



## Health and Social Care Scrutiny Committee

**Date:** TUESDAY, 1 MAY 2018  
**Time:** 11.30 am  
**Venue:** COMMITTEE ROOMS, WEST WING, GUILDHALL

**Members:** Chris Boden  
Wendy Mead  
Emma Edhem  
Alderman Alison Gowman  
Michael Hudson  
Vivienne Littlechild

**Enquiries:** Joseph Anstee  
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**Lunch will be served in Guildhall Club at 1PM**  
**NB: Part of this meeting could be the subject of audio or video recording**

**John Barradell**  
Town Clerk and Chief Executive

# AGENDA

## Part 1 - Public Reports

1. **APOLOGIES**
2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
3. **ORDER OF THE COURT OF COMMON COUNCIL**  
To receive the Order of the Court of Common Council from 19 April 2018.  

**For Information**  
(Pages 1 - 2)
4. **ELECTION OF CHAIRMAN**  
To elect a Chairman in accordance with Standing Order 29.  

**For Decision**
5. **ELECTION OF DEPUTY CHAIRMAN**  
To elect a Deputy Chairman in accordance with Standing Order 30.  

**For Decision**
6. **CO-OPTION OF A HEALTHWATCH REPRESENTATIVE**  
To co-opt one representative from Healthwatch City of London.  

**For Decision**
7. **APPOINTMENT OF INELJHOSC REPRESENTATIVE(S)**  
To appoint representative(s) to the Inner North East London Joint Health Overview and Scrutiny Committee.  

**It is proposed that the Chairman and Deputy Chairman are appointed.**

**For Decision**
8. **MINUTES**  
To agree the public minutes and non-public summary of the meeting held on 13 February 2018.  

**For Decision**  
(Pages 3 - 10)
9. **NHS 111 SERVICE**  
Report of Homerton University Hospital Foundation Trust  

**For Information**  
(Pages 11 - 18)

10. **INTEGRATED COMMISSIONING PROGRAMME - HEALTH AND SOCIAL CARE**  
Report of the Director of Community and Children's Services  

**For Information**  
(Pages 19 - 24)
11. **CANCER SCREENING - 62-DAY TREATMENT TARGET**  
Verbal Update  

**For Information**
12. **ANNUAL WORKPLAN**  
Report of the Town Clerk  

**For Decision**  
(Pages 25 - 28)
13. **INNER NORTH EAST LONDON UPDATE**  
To update Members on the activities of the Inner North East London Joint Health Overview and Scrutiny Committee since the last meeting.  

**For Information**  
(Pages 29 - 60)
14. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
15. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
16. **EXCLUSION OF THE PUBLIC**  
MOTION - That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part I of the Schedule 12A of the Local Government Act.

#### **Part 2 - Non-Public Reports**

17. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
18. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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# Agenda Item 3

BOWMAN, Mayor	<b>RESOLVED:</b> That the Court of Common Council holden in the Guildhall of the City of London on Thursday 19th April 2018, doth hereby appoint the following Committee until the first meeting of the Court in April, 2019.
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## HEALTH & SOCIAL CARE SCRUTINY COMMITTEE

### 1. **Constitution**

A non-Ward Committee consisting of,

- Any 6 Members appointed by the Court of Common Council
- 1 Co-opted Healthwatch representative.

The above shall not be Members of the Community & Children's Services Committee or the Health & Wellbeing Board.

### 2. **Quorum**

The quorum consists of any three Members. [N.B. - the co-opted Member does not count towards the quorum]

### 3. **Membership 2018/19**

- 3 (3) Christopher Paul Boden
- 3 (3) Alison Jane Gowman, Alderman
- 3 (3) Michael Hudson
- 3 (3) Vivienne Littlechild, J.P.
- 3 (3) Wendy Mead, O.B.E.
- 2 (2) Emma Edhem, *for three years*

together with the co-opted Member referred to in paragraph 1 above.

### 4. **Terms of Reference**

To be responsible for:-

- (a) fulfilling the City's health and social care scrutiny role in keeping with the aims expounded in the Health and Social Care Act 2001 and Part 14 of the Local Government and Public Health Act 2007 (Patient and Public Involvement in Care and Social Care);
- (b) agreeing and implementing an annual work programme; and
- (c) receiving and taking account of the views of relevant stakeholders and service providers by inviting representations to be made at appropriate meetings.

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## HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

Tuesday, 13 February 2018

**Minutes of the meeting of the Health and Social Care Scrutiny Committee held at the Guildhall EC2 at 11.00 am**

### **Present**

#### **Members:**

Chris Boden (Chairman)	Michael Hudson
Wendy Mead (Chief Commoner) (Deputy Chairman)	Vivienne Littlechild
Emma Edhem	Steve Stevenson
Alderman Alison Gowman	

#### **Officers:**

Farrah Hart	-	Community & Children's Services Department
Joseph Anstee	-	Town Clerk's Department
Simon Cribbens	-	Community & Children's Services Department
Adrian Kelly	-	Community and Children's Services

### **1. APOLOGIES**

Apologies for absence were received from Jo Wilson (NHS England).

### **2. MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

Alderman Alison Gowman, Vivienne Littlechild and Steve Stevenson declared standing interests by virtue of being residents in the City of London, and registered with the Neaman Practice.

### **3. MINUTES**

**RESOLVED** – That the public minutes of the meeting held on 30 October 2017 be agreed as a correct record.

#### Matters Arising

##### Defibrillators

The Director of Community and Children's Services informed the Committee that officers had engaged with the Community Heartbeat Trust and were working on a scheme to encourage business to make defibrillators installed on their premises publicly available. There would be a proposal going to the Health and Wellbeing Board to take the scheme forward.

## Employment for People with a Learning Disability

The Director of Community and Children's Services informed the Committee that learning disabilities were not recorded specifically in the City of London Corporation's employment data. With regards to employees declaring a disability, 2.7% of employees declared a disability, and 13% of employees had not declared their disability status.

The Committee noted that the City Bridge Trust was currently funding two schemes with the aim of supporting people with disabilities into employment, including the Bridge to Work programme. The Committee noted that the Corporation was not on this scheme as an employer. A Member suggested that officers link with the Corporation's Disability Inclusive Network for insight into the matter.

### **4. GP SERVICES IN THE CITY**

The Committee received a report of the City and Hackney Clinical Commissioning Group (CCG) and welcomed Sue Neville and Shahannu Uddin, representatives from the Neaman Practice and Richard Bull from City and Hackney CCG. The Committee was given an update on the Neaman Practice and its current performance. The practice currently had around 9400 registered patients, and provided a variety of services alongside GP, nurse and pharmacy appointments such as chiropody, physiotherapy and smoking cessation, and also offered a duty doctor scheme, which had been successful.

Practice staff were aware of difficulties with the phone system and were working hard to find a system which maximised the capacity of the reception staff to take bookings for appointments both over the phone and face-to-face. The practice had been selected for City and Hackney's 'South Hub' and would be open from 8am until 8pm on Saturdays from April 2018. The practice was also aiming to increase its capacity and hold an extra three hours of appointments during the week. There were plans to increase capacity for booking online appointments to up to 6 weeks in advance.

The Committee noted the practice's performance against the CCG's Primary Care Quality Dashboard. Whilst there were some areas of underperformance the practice's overall score was higher than the City and Hackney average and above the London and National benchmarks. The Committee noted that the practice was within BMA guidelines for weekly appointments per 1000 patients and number of registered patients per doctor. The Committee noted that the practice's administrative obligations and accountability to the local GP Confederation often had to take a high priority as the practice needed to meet certain targets in order to receive funding.

The Chairman reminded the Committee that it was important to keep context of the patients being served in mind when considering the performance data of the practice, as it had an unusual catchment area with some of the lowest areas of deprivation in the country, thus skewing the data. The Committee was informed that the practice had met its funding-related targets and was working hard to improve any areas of underperformance. Staffing was a significant

issue, but the practice was working hard to recruit both medical and non-medical staff in order to meet demand and operate at full capacity.

The Chairman asked the Neaman Practice representatives if the Babylon GP service had impacted on the practice. Whilst it was not currently a big issue for the Neaman Practice specifically, it may escalate in the future, as it could attract younger patients who may deregister from GP Practices, which would have a knock-on effect on the funding received by the practice as well as increasing relative workload. The Committee was informed that the Babylon service was creating a problem for GP practices in other areas. The Chairman suggested that the Committee could look at the Babylon service at a future meeting, as it was theoretically a positive thing but was seen to be having negative effects, and could have further implications with regards to cancer screening if younger patients were not registered with GPs.

The Committee noted the draft scoping paper for an options appraisal for the Neaman Practice. A small working group was to be convened to consider options to improve access to the practice, and work out the scope for expansion, the practice's relationship with neighbouring practices and the effect of expansion or relocation on the practice's catchment area. The Committee noted that the premises costs for the Neaman Practice's current location were far higher than the CCG average, but was assured that if the Practice was to be relocated it would remain within the City of London.

The Committee thanked Sue Neville, Shahannu Uddin and Richard Bull for attending and for their contributions to the meeting.

**RESOLVED** – That the report and briefing papers be noted.

**5. UPDATE ON CHANGES TO CANCER SERVICES AND BREAST CANCER SCREENING**

The Committee received a report of NHS England and welcomed Siobhan Harper from the City and Hackney CCG, and Kathie Binysh and Sarah Galbraith, representatives from NHS England to the meeting. The Committee was given an overview of cancer services and breast cancer screening in the City of London. All CCGs were monitored on cancer standards and rated by the Integrated Assessment Framework (IAF) on key indicators such as waiting times, survival rates, patient experience and staging.

Siobhan Harper informed the Committee that City and Hackney CCG was underperforming by these standards. There was a need for improvement in cancer services, and this was a high-profile focus of the CCG. There were some issues specific to the area, but performance in City and Hackney had been poor in the last year, with particular issues in the delivery of 62-day referrals for cancer screening. However, performance had been encouraging with regards to survival rates where the CCG was improving significantly. The Committee was informed that there was a lot of work ongoing to learn from methods in other European countries where cancer services were better. A Member expressed concern that the cancer unit at St. Bartholomew's was not delivering what had been expected when it had opened.

Members noted that the CCG's level of 65.4% for urgent referrals within 62 days was well below neighbouring CCGs and was a significant cause for concern, as the shortfall was greater than in other places. Members expressed the urgent need to work past difficulties and barriers, and made suggestions for increasing referral numbers, such as making screening locations more convenient, and increasing engagement with patients to understand any reasons that might cause barriers to screening. Siobhan Harper told the Committee that there had been some discussion about introducing mobile CT scans, and a GP endorsement service had been commissioned. As Homerton Hospital had very small numbers of patients being referred, each person had a bigger influence on the data. The NHS Trust was a diagnostic centre which sometimes caused bureaucratic delays, as there was a need to refer patients to other places for treatment. The CCG had met its targets in this area in December and was close to the target in January and so far in February, indicating some improvement.

Members suggested that any structural issues also needed to be analysed. As there was a clear shortcoming, the issue needed to be looked at closely to gain a fuller understanding and identify as many possible routes to improvement. Members suggested that a report be brought back to a future meeting to examine the CCG's progress in this area.

Kathie Binysh then gave the Committee an overview of breast screening in the City of London and Hackney. Breast screening coverage in London as a whole was the lowest in England, although this was a long-standing issue. The data for City and Hackney was encouraging, as coverage had increased by 2.9% over the last year and was the third-highest for Central and East London. The Committee noted that the Neaman Practice coverage, at 65.6% was higher than the average for City and Hackney CCG GP practices.

Coverage was an ongoing concern, as it was vital for as many women as possible to take up the offer of breast screening. There were a number of reasons women did not take up the offer, and so efforts were made to influence these factors where possible. Whilst there had been recent challenges like workforce capacity, overall uptake was increasing in City and Hackney and Central and East London. There were a number of initiatives being actioned to improve uptake such as second timed appointments, pre-appointment reminder texts, commissioning Community Links to contact women who DNA screening appointments and marketing strategies. NHS England London would continue to work with a variety of partners to implement and roll out interventions that have been shown to improve uptake and coverage.

The Committee noted that whilst the City of London had relatively high population turnover, this was likely to be caused predominantly by younger patients and should not have a significant impact on screening numbers. The Director of Community and Children's Services expressed some concern that the statistics for the City of London had been grouped in with Hackney, as there were City-specific figures available from other sources. The report had not

provided some data that would have been helpful to the Committee, and some of the data that had been provided was confusing or poorly presented.

In response to queries from the Director of Community and Children's Services, Sarah Galbraith told the Committee that the Community Link service had been piloted in Hackney (but not the City of London), and that wider rollout was slow and dependent on capacity within the service. A serious incident communicated by St. Bartholomew's in 2016 had been caused by a major IT issue which affected the breast screening service, causing the service to cease screening for four weeks. The investigation and subsequent recovery process was still ongoing, and a clinical harm review had been undertaken. Sarah Galbraith told the Committee that the data used in the graphs had come from the national team rather than the City and Hackney CCG, but that they would look at improving the graphs and data available.

The Committee thanked Sarah Galbraith, Kathie Binysh and Siobhan Harper for attending and for their contributions to the meeting, and asked to be kept informed about cancer services at St. Bartholomew's and breast cancer screening in the City of London.

**RESOLVED** – That the report and briefing papers be noted.

**6. PROPOSAL TO MERGE CEDAR LODGE WITH THAMES HOUSE**

The Committee received a report of the City and Hackney CCG and welcomed Dan Burningham, representing the City and Hackney CCG, and Dr Waleed Fawzi, representing the East London NHS Foundation Trust, to the meeting. The report presented an outline proposal to merge two continuing care dementia wards to create a shared older adult dementia inpatient ward at Thames House Ward, Mile End Hospital. The involved the closure of Cedar Lodge, a ward based on The Lodge site in City and Hackney, and increasing the number of beds available at Thames House Ward from 12 to 18 beds.

There had previously been three wards on The Lodge site, but as 2 had been relocated Cedar Lodge was now isolated. Cedar Lodge currently had no onsite junior doctor coverage and required ambulances in emergencies. Patients had previously been expected to live in these wards before end of life care. However, the need for beds had reduced in the last 5 years as more patients were being assessed as requiring nursing home care. If physical needs predominated, then a care setting was thought to be more appropriate. The aim of the proposal in bringing the two wards together was to create a centralised inpatient service where patients with physical needs could be treated before eventually returning to being nursed in the community. As both wards were under-occupied and under-utilised, the merger would increase financial and staffing provision and enable the use of therapies that could not currently be provided at Cedar Lodge.

Whilst there were wider issues with regards to funding allocation and the delineation between healthcare and social care, the merger was a medium-term solution which would provide a better service than at present in both wards, and was part of an overall strategy to improve standards in Older Adults

inpatient services and a commitment to integrated care. The Committee noted that there were no patients from the City of London currently admitted at either ward. Members agreed with the proposal and endorsed the plans for the merger.

**RESOLVED** – That the Committee note the report and attached briefing paper, and endorse the proposal that the reconfiguration proceeds without the need for any further stakeholder or public consultation, beyond that already planned or undertaken.

7. **UPDATE ON TRANSFORMATION OF LOCAL SEXUAL HEALTH SERVICES**  
The Committee received a report of the Director of Community and Children's Services concerning local sexual health services. The Director of Community and Children's Services informed the Committee that a new custom-built sexual health clinic would open at 80 Leadenhall on 3 April 2018. Officers had taken action to promote the new clinic, including posters and press releases, and would be in contact with the Barbican Centre and other places to spread awareness of the availability of the new clinic.

The new clinic would enable work postcodes used by City workers attending the clinic to be filtered out, and so ensure the City of London Corporation was not paying for the residents of other boroughs. As the clinic was in a more convenient location, it was hoped the new clinic would attract more City workers.

**RESOLVED** – That the report be noted.

8. **INNER NORTH-EAST LONDON UPDATE**  
The Committee received the minutes of the last meeting of the Inner North-East London Joint Health Overview and Scrutiny Committee (INELJHOSC). The Committee noted that the JHOSC had also discussed the Babylon GP service. The Chairman informed the Committee that he was unable to attend the next meeting and asked that if available, another Member of the Committee attend in his place.

**RESOLVED** – That the minutes of the last INELJHOSC meeting be noted.

9. **ANNUAL WORKPLAN**  
The Committee received a report of the Town Clerk updating them on the annual workplan. The Chairman suggested that the Committee could revisit the Corporation's role in supporting people with learning disabilities. Committee Members suggested the Babylon service and NHS 111 system and its rollout could be discussed the next meeting. A Member suggested that the newly-appointed Accountable Care Officer discussed at the INELJHOSC could be invited to a future meeting.

**RESOLVED** – That the annual workplan be noted and would be updated ahead of the next meeting.

10. **ANNUAL REVIEW OF TERMS OF REFERENCE**

The Committee considered a report of the Town Clerk concerning the annual review of the Committee's terms of reference.

**RESOLVED** – That the terms of reference of the Committee be approved for submission to the Court as set out.

11. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

There were no questions.

12. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

There was no other business.

13. **EXCLUSION OF THE PUBLIC**

**RESOLVED** – That, under Section 100A of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part 1 of Schedule 12A of the Local Government Act.

<u>Item Nos.</u>	<u>Exempt Paragraph(s)</u>
14	3
15-16	-

14. **NON-PUBLIC MINUTES**

**RESOLVED** - That the non-public minutes of the meeting held on 30 October 2017 be agreed as a correct record.

15. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

There were no questions.

16. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

There was no other business.

**The meeting closed at 1.00 pm**

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Chairman

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# NEL 111 Service (Integrated Urgent Care – IUC)

City of London Corporation Scrutiny, 1<sup>st</sup> May  
Nina Griffith, Workstream director, unplanned care

# The Vision

- *Access, Assessment, Advice, Treatment*
- *The vision:*

*If I have an urgent need, I can phone a **single number (111)** and they will, if necessary, arrange for me to **see or speak to a GP**, or other appropriate **clinician / healthcare professional** – **any hour of the day and any day of the week.***

# 8 key elements of the 111 service

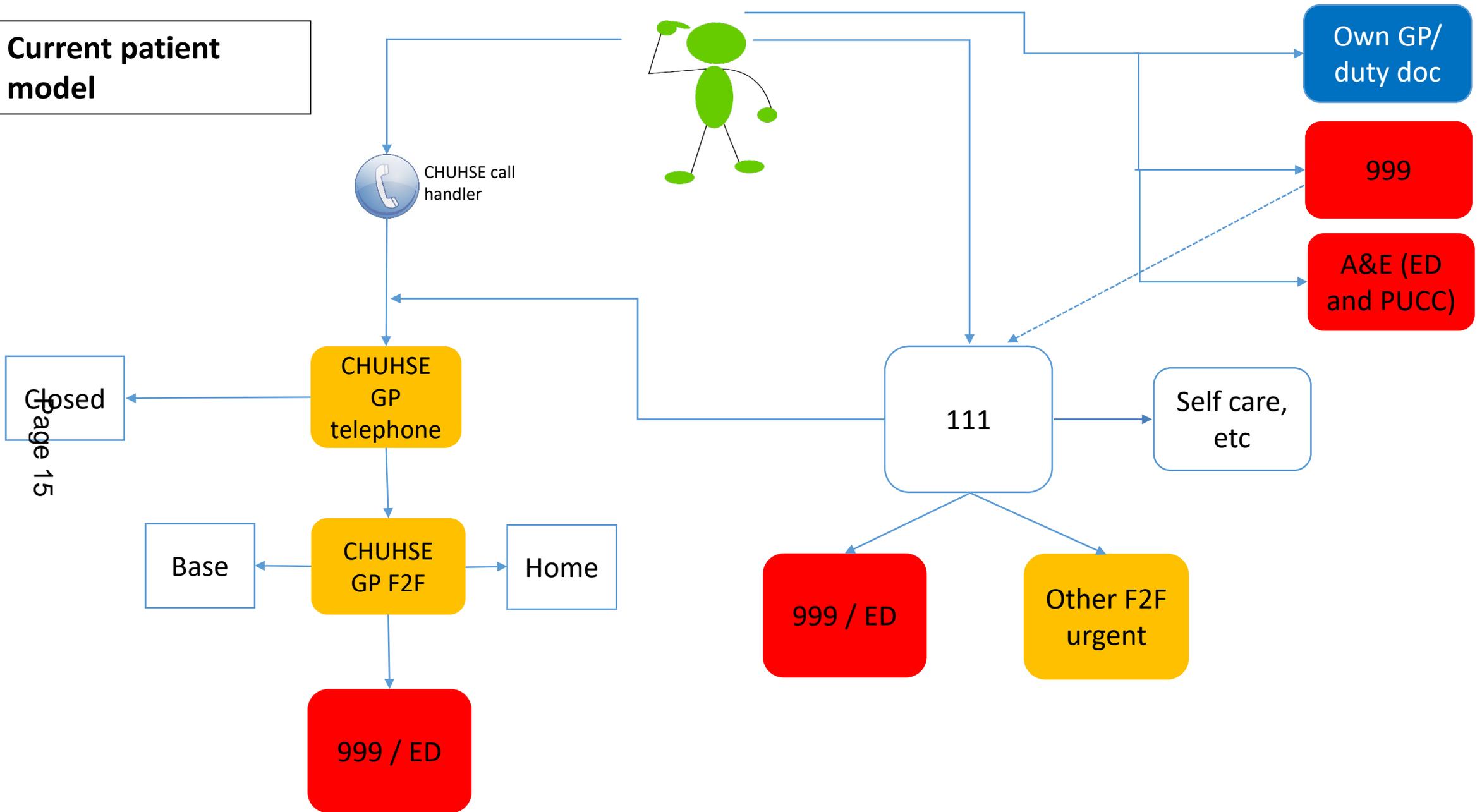
## **The NHSE specification**

1. A single call to get an appointment Out of Hours (OOHs)
2. Data can be sent between providers
3. The capacity for NHS111 and OOHs is jointly planned
4. The Summary Care Record (SCR) is available in the hub and elsewhere
5. Care plans and patient notes are shared
6. Appointments can be made to in-hours GPs
7. There is Joint governance across urgent and Emergency Care providers
8. There is a Clinical Hub containing GPs and other health care professional

# From the patients' perspective

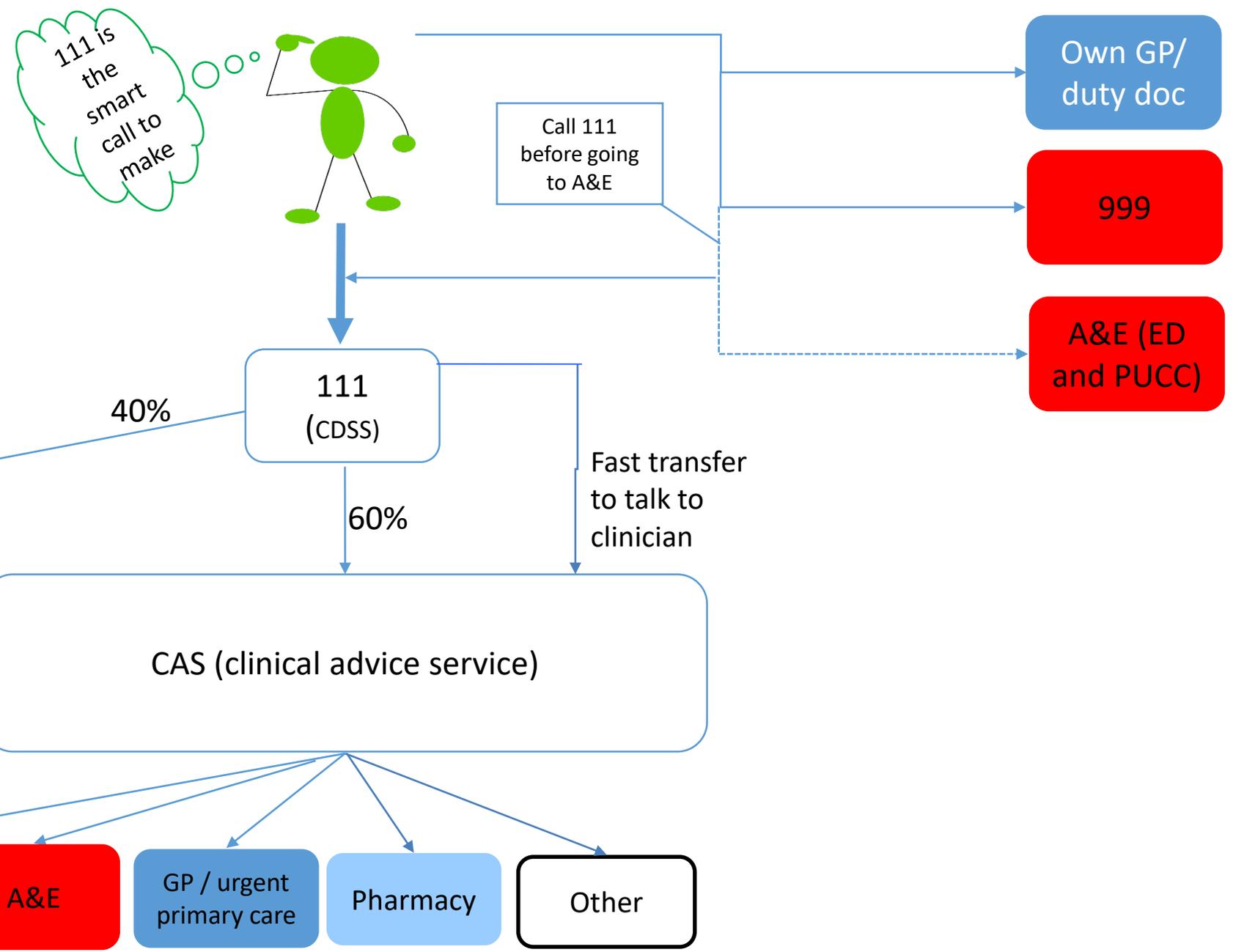
- A **single number** – NHS 111 – for all your **urgent health needs**
- Be able to **speak** to a **clinician** if needed
- Your **health records available** to clinicians treating you wherever you are (111, 999, community, hospital)
- To be **booked** into the **right** service for you, when **convenient** to you
- A clinically **appropriate response to 999** which may be: treatment advice by phone, in person by ambulance staff, or taken to hospital
- Care **close to home** (or at home) unless you need a specialist service
- **Access to specialist care services** (e.g. major trauma/stroke) through a network that includes specialist hospitals in your wider area

**Current patient model**



Page 15

**Proposed model**



Page 16

# Time-frames

- February 2018: LAS awarded contract for NEL 111 service
- 1<sup>st</sup> August 2018: Go live for new service. At this point the CHUHSE telephone service will cease, but CHUHSE will continue to provide a face to face GP out of hours service until end March 2019
- We are working to develop our new face to face GP out of hours service to replace CHUHSE from 1<sup>st</sup> April 2019

# What this means for City residents

- Patients that need an urgent GP appointment will be directed to the extended access hubs during their opening hours – there are 2 hubs in the south of the borough –the Hoxton practice during weekday evenings and the Neaman on Saturdays. We are scoping the possibility of having more hubs
- The out of hours GP home visiting service will continue for those patients that need to see a GP but cannot leave their home
- If a patient needs to go to a UTC or ED, these do not need to be within borough boundaries and the 111 service will take account of the patient's current location in determining which one they recommend. We are working with the 111 team to ensure that this works for City patients

<b>Committee</b>	<b>Dated:</b>
Health and Social Care Scrutiny Committee	1 May 2018
<b>Subject:</b> Integrated Commissioning Programme – Health and Social Care	<b>Public</b>
<b>Report of:</b> Andrew Carter, Director of Community and Children’s Services	<b>For Information</b>
<b>Report author:</b> Ellie Ward, Integration Programme Manager	

## Summary

The City of London Corporation entered into integrated commissioning arrangements with City and Hackney Clinical Commissioning Group to commission together across health, public health and social care. These arrangements began in April 2017.

This report updates Members on the progress of the integrated commissioning programme and two current key pieces of work within it – the development of a local integrated care model (the neighbourhood model) and the pooling of budgets for Continuing Health Care and Adult Social Care.

## Recommendation

Members are asked to:

- Note the progress of the integrated commissioning programme for health and social care and the two current key pieces of work within it.

## Main Report

### Background

1. The City of London Corporation entered into integrated commissioning arrangements with City and Hackney Clinical Commissioning Group (CCG) in April 2017 to commission together across health, social care and public health. The London Borough of Hackney also entered into similar but separate arrangements with the CCG.
2. The aim of the integrated commissioning arrangements is to reduce duplication and silos of service, make the best use of combined resources and improve health and wellbeing outcomes for the local population.

3. The original proposal included the pooling of all relevant budgets across health, social care and public health into one budget. However, at the direction of NHS England, partners have agreed an incremental approach to the pooling of budgets.
4. A governance structure was established and includes 4 workstreams to deliver work focused on transforming services. The four workstreams are unplanned care, planned care, prevention and children, young people and maternity services.
5. There is also a Transformation Board which consists of Senior Officers from across the health and care system who make recommendations to the Integrated Commissioning Board (ICB). The ICB includes three City of London Corporation Members who form an integrated commissioning sub-committee of the Community and Children's Services Committee.

### Current Position

6. The workstreams have been meeting for some time and have a number of priorities that they are working to deliver. These are summarised below.

<b>Workstream</b>	<b>Priorities include...</b>
Unplanned Care	<ul style="list-style-type: none"> <li>- Delivery of urgent care</li> <li>- Reducing Delayed Transfers of Care</li> <li>- Development of the Neighbourhood model (see below)</li> </ul>
Planned Care	<ul style="list-style-type: none"> <li>- Pooling of Continuing Health Care and social care budgets (see below)</li> <li>- Transformation of Outpatient Services</li> <li>- City of London Community Health Services</li> <li>- Housing and Health</li> </ul>
Prevention	<ul style="list-style-type: none"> <li>- Making Every Contact Count</li> <li>- Smoking cessation and alcohol reduction</li> <li>- Workplace health</li> </ul>
Children's Young People and Maternity	<ul style="list-style-type: none"> <li>- Improving emotional health and wellbeing</li> <li>- Strengthening the offer of support for vulnerable groups</li> <li>- Improving the offer of care in maternity and early years</li> </ul>

## **5.1 *Development of the Neighbourhood Model***

- 5.1.1 The neighbourhood model is an integrated care model at a local level based around GP services. Each neighbourhood is based on groups of practices with a registered population of between 30,000 and 50,000. There are eight neighbourhoods across City and Hackney and the Neaman Practice is in the South West 2 neighbourhood.
- 5.1.2 There will be a neighbourhood management group consisting of GPs in the neighbourhood and an operational model that will be put in place. This allows neighbourhoods to tailor and focus services more on their specific neighbourhoods. Given the unique situation of the City and the Neaman Practice, the operational model will be bespoke for the City of London.
- 5.1.3 Work is currently underway to consider what the operational model will look like for the City of London / Neaman practice and considerations include:
- The social work input into the Neaman Practice
  - What services the Neaman may wish to call upon from the wider neighbourhood for example geriatrician services
  - How the voluntary sector can play a prominent role in the neighbourhood and how existing community support services can be drawn into the integrated approach
- 5.1.4 Development of the neighbourhood model is phased, and the first neighbourhood will go live in August 2018. As the neighbourhood model develops and matures there will be more opportunities to build stronger links with other services such as housing and schools.

## **6.2 *Pooled budgets for Continuing Health Care and Adult Social Care packages***

- 5.2.1 In February 2018, Members of the Integrated Commissioning Sub-Committee endorsed the pooling of Continuing Health Care (CHC) budgets and adult social care packages. This was then agreed by the Community and Children's Services Committee in April 2018.
- 5.2.2 The funding to be pooled is a proportion of the total CCG CHC budget, the budget for City of London Corporation adult social care packages (home care and accommodation-based support) and a contribution of funding for commissioning and brokerage support.
- 5.2.3 The pooling of the budgets also requires a number of processes and procedures to be put in place to facilitate decision making around the pooled budget. The development of this will start shortly but there are a number of specific considerations for the City of London Corporation. These include:
- How the existing decision-making structures within the Department may need to change

- How the needs of residents registered with a Tower Hamlets GP who require CHC will be considered

## **Risk Management**

7. The integrated commissioning programme has its own risk register. Workstreams are responsible for raising the risks for this risk register and red risks are reported to the ICB each month.
8. Any large transformation project also has its own risk register.
9. The City of London Corporation manages any integration risks specific to the organisation through the internal Integration Programme Board.
10. The pooling of budgets for CHC and adult social care packages will be governed by a S75 agreement which will include a new risk share agreement.

## **Corporate & Strategic Implications**

11. One of the key priorities of the Corporate Plan 2018-2023 is to contribute to a flourishing society with people enjoying good health and wellbeing.
12. Health and social care integration is an action of the Department of Community and Children's Services Business Plan.
13. Health and social care integration is a priority in the Joint Health and Wellbeing Strategy.

## **Implications**

### ***Legal implications***

14. The Comptroller & City Solicitor has been involved throughout the development of the integrated commissioning arrangements and the associated legal agreements.

### ***Financial implications***

15. The specific financial implications related to pooling of budgets are set out in the committee report under background papers.

### ***Procurement implications***

16. The Procurement Team have been consulted throughout on the proposals for integrated commissioning. As proposals develop, procurement will be involved in further discussions.

### ***Health Implications***

17. One of the key objectives of the integrated commissioning arrangements is to

improve health and wellbeing outcomes for the residents of the City of London and Hackney.

### ***Equalities Implications***

18. An Equalities Analysis was carried out as part of the development of the overall integrated commissioning arrangements. Analysis is also carried out as part of business cases for specific proposals, such as the new approach to commissioning and funding CHC and adult social care packages. No negative impacts on any particular protected characteristic under the Equality Act 2010 have been identified.

### **Conclusion**

19. The City of London Corporation entered into integrated commissioning arrangements with City and Hackney CCG in April 2017.

20. This report sets out some of the priorities that workstreams are currently working to deliver and provides details on two current key pieces of work – the development of the neighbourhood model and the pooling of budgets for CHC and Adult Social Care packages of care.

### **Appendices**

- None

### **Background Papers**

Community and Children's Services Committee 13 April 2018 Item 5 – Integration of Continuing Health Care and Adult Social Care Budgets

### **Ellie Ward**

Integration Programme Manager, Department of Community and Children's Services

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<b>Committee:</b>	<b>Date:</b>
Health and Social Care Scrutiny Committee	1 May 2018
<b>Subject:</b> Annual Workplan	<b>Public</b>
<b>Report of:</b> Town Clerk	<b>For Decision</b>
<b>Report author:</b> Joseph Anstee, Committee & Members' Services	

## Recommendation

Members are asked to agree the frequency of meetings and dates for 2018/19 meetings, to consider the principle of including items that ensure regular internal scrutiny is carried out, and review the Committee's current workplan.

## Main Report

### Meeting Dates

1. The Committee meets on average three times a year, with one additional date in the summer months for a visit.
2. It is proposed that this schedule be retained with the following dates:
  - 6 November 2018, 11.30am
  - 27 February 2019, 11.30am
  - 15 May 2019, 11.30am

### Workplan

3. Last year, Members agreed that a mixture of Social Care and Health issues be considered at each Health and Social Care Scrutiny meeting with Members of the Committee (including the co-opted Member) retaining the ability to call in issues or services at any time.
4. This reflected the need for a flexible work programme, as other priorities can emerge during the year at relatively short notice, and that the timing of a number of local and regional consultations from other health and social care bodies can also be subject to change.
5. To ensure that the Committee fulfils its remit of scrutinising internal as well as external services Officers propose that the following items should normally be considered at each meeting:
  - At least one Social Care issue, from a service commissioned or provided by the City of London Corporation
  - Two to three health issues, at least one from a public health service commissioned by the City of London Corporation

6. Members are asked to note that, with the agreement of the Chairman, it may be necessary to vary this arrangement to take account of the factors set out in Paragraph 4.
7. Future agendas can be discussed at each meeting to raise any issues and to determine which topics or services should be considered at the next meeting, to ensure the Committee is able to anticipate emerging issues and priorities in health and social care.

### **Conclusion**

8. Members are asked to consider the structure of the workplan, as proposed at paragraph 5, and whether the frequency of meetings should remain at three times a year along with a summer visit.
9. The current workplan is attached as an appendix to this report.

### **Appendices**

- Current Annual Workplan

### **Joseph Anstee**

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## Health & Social Care Scrutiny Committee – Annual Workplan

Members are reminded of the agenda items suggested at the 8<sup>th</sup> May meeting and the scheduled dates for future meetings of the Committee. Future agendas can be discussed at each meeting to raise any issues and to determine which topics or services should be considered at the next meeting.

Subject List Brought Forward	Date Proposed	Information	To be considered by the Committee
NHS 111 Service	13 February 2018	To discuss the rollout of the NHS 11 service in the City of London.	1 May 2018
Employment of Individuals with Learning Difficulties	30 October 2017	To discuss work going on in the Corporation to encourage employment and address stigma.	1 May 2018
Babylon GP Service	13 February 2018	Officers to look into the impact of the Babylon GP service and see if a report could be presented.	TBC
Accountable Care Officer	1 February 2018	The accountable care officer or a senior member of STP staff to be invited to a future meeting to discuss the changing role of the CCG and the new East London Healthcare Partnership.	TBC
Royal London Dental Hospital/Barts Health	8 May 2017	Officers to look into and see if a report could be presented regarding appointments systems.	TBC
Post-election Health Announcements	8 <sup>th</sup> May 2017	Headline changes to be circulated electronically to the Committee after elections, and details to be presented when available.	Ongoing

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<b>Committee(s):</b> Health and Social Care Scrutiny Committee	<b>Date:</b> 1 May 2018
<b>Subject:</b> Inner North East London Joint Health Overview and Scrutiny Committee Update	<b>Public</b>
<b>Report of:</b> NHS North East London Commissioning Alliance	<b>For Information</b>

## **Main Report**

As members may be aware, the last meeting of the Inner North East London Joint Health Overview and Scrutiny Committee, originally scheduled for 28 February 2018, was cancelled due to adverse weather conditions. Most local authorities and the NHS were subject to a period of purdah before the local elections on Thursday 3 May 2018, and an attempt to reschedule the meeting before the beginning of this period was unsuccessful.

In lieu of a rescheduled meeting, a letter was sent to the NHS North East London Commissioning Alliance containing questions relating to the agenda items for the cancelled meeting. The questions related to the Accountable Care System, the Joint Commissioning Committee, East London Health Care Partnership (ELHCP) Finance, ELHCP Cancer Services, and Estates. The Committee has been provided with the letter sent out, and the letters and documents received in response from the NHS to the JHOSC.

## **Recommendation(s)**

Members are asked to note the report and documents provided on behalf of the JHOSC.

## **Papers attached**

- Letter sent on behalf of the INELJHOSC to NHS
- North East London Commissioning Alliance and ELHCP response to INELJHSOC letter
  - Appendix A – QIPPs and CIPs
  - Appendix B – ELHCP Principles of Payment
  - Appendix C – Estates Update

## **Joseph Anstee**

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## Inner North East London Joint Health Overview & Scrutiny Committee

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Reply to: daniel.kerr@towerhamlets.gov.uk

March 2018

Dear Jane Milligan,

### Questions to NHS relating to the agenda items for the cancelled meeting of the Inner North East London Joint Health Overview & Scrutiny Committee (INEL JHOSC) on 28 February 2018

As the INEL JHOSC meeting had to be cancelled because of the inclement weather conditions the Committee would like to take up your offer to submit the following questions which we had intended to ask at the meeting.

#### Item 4 - Single Accountable Officer Spotlight

- 1) The one tier of governance not mentioned once in this item is the Accountable Care System. There is some confusion about whether there will be a number of borough level systems across WEL areas, or if there will be just one that runs at a WEL level. Could you please confirm?
- 2) Where does the buck stop in a borough when it comes to deciding "the patients' best interests" and where financial risk should be shouldered? Is it with the CCG MD or the SAO?
- 3) What if a borough decides they want to go it alone?
- 4) There aren't many specifics in this document. You state "*Working together means reducing fragmentation and duplication by adopting common approaches, and doing things where appropriate and beneficial to do so*" (p.20). What are examples of these and how is it decided which to do together or separately? And what happens if there is a disagreement on this? How will a disagreement be resolved?
- 5) You say "no plans to facilitate money being moved from one CCG area to another" (p.26) yet we are aware from City and Hackney CCG Governing Body meetings over the past 18 months or so that City and Hackney has been asked a number of times to use part of its surplus to provide financial balance across the STP patch.

- 6) We do not feel that Hackney residents will see the new NEL NHS 111 services as better than what they already receive from CHUHSE. What improvements in the service do you expect from the new model and what reassurances can you give to residents about maintaining the standard of service they currently receive?
- 7) What will the additional combined cost be for these new tiers of governance?

#### **Item 4 – Joint Commissioning Committee (tabled paper)**

The Committee would like to note that an issue this important appears as an additional tabled item and recommends that this this requires full agenda item at the next meeting.

- 1) How will the role of the Joint Commissioning Committee differ from the NEL Commissioning Alliance? Why are two bodies required and how do these new bodies relate to the ELHCP?
- 2) Can you provide more detail about who will sit on the JCC, what their responsibilities will be and how often the committee will meet?
- 3) What consultation has there been with Boroughs in setting up the JCC? What has their feedback been and how has this been incorporated into the structure of the final committee?
- 4) How will the JCC work with local authorities? The only local authority reps are 1 commissioning officer from each borough. Whilst we acknowledge that this is an NHS body can you explain what steps you will take to make it both more transparent and accountable to local residents considering it will be recommending very significant commissioning decisions.
- 5) Following on from question 4, what will each individual borough's "line of sight" be to decisions taken at the JCC? Can you provide some examples of decisions that we expect to be taken at the JCC in future
- 6) It is unclear what percentage of each individual CCG budget the JCC will have control over. The briefing paper seems to indicate that there is a change to the CCG constitution meaning the JCC will exercise such commissioning powers as are delegated to it by the [CCG] governing body. What powers are being delegated to it?

#### **Item 5 – ELHCP Finance**

- 1) The report feels incomplete as a summing up of the financial health of the current stage of the STP. Is an update on funding and ability to meet savings or income generation targets available for the various transformation plans the Committee has been informed of? Are there any specific areas that are over or under-achieving in this sense?

- 2) There is very significant variance in the financial position of the 7 CCGs and the 5 Acute Trusts between Inner and Outer NEL. If the new centralising finance structure levels this out Inner NEL will lose out significantly. How will ELHCP respond to residents of INEL boroughs who might argue that their CCGs statutory responsibility is primarily to them?
- 3) ELCHP Payment development work – 1st bullet point (i) *Agreed should introduce evolutionary changes to payment*. What are these changes? (ii) *Longer term payment*. What are these? What responses were received on the consultation about capitated budgets? And how has this fed in to developments?
- 4) In reference to the system bridge diagram, even if we achieve all our targets, we are still left with an £81 mill deficit. How will that be addressed?
- 5) How far can you make £20mill of efficiency savings without compromising quality or reach of services?
- 6) What do the 13 co-developed ‘principles of payment’ referred to? Which groups have endorsed them and how many people do they represent?
- 7) You say that payment reform has already been tested in the Vanguard area of Tower Hamlets. What did this consist of and what were the outcomes?
- 8) What support will there be for CCGs in deficit or with red ragged risks and how will this affect the resources of those who aren't?
- 9) In the RAG assessment, what do you mean when you talk about unidentified risks? How can these be measured if they're unidentified?
- 10) The Barts Health Trust has high levels of deficit and yet it would appear to be the BHR area that is in deficit. What are the specific challenges to dealing with this?
- 11) Could you please provide an update on King George's? When will a decision be made on the downgrading of services?
- 12) The government has now delayed plans to lay Regulations on ACOs before Parliament until a public consultation completes and the Health Select Committee reports. Also, the two Judicial Reviews on STPs are making progress. In the High Court last week one of the campaigns won a cap on costs should they lose. What's ELHCP's contingency plan here if these succeed?

## Item 6 – ELHCP Cancer

- 1) Our STP might have the poorest performance across certain cancer indicators but it's clear that issues are at their most acute in Newham. What extra resources or plans are there to address prevention and look at improving screening levels, particularly within the communities who are particularly poorly represented? What research has been carried out into these issues?
- 2) In particular what work is being done to address levels of bowel cancer screening, breast cancer screening and lung cancer screening (particularly in the Asian community)?
- 3) What work is being done to address workforce gaps
- 4) Many studies have shown that there is lower awareness of cancer symptoms amongst BME communities and those lower down the socio-economic scale. Thinking of the NEL populations can we have some more details about the education programmes planned by the ELHCP (pg10).
- 5) Can you provide further information on how the pathway works for those who will go on to die from cancer? Work stream 5 talks mainly about recovery and living with disease. How are patients passed on, supported and managed into end of life care if their prognosis isn't good.
- 6) What are our statistics like for early/scheduled/routine screening take up i.e. cervical smears, mammograms? How does this compare with national and London statistics?
- 7) Hackney Public Health team has published a Migrant Health Needs Assessment. Could this be of use in designing services? There are shocking statistics on cervical screening take up by BAME women.
- 8) Members in Hackney performed a review a few years ago on 'cancer survivors' and one thing we found was that the Acute sector was pushing against any spend on wellbeing approaches (e.g. alternative therapies, social prescribing etc.) for those living with and beyond cancer. These very beneficial therapies and group sessions (often provided via Macmillan) kept people well and motivated and out of A&E but their funding was drying up. Unless there is serious movement of some funding from Acute to Prevention isn't this just rhetoric?
- 9) We participated in various JHOSCs on reconfiguration of cancer services the focus of which was broadly to consolidate specialist cancer services at St Barts, UCL, Royal Free to maximise expertise and drive up survival rates with the remaining hospitals being effectively reduced to providing follow-up care. Outer NEL was very

resistant to these changes but Inner supported them, for obvious reasons. How has this worked out? Have the survival rates for Urology (one of the initial areas of focus) gone up?

## **AOB**

- **Estates**

The Committee asked to receive a brief verbal update on Estates, with a view to a more detailed agenda item coming to the Committee meeting in the summer. Could you please provide an update on the progress made in this area, detailing how the strategy is set to be developed (detail timelines, meetings etc.), and how local authorities will be engaged?

- **Questions from the public**

- 1) First, given the lack of recent substantive information on the NEL Health and Care Partnership website, we would be grateful if representatives from the Partnership can provide an update on the current plans and progress on developing:
  - Accountable Care Partnerships (that, we understand, may also be called Integrated Care Partnerships now)
  - Integrated Care Systems and
  - Accountable Care Organisations across the North East London footprint.
- 2) What position does the INEL JOSOC take on these developments and how is the Committee ensuring scrutiny, given the increasing public concerns emerging about these models for so-called 'integrated care'.

Yours sincerely,

Councillor Clare Harrisson  
**Chair of Inner North East London Joint Health Overview and Scrutiny Committee**

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Councillor Clare Harrisson  
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3 April 2018

Dear Councillor Harrisson

Thank you for your letter regarding questions for the local NHS following the cancellation of the INEL JHOSC due to be held on 28 February 2018. I am sorry that the meeting was cancelled due to adverse weather conditions and am happy to attend a future meeting if helpful.

Before answering the committee's questions, I wanted to explain the difference between the East London Health and Care Partnership (ELHCP) and the NHS North East London Commissioning Alliance (the alliance), which are two separate organisations, both led by me, as executive lead and accountable officer respectively, as it appears there may be some confusion.

ELHCP is the partnership set up to deliver NEL sustainability and transformation plan and its membership consists of the seven CCGs, eight councils, three hospital trusts (the Homerton, Barts Health and BHRUT) and two mental health and community trusts (NELFT and ELFT). I am the executive lead of ELHCP – I act as the convener of the Partnership bringing members together and providing the leadership to deliver the plan.

The Alliance is the name for the seven CCGs across north east London working together. I am the accountable officer (like a chief executive) for each of the seven CCGs and was appointed permanently in November 2017. My role is to make sure the CCGs meet all their legal / statutory responsibilities. I am responsible for ensuring that the CCGs fulfil their duties to exercise their functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of local people while maintaining value for money.

### **Single accountable officer/Alliance**

In October 2017 we ran an event for providers and commissioners across the WEL system to look at synergies between the borough-based work, and it was agreed that:

- There is a clear need to align WEL level and borough level work as we move forward and to proceed in line with the principle of subsidiarity (i.e. leadership should be devolved to the local level wherever possible).

There are many areas of change where it is natural for leadership to be at borough level but also some areas where the opportunity to work consistently across a bigger footprint to plan and implement change is of value. We are working across organisations at north east London (including with local councils) to establish what is done at each 'level' of the system: borough, WEL, NEL and London-wide. To be clear however, CCGs remain the accountable organisation and this is not changing.

The majority of decision making will continue to be at a local level (CCG governing body), and will be made by clinical leads, supported by the accountable officer and the managing director.

As previously advised, we expect the commissioning divide to be as follows:

<b>Local commissioning</b> (at individual governing body level)	<b>NEL commissioning</b> (seven CCGs through the JCC)
All integrated commissioning with local authorities for example adults, children, prevention Provider development Primary care development Contracting, prescribing, pharmacy Contracting and commissioning with major providers: Community services contracting Mental health contracting Acute commissioning and contracting	Commission services jointly – e.g. London Ambulance Service and integrated urgent care, specialist commissioning Alignment of commissioning strategies (e.g. urgent and emergency care, mental health, planned care) Assurance

All CCGs in north east London have signed up to the NEL commissioning alliance, and share an accountable officer. We would try very hard to resolve any issues before a CCG reached the stage of wanting to 'go it alone'. We have also built in safeguards around local decision making at the JCC. For example, decisions can only be reached when all CCGs are represented and must be reached unanimously. This helps support our consensual approach.

I'd also like to point out that the Alliance cannot move money permanently between CCGs. One of the benefits of working together however, is that there is an opportunity to look at the potential to share financial risk where appropriate. This would take the form of a loan, for example, in order to provide financial balance. This is not to the detriment of the people of Hackney and the City of London and would not result in less money being spent on health services in the area.

There are no additional costs for these new tiers of governance. All CCGs have committed to delivering these changes within the current running cost allocations. Where we anticipate doing things once across NEL, any efficiencies will allow us to focus resources elsewhere particularly on the priorities for driving improvements in the health outcomes for local people

### **Joint Commissioning Committee**

The JCC is the decision making body of the NEL Commissioning Alliance, like the way a governing body is the decision making body of the CCG. It is accountable to individual CCG governing bodies. The JCC feeds into the ELHCP.

As previously advised, the membership of the JCC is as follows:

<b>CCG</b>	<b>Chair</b>	<b>Lay member</b>	<b>LA rep (non-voting)</b>
<b>Barking and Dagenham</b>	Kash Pandya (acting chair until elections complete)	Kash Pandya (Specialty: Audit)	Mark Tyson, Commissioning Director, Adults' Care & Support
<b>Havering</b>	Dr Atul Aggarwal	Richard Coleman (Specialty: PPI)	Mark Ansell, Public health consultant
<b>Redbridge</b>	Dr Anil Mehta	Khalil Ali (Specialty: PPI)	Adrian Loades, Corporate Director of People
<b>City and Hackney</b>	Dr Mark Ricketts	Sue Evans (Specialty: Audit)	Ellie Ward, Programme Manager (City of London)  Gareth Wall, Head of Public Health (Hackney)
<b>Waltham Forest</b>	Dr Anwar Khan	Alan Wells (Specialty: PPI)	Linzi Roberts-Egan, Deputy Chief Executive - Families
<b>Newham</b>	Dr Prakash Chandra	Andrea Lippett (Specialty: Governance)	Grainne Siggins, Executive Director - Strategic Commissioning
<b>Tower Hamlets</b>	Dr Sam Everington	Noah Curthoys (Specialty: Governance)	Denise Radley, Corporate Director: Health, Adults and Community.

**Other voting members:**

- Jane Milligan, accountable officer

**Non-voting members:**

- Financial representative
- Secondary care consultant
- Registered nurse

It is intended that the JCC will meet bi-monthly, alternating with individual CCG governing body meetings.

We held a NEL workshop as part of developing the Alliance / JCC in December 2017 to which all local authorities were invited. Part of the local authority feedback was to make sure that all LAs were represented at the JCC and that it should be LAs that decide on who should be the representative. We adopted this approach in setting up the JCC. All local authority chief executives were invited to nominate their representative on the JCC, so they could ensure they were represented by the best person. This was solely a Council decision.

Like individual CCG governing body meetings, the JCC will meet in public – the public are welcome to attend the JCC and the JCC meeting dates and agenda items will be promoted to stakeholders and the public – we would welcome the JHOSC's suggestions about how best to do this. Members of the public will also be able to ask questions at the JCC.

The chair and lay member are expected to report back on the JCC to individual CCG GBs. The JCC is accountable back to the individual CCG governing bodies through their representatives on the JCC. We will have this as a standing item on each CCG governing body.

In terms of what percentage of each individual CCG budget the JCC will have control over, the JCC does not work like this. It has been established to enable collaborative commissioning and allow decisions to be made at a NEL-wide level as set out earlier

## **NHS 111**

The new integrated 111 service starts on 1 August 2018, and will have a range of clinicians available that will be able to provide advice over the phone which will mean many people will not need to then visit A&E, or another urgent care service. It will be provided by London Ambulance Service (LAS), which has extensive experience of delivering urgent and emergency care and advice, and already deliver a similar service in other parts of London.

The main driver for the change in the service is to ensure that everyone in north east London has access to the same benefits of the new integrated NHS 111 service. We want the service to be easy to use and understand, and provide a seamless transfer to a local urgent care service where people need to see a clinician in person, by booking appointments with the right service for them.

This contract will be carefully monitored and LAS, like all providers, will be held to account for its quality and performance.

## **ELHCP finance**

The projected 2017/18 position within the attached JHOSC paper is currently being revised. The position includes savings and transformations already being implemented in 17/18. Appendix A shows these.

For 2018/19 planning, there are currently planned savings of:

£88.5m - CCG QIPP (Quality, Innovation, Productivity and Prevention)

£24.4m - Specialised Commissioning

£130.3m - Trust CIP (Cost Improvement Programme)

Totalling £243.2m planned savings (net after accounting for investments)

The plans for 2018/19 also assume £55m transformation funding. Being awarded Sustainability and Transformation Funding is dependent on organisations achieving their 2017/18 control total.

In terms of the variance in financial position, there is a strong correlation between the distance from CCG target allocation and their respective financial positions. The inner NEL borough CCGs are broadly above target and are able to generate historic surpluses, while the outer borough CCGs are broadly below or close to target and have experienced more distressed financial situations, although this situation is being addressed with the national NHSE policy of 'pace of change' and gradual movement towards target.

The two largest acute providers in NEL (Barts and BHRUT) have experienced financial difficulties for a variety of complex reasons. There are no plans to 'level out' the resource allocation between the organisations within NEL. CCG allocations are set by NHSE and can only be altered by agreement with the governing body of the CCG in question. In recent years the CCGs in NEL have operated a joint risk share arrangement agreed by all of the CCG governing bodies which supports financial stability for the benefit of all NEL organisations.

The seven CCGs working as an alliance under a single AO are exploring ways in which management costs can be reduced and resources used more efficiently. In time this may include more sharing of resources and closer collaboration.

This relates to the administration and reporting of financial and other commissioning information and would not impact on the allocation of resources, the responsibility for which remains with the CCG governing bodies.

### **ELHCP payment development work**

Development to payment have focused on two main areas for 2018/19:

1. Sharing gains and supporting efficient use of system resource: Where costs are currently subject to pass through arrangements the ELHCP payment development group recommends introducing gain share arrangements (via a block contract). This allows providers and commissioners to benefit from efficiencies and innovation that support more effective and efficient use of system resource. Proposed changes will focus on payment for patient transport and pass through costs for drugs and devices.
2. Further changes for 2018/19 payment will be focused on supporting the transformation of outpatient care, which is in line with the steer from ELHCP clinical senate and board. Clinical and finance colleagues across ELHCP are working together to clarify the clinical objectives and develop options for how payment can best support them. Where agreements can be made in time for the start of the contract they may apply from that point. In other cases within year changes may apply, this will represent a step forward and support clinical colleagues working to transform care.

We are developing options for longer term payment reform based on feedback from the consultation; input from the ELHCP Clinical Senate and Board and evidence of best practice from other health and care systems. Finance and clinical colleagues are focused on developing contract agreements for 2018/19. Following agreement of relevant contracts and contract amendments, the ELHCP payment development group is planning to reengage with system leaders to consider options for longer term payment development, and to consider enablers of change that may need to be put in place in the near term.

Capitated payment was supported by a significant minority of respondents and was also the payment approach suggested most often in feedback. However, other respondents were concerned that a capitated payment approach may not enable enough emphasis on quality or patient outcomes.

The consultation process enabled partners to kick off a discussion across the ELHCP about how they can start to work together differently to meet collective challenges and serve our population better. Feedback from the consultