group, there remains an ongoing need. It is expected that through extension of the programme additional individuals can be reached through GP practice based engagement, which aligns with national evidence for increasing cancer screening uptake.

Further work we are undertaking with the Cancer alliance, NELCA and our public health colleagues includes:

- Development of appropriate campaign resources which will be locally tailored versions of the national Be Clear on Cancer campaigns
- A targeted social media campaign to link users with campaign resources
- Outreach and engagement of community organisations and leaders
- Recruitment and training of volunteers to deliver outreach
- Face to face engagement with individuals from target groups through outreach events and activities
- Engagement with community and faith leaders to contribute to campaign
- Distribution of language appropriate information materials

9. Housing First

This project is progressing well and the tender is out for procurement. We are working closely with both LBH and COL. The key elements are:

- 3 year contract
- Contract value upper threshold £225k per annum.
- Up to 20 places (including at least 3 in the City)
- Must show fidelity to the model
- Must come with accommodation and support - can be a partnership

Indicative High Level Timeline

Activity	**Start Date**
Publish Tender/OJEU Notice	Mid Feb 2019
Deadline for return of tender	End of April 2019
Individual tender evaluations	May - End of June
Bidder Presentations	May 2019
Internal Moderation (consensus agreement)	Early June
Contract Award Report submitted to LBH Governance Services	July
Contract Award	September 2019
Contract mobilisation	Three to six months.

10. Neighbourhood health and care services

The workstream has hosted the Task and Finish Group working on the redesign of Neighbourhood Health and Care community services programme. this project is system focused working with the Integrated Care System (ICS) convener and all of the workstreams.

To date this has involved a series of service redesign workshops involving a wide range of services across the four workstreams, which have generated a clear mandate on the future of community services in City and Hackney. A report on the workshops is attached as appendix 2.

Since the project began in the autumn 2018, the national context has emphasised the role of community services and the case for integration through the publication of the Long Term Plan (LTP) for the NHS. This also includes the introduction of Primary Care Networks. The vision described in the LTP has confirmed that City and Hackney is extremely well placed to progress its integrated care system through the workstreams with the Neighbourhoods Programme and the work undertaken through the community services project as cornerstones to the future model. Work to formalise the next steps and the relevant milestones is currently underway and will be confirmed within the next month.

11. Finance

The consolidated Planned Care position at Month 10 is £9.2m adverse forecast. The underlying Planned Care workstream position is driven by:

- The London Borough of Hackney (LBH), where Learning Disabilities has a £4m pressure due to increased demand. The LBH forecast includes a contribution of £1.9m from the CCG for the LD Joint Funding Pilot. This non recurrent drawdown was badged to support LD packages. A report from PWC on the work jointly undertaken by the CCG and LBH on the pilot joint LD programme of work was agreed by the CCG's Governing Body in February for agreement of the level of non-recurrent monies to be deployed this year to support the health needs of LD packages .
- The LD forecast is in line with the outturn of the previous financial year and LBH plan to mitigate any year end deficit with council reserve funding. In addition to this, the Local Authority are experiencing delays in achieving some of the £2.5m Housing Related Support (HRS) savings profiled for this year resulting in an additional £0.9m overspend.
- In month 10 The London Borough of Hackney, have benefitted from a £0.3m one off Public Health grant to support Voluntary Sector mental health provision within Adult Social care. In additional to this £0.3 Winter pressure funding has been allocated to the LA which has helped mitigate some of the over spend.
- The CCG's forecast over spend of £4m is driven by the following acute contracts: Homerton (£2.2m); Barts Health (£0.4m) due to regular attenders in clinical haematology and medical oncology; Whittington Hospital (£0.3m) and Guys and St Thomas' (£0.4m).The position also includes Continuing Health Care forecast overspend of £0.6m relating to Funded Nursing Care.
- Acute finance and activity over-performance continues broadly in line with the run rate trend and is being managed through Acute and General reserves. The CCG has presented a proposal to the Homerton based on audit results, to adjust and reimburse finance and activity anomalies that have driven some of the over performance experienced at the Trust. The discussions are still ongoing with an aim to resolve by mid March.

12. Patient Engagement

As with all workstreams, Planned Care is committed to patient engagement and co-production in the planning and delivery of public services. We have 2 resident/patient representatives on the CLG who attend all meetings as well as providing specific advice and oversight of patient involvement within our plans and priorities. We work with existing groups locally as well as requesting specific pieces of engagement work from expert patient/resident organisations. With all our major transformation projects we aim to ensure that we are not disadvantaging people with disabilities or creating further inequalities or problems with access to services and our patient/resident representatives are fundamental to this.

Our current plans are described below:

Outpatient Transformation	• Patient choice is essential. Appointments structure and communications need to be individualised and personalised • An easier electronic system where a patient can pick a time slot available is needed. GPs could also book the patient into their preferred time slot. • Outpatients process needs to be streamlined across referral, booking, appointment and results. • Make it easier for people to change appointment times • Patient should be able to select most convenient form of communication for them – active signup and choice should be built into patient checklist. Preference needs to be recorded on GP and hospital notes. Need to consider accessibility and language needs. • Text and phone call reminder should be used more as they work well. • Option to receive confirmation and results over email, text or phone call should be given in an opt-in way • Some people would like the choice of appointments in the community or at a local GP so they don't need to travel to hospital. • A one stop shop or having appointments for different things in one day should be offered but isn't appropriate for everyone. • Waiting times for appointments and results are too long • Needs to be more holistic treatment of people particularly those with long term conditions. • Group consultations and checks can work for some things (e.g. type 2 diabetes) so people can have peer-support and self-help. • Staff need to interact with patients as equals including by explaining why the appointment is needed. • Homerton have now instigated more wide spread text messaging of reminders for appointments. • The Homerton are now looking at IT solutions to offer choice to patients in how they receive letters or other communications. There options will be discussed and agreed with stakeholders later in the year. • Proposals for a community pathway and services for acne are being discussed and services wills start later in 2019. • More routine follow ups will be carried out in primary care for PSA monitoring. This should commence in April 2019. • **This report is being used to help develop work in 2019 on transforming outpatient's services.** • **The principles of choice, equity of access and individualised approach will underpin all work undertaken.**
Stroke	• A 'Let's Talk about stroke' - event on Tuesday 5 February at the Graeae Theatre. Over 70 people came along to share their experiences and to talk about how stroke support services can better meet the needs of City and Hackney residents. We will be in contact with all attendees to let them know what happens next and how their feedback is helping to shape services.

Risks and mitigation

Risks Register and Issue Log - March 2019

Issues Log

Ref	Description	Impact if not managed	Inherent rating			Current rating			Actions required	Target rating			Latest action to move the issue	Planned Care workstream responsible person	Status (open, pending or closed)	Notes
			Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total				
PC 11	There was an increase in elective activity in Q1 2018/19 which has continued throughout the year and will result in a budget overspend	Spending in other areas will need to be redirected to deal with any overspend. The risk to the overall CCG budget will result in an increased focus and reporting requirements from NHS England	5	4	20	5	4	20	Overall the Homerton response is that the increased activity reflects an increase in need. The reason for the increase in activity has not been fully explained (there has not been an increase in primary care referrals) and the situation continues to be investigated. An action plan has been implemented to address the causes of the overperformance.	3	3	9	Delivery of the action plan agreed with HUH is nearing completion. The C2C audits have been completed and established irregularities in counting which were mostly accepted by HUH across the four specialties. An agreement on contract values has been reached and a further audit programme for 2019 in Q1 have been agreed. Daycase activity will also be audited in Q1. Regular updates are being provided to the Planned Care CLG and an update will be provided to the ICB in March.	Siobhan Harper supported by River Calveley	Open	

Ref	Description	Impact if not managed	Inherent rating			Current rating			Actions required	Target rating			Latest action to move the issue	Planned Care workstream responsible person	Status (open, pending or closed)	Notes
			Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total				
PC 1	Financial pressures in the LD service	This pressure is creating challenge to current partnership arrangements and may impact on • the CLG proposals for future pooled budget develop-ments	5	4	20	4	3	12	The system partners need to agree a shared transformation and recovery plan for the LD service	3	3	9	The CCG has confirmed a contribution of £1.9m to the LD section 75 in respect of health costs within existing care packages, based on the joint funding pilot and validated by PWC. The CCG, LBH and CoL have agreed a way forward to establish the arrangements for 19/20 and the PC workstream will lead on producing a plan in response to this proposal. Proposals for the joint funding of LD services alongside wider budget pooling from April 2019 has been agreed at ICB	Simon Galzyinski/ Siobhan Harper supported by Matt Stafford	Open	
PC 7	Cancer 62 days target at Homerton has been missed for a number of months this year	This has already impacted on the most recent CCG rating from NHS England and will continue to	4	4	16	3	3	9	Action Plan to be developed by the workstream to improve the IAF rating. Regular performance monitoring meetings with HUH to be maintained.	3	3	9	There are weekly and fortnightly performance management discussions regarding the cancer position. NCEL improvement plan in place and Homerton is required to deliver local actions.	Siobhan Harper supported by Sue Maughn	Open	Close if performance is maintained.

Ref	Description	Impact if not managed	Inherent rating			Current rating			Actions required	Target rating			Latest action to move the issue	Planned Care workstream responsible person	Status (open, pending or closed)	Notes
			Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total				
		do so if not addressed.											HUH 62 day standard has improved in September 2018 – January 2019. The risk to CCG performance remains linked to backlog in surgical patients at UCLH. Actions to improve are in the NCEL system plan. Despite improvements in a number of areas cancer services have received an 'inadequate' rating from NHS England following a recent inspection. Stakeholder consultation is currently underway on the details of an improvement plan to be implemented across all aspects of cancer services.			
PC 8	Failure to meet the quality premium for Continuing	• Poor patient care • Additional scrutiny	4	4	16	3	3	9	Development of an assurance plan outlining actions to meet targets for location of assessment and	3	2	6	Our performance continues to improve and we are hoping to meet the targets for Q4.	Siobhan Harper supported by Cindy Fischer	Open	

Ref	Description	Impact if not managed	Inherent rating			Current rating			Actions required	Target rating			Latest action to move the issue	Planned Care workstream responsible person	Status (open, pending or closed)	Notes
			Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total				
	Health Care (CHC)	from NHSE • Loss of income							completion of decision within 28 days of referral. We have agreed on a CHC CQUIN with the Homerton.				January • 7% completed in acute • 62% assessments completed in 28 days • 0 cases exceeding 26 weeks February • 17% completed in acute • 92% assessments completed in 28 days • 0 cases exceeding 26 weeks			

Risk Register

Ref	Description	Consequence if risk occurred	How will you recognise that the risk is beginning to/is occurring?	Inherent rating			Current rating			Actions required to - mitigate risk - reduce impact and/or probability - reach target risk	Target rating			Latest action to move the risk to target (if not already achieved)	Planned Care workstream responsible person	Notes
				Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total			
Workstream risks																
PC 12	During 2017/18, limited stock availability of some widely prescribed generics significantly drove up costs of otherwise low cost drugs. The price concessions made by DH to help manage stock availability of affected products, were charged to CCGs - this arrangement (referred to as NCSO) presents C&HCCG with an additional	Spending in other areas will need to be redirected to deal with any overspend. The risk to the overall CCG budget will result in an increased focus and reporting requirements from NHS England	Monthly budget reports and monthly QIPP Reports will be routinely monitored but no QIPP plans will be able to impact these cost pressures	5	4	20	5	4	20	There are no QIPP activities that can be implemented that will have an impact on these cost pressures because they are DH/ NHSE directives on national pricing strategies to address national drug shortages and shortages in funding for community pharmacy contracts	5	4	20	We are unable to manage this direct risk, but have wider QiPP plans for the overall primary care prescribing budget which will deliver savings to enable impact of this drug pricing risk to be better tolerated [During 2017/18 the total year end impact for C&H was £1.2M NCSO - however the wider QiPP work delivered savings higher than the £1.2M cost pressure]	Siobhan Harper supported by Rozalia Enti.	

Ref	Description	Consequence if risk occurred	How will you recognise that the risk is beginning to/is occurring?	Inherent rating			Current rating			Actions required to - mitigate risk - reduce impact and/or probability - reach target risk	Target rating			Latest action to move the risk to target (if not already achieved)	Planned Care workstream responsible person	Notes
				Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total			
	cost pressure of for 2019/20															
PC 4	Staff at the statutory organisations responsible for the delivery of Planned Care priorities fail to buy into the process	Organisations continue to work in silos and opportunities to deliver efficiencies or improved outcomes fail to be achieved	Engagement with stakeholders via the Core Leadership Group and individual project teams.	4	3	12	3	3	9	Stakeholders recruited to the Core Leadership Group from across the relevant partner organisations Individual projects engage with relevant stakeholders Resources are invested in engaging with stakeholders at all levels	3	1	3	Core leadership meetings regularly established. A 'get to know you' session for members was delivered in February and a follow-up Away Day in August 2018. Further engagement is planned. A System Management group meets monthly and an oversight/steering group is being created for joint funding projects. The System Management Group has recently been expanded to included clinical and resident representatives.	Siobhan Harper and Simon Cribbens	
PC 5	Insufficient resources are committed to deliver the workstream 'Asks'	Programme milestones fail to be delivered on time due to a lack of available resources	Individual project and CLG reporting	4	3	12	4	2	8	As part of the development of the individual projects statutory services will be required to commit the necessary resources.	4	1	4	Continue to develop plans which include staff	Siobhan Harper and Simon Cribbens	

Ref	Description	Consequence if risk occurred	How will you recognise that the risk is beginning to/is occurring?	Inherent rating			Current rating			Actions required to - mitigate risk - reduce impact and/or probability - reach target risk	Target rating			Latest action to move the risk to target (if not already achieved)	Planned Care workstream responsible person	Notes
				Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total			
PC 6	The work of the Planned Care Workstream is perceived as only being about the delivery of savings rather than helping people to live more independently	Patients and other stakeholders fail to buy into the process and opportunities to deliver improved outcomes for service users are not achieved.	Feedback from stakeholder engagement	4	3	12	4	2	8	Project scoping will focus on efficiency savings AND opportunities to improve outcomes and this will be monitored throughout delivery	4	1	4	Regular stakeholder, resident and patient engagement agreed by the CLG to ensure the programmes and projects within the workstream are well understood. This has been incorporated into the work of the individual asks.	Engagement enabler group and all CLG members	
Project risks																
PC 3	Anti-coagulation service is not fully utilised	Patients will not receive a service from primary care. QIPP plans may not deliver	Feedback from the project implementation group	3	4	12	3	3	9	On-going relationship building and joint working at the project group Detailed project plan for transfers to practices outlined	3	2	6	CCG has proposed a timetable to support clarification and resolution of governance concerns so that actions would then be completed by 22nd April 2019	Siobhan Harper supported by Jan Tomes and Laura Sharpe	
PC 10	End of national funding for Pharmacy First and impact on primary care	Risk end of national funding for Pharmacy First increases pressure on primary care as residents on low	Feedback from CCG Medicines Management team	2	4	8	2	4	8	Work with key partners to develop a local Pharmacy First service.	3	2	6	Implementation strategy for a revised Pharmacy First scheme that addresses the decision to cease prescribing certain over the counter drugs to be finalised.	Siobhan Harper supported by Rozalia Enti.	

Ref	Description	Consequence if risk occurred	How will you recognise that the risk is beginning to/is occurring?	Inherent rating			Current rating			Actions required to - mitigate risk - reduce impact and/or probability - reach target risk	Target rating			Latest action to move the risk to target (if not already achieved)	Planned Care workstream responsible person	Notes
				Impact	Likelihood	Total	Impact	Likelihood	Total		Impact	Likelihood	Total			
		incomes are now required to attend their GP practice to a prescription for medicines available free of charge, direct from their pharmacy														
PC 9	HUH are unable to recruit appropriate staff to deliver the Outpatient transformation programme	Delivery of Outpatient transformation is delayed and/or fails to achieve the desired quality.	Progress reporting from the project team	3	3	9	3	2	6	Comprehensive recruitment process to be followed.	3	1	3	Programme Manager recruited and in post. Monitoring to continue to ensure that staffing resources are sufficient.	Siobhan Harper supported by River Calveley	

Siobhan Harper - Director, Planned Care Workstream
28.3.19

[i] Data describing incidence for cancer between ethnic groups are based on small numbers of cancer cases, and should be interpreted with caution. Source: Public Health England National Cancer Registration and National Cancer Registration and Variation in cancer incidence by ethnicity across London in 2015 2015 accessed online from: http://www.ncin.org.uk/view?rid=3709

[ii] Cancer Research UK 2017 accessed online from https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/past-bowel-cancer-screening-campaigns

[iii] Wardle et al, 2016 doi: 10/1016/S0140-6736(15)01154-X

[iv] Moss et al, 2017 doi: 10.1136/gutjnl-2015-310691

City & Hackney Neighbourhood Health and Care Services Programme

Learning from whole system workshops and next steps

Update to Integrated Commissioning Boards, March 2019

Hackney

CITY OF LONDON

NHS
City and Hackney
Clinical Commissioning Group

The strategic context for integrated care

- City and Hackney face a number of pressing health needs, changing demography and ongoing pressure on inpatient resources, but this is set against a strong track record of primary and community care delivery with high performing services already leading to great numbers of patients receiving care closer to home.
- Within this context health and care services in City and Hackney perform well, however the changing nature of the local disease burden – specifically the continuing impact of lifestyle factors, the need to more effectively address the wider determinants of health and the predicted growth of patients living with two or more long-term conditions – is likely to render these service models unsustainable.

A focus on integrated care in out-of-hospital services

- Out-of-hospital services will be the building blocks of integrated care. These services feature heavily in both the recently published NHS Long-Term Plan and the new GP contract proposals.
- By moving away from multiple silo-ed, 'one size fits all' services towards more targeted, preventative and joined-up care, they have the power to dramatically improve the lives of patients and have a much wider effect on the rest of the local health and care system.
- By local out-of-hospital services we mean the following services and spending:
  - community health services (£33m),
  - related social care (£18m of Better Care Fund pooled services, £18m of Hackney social care services and £2m of City of London social care services),
  - mental health services in the community (£21m),
  - whole-population (non-delegated) primary care services (£11m)
  - acute urgent care and GP out-of-hours services (£4m).
- The funding envelope for these services in City and Hackney is approximately £120m annually. We refer to these services together as out-of-hospital services because we want to emphasise their combined significance despite them having been historically commissioned separately.

Our approach to redesigning care

- The Neighbourhood Health and Care Services Programme was set up to consider the transformation of out-of-hospital services. Our original intention was for this work to inform a formal service redesign and procurement exercise starting in March 2019.
- We held a series of workshops in January 2019 to ask staff and stakeholders to inform this process. The workshops indicated a willingness and desire from the partners on the ground to deliver integrated care across organisational boundaries, and to develop new models of care, but they also highlighted a number of major barriers and obstacles.
- Staff reported that current commissioning arrangements, financial incentives and outcome measures do not support joint work across organisations to co-ordinate care. However, the majority of barriers identified were cultural and behavioural in nature, requiring system leadership, shared values, and investment in collaborative learning and solution building.
- It was clear from the workshops that the programme as originally envisaged was focused too narrowly on the structure and process of redesign but did not fully address the behavioural and leadership aspects of change management necessary to deliver a system-level transformation of care.

We held workshops throughout January with staff from across health and care in City and Hackney

8

workshops held

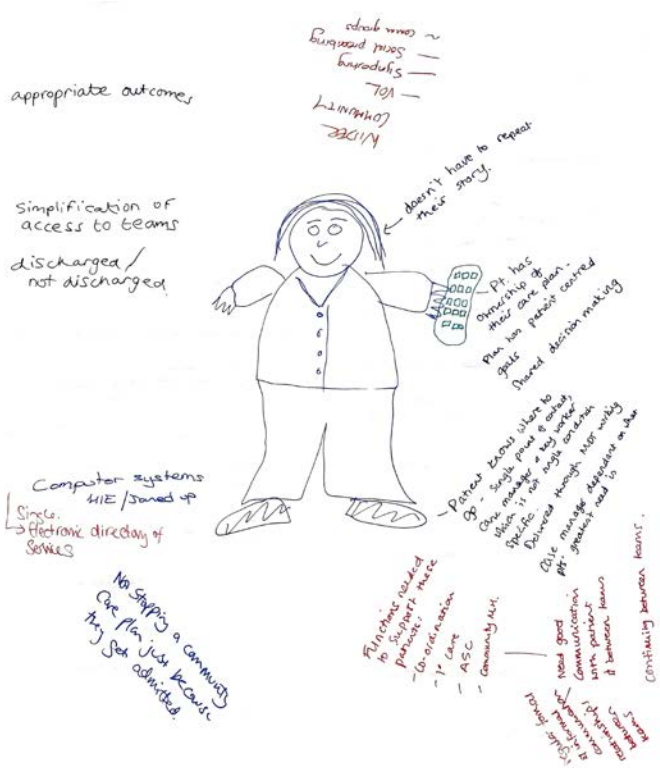
Approx.

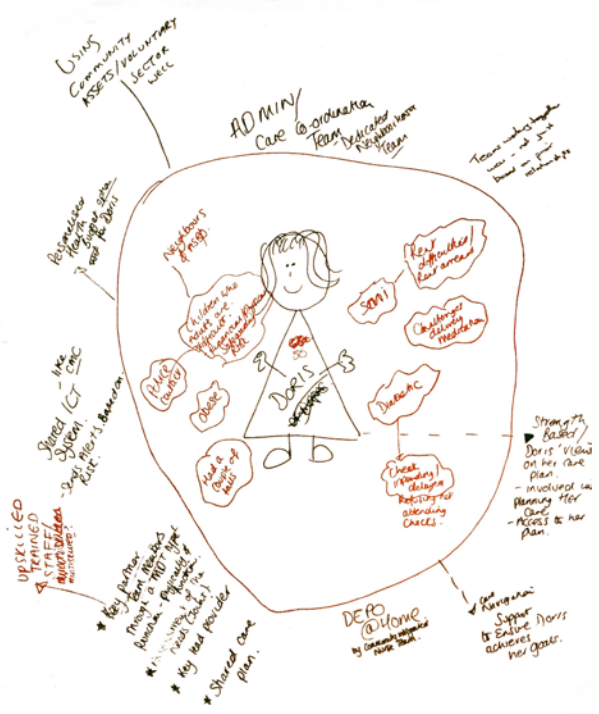
200

participants

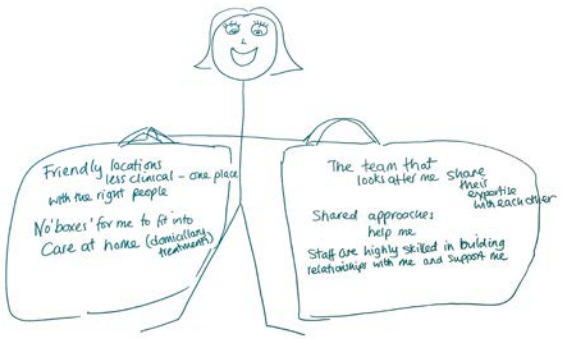
Wide representation of partners from across the local system:

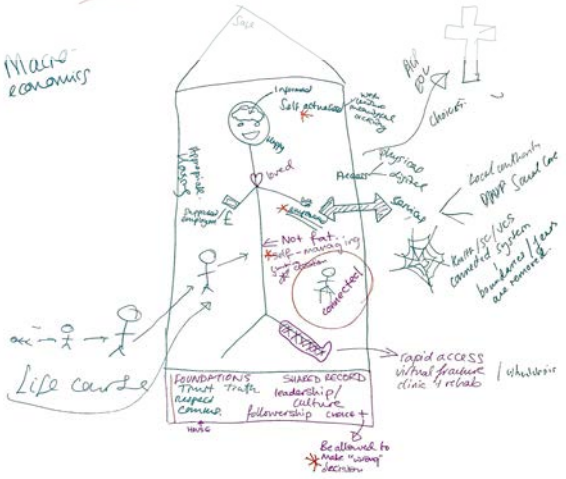
- CCG, patient representatives, primary care, Homerton (acute and community), ELFT (mental health), Learning Trust (schools), local authority (social care), charity and voluntary sector

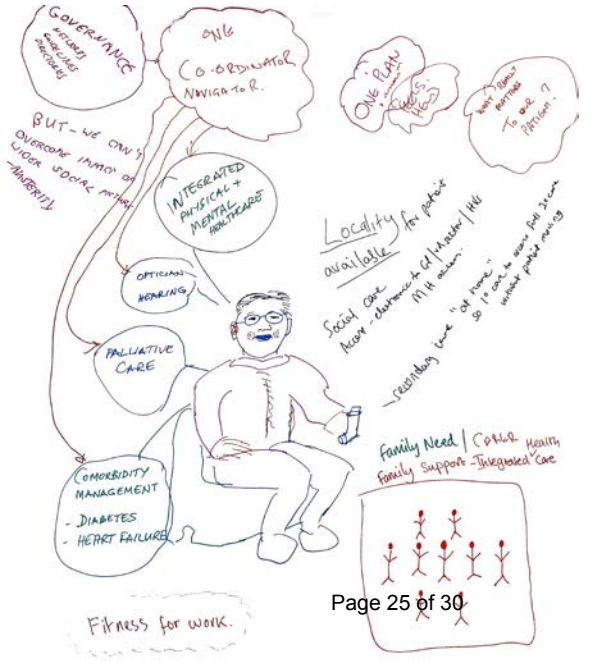




Staff shared their visions of what amazing joined-up services would look like for patients in the future…







We asked staff to define the integrated patient-centred care they wanted to provide – which aligned closely with what residents have told us they want…

Resident statements: "What is important to me and what I value for my health, care and wellbeing:"

- Patient at the centre
- Joined-up care
- Equality between staff and the public - working together, clear communication and speaking the same language
- People are listened to and heard
- Responsible patients and staff
- Money is used well
- Community and neighbourhood
- Accountable and transparent staff and politicians
- Public are involved including in decisions
- Properly funded services
- Flexible support adapted to local and individual need
- Equal for all including equitable access
- Tackling causes and better prevention
- One-to-one care
- Equal treatment of mental and physical health
- Greater happiness and wellbeing
- Recognise people's skills and empower them to help themselves
- More training, education and employment for people
- Continuity of care
- Free health care

Workshop definition of integrated care:

- Care which addresses the holistic needs of patients as human beings, both physical, mental and social, and which is preventative and empowering;
- Care which is experienced by patients as consistent and co-ordinated, delivered in a joined-up way either at home, from a GP practice or local community location at Neighbourhood level or virtually, and only in hospital when truly necessary;
- Patients supported to make the best use of their own resources, rather than being treated like illnesses to be managed or problems to be solved;
- Patients being the owners of care plans which are based on patient-centred goals;
- Care delivered by staff who are empowered to work together as they see clinically fit in order to provide patients with more-coherent, less fragmented support; and
- Services and teams which are focused on supporting cohorts of patients to stay well rather than organised narrowly around professional or disease-specific specialisms.

Workshop participants identified seven key barriers to effective joint working as a system…

- A **culture** of 'them and us' between different organisations and professions, and between generalists and specialists, based on a lack of trust, and lack of awareness of different approaches and viewpoints;
- The current system of **contracts and commissioning**, where different teams and organisations are held to different performance standards and funding arrangements, and thresholds and referral criteria make it hard to operate more flexible clinical judgement;
- The way that **time and space** are managed, specifically with staff time heavily regulated by process – leaving them little ability to be flexible, with the same challenges also applying to the opportunity to share **infrastructure** resources such as buildings and equipment;
- The effects of mental and physical **organisational boundaries** such as complex referral systems, differing priorities, lack of collaboration, silo-ed working and thinking, and passing patients back and forth between organisations rather than taking more joint responsibility for finding solutions;
- Different contracts and funding arrangements leading organisations to be protective of **resources and capacity**, making it harder to flexibly align resources adaptively around the needs of patients;
- The lack of coherent **common goals and values** role-modelled by leaders, that endorse the need for collaboration and joined-up working and thinking, as well as organisational commitment to multi-agency working; and

Participants also identified changes they wanted from leaders – challenging them to build on the relationships between organisations:

- By ensuring that leaders in partner organisations collaborate and role-model the necessary commitment and common purpose; sharing resources and enabling staff to change the way they work;
- By empowering teams to work differently, engage with partners and to increase ambitions around multi-agency working – removing competitive or monolithic practices that serve to disempower teams or fragment or confuse responsibility for care;
- By changing how success is measured, so that focus moves away from proscriptive process measures towards population outcome measures, underpinned by a whole-system agreement to enable a more values-led, trusting and adaptive system environment.

Primary Care Networks

- As part of the NHS Long Term Plan a five year framework to change the GP contract was announced. A key part of this is the development of Primary Care Networks (PCNs) for populations of 30-50,000
- In the first year each network will receive funding to employ one social prescriber and 70% of the cost of hiring one pharmacist
- Each network will be led by a GP in the role ofpart time clinical director
- By 2024 each network will have:
  - 5 pharmacists
  - 3 social prescribers
  - 3 first contact physiotherapists
  - 2 physician associates
  - 1 community paramedic
- The hope and expectation is that PCNs in City and Hackney will operate on the same footprint as neighbourhoods
- We also need to make sure these additional resources work seamlessly with the rest of the local system

The case for a change programme

- Overcoming competitive behaviours and building trust and collaboration between clinicians in different organisations will be key to delivering integrated care in out-of-hospital services, in whatever form it is commissioned. As stated recently by the King's Fund, "the principal benefits of integrated care result from clinical integration rather than organisational integration" .
- This change cannot be owned by one organisation in the system on its own, be it the CCG or any of our key partners; a system-level approach is required, owned collectively.
- We propose a system-level change programme with the following elements:
    - Visible system-level leadership, role-modelling the behaviours that will deliver integrated care;
    - Action to address organisational processes and behaviours that hinder collaboration on integrated care, particularly in multi-agency clinical teamwork and service co-ordination;
    - System-level learning projects in priority areas where maximum benefit could be achieved from deeper integration, with change developed from the bottom up by clinical teams
    - Investment in more trusting relationships across the system, focusing more on common values, goals and outcome measures and less on organisational differences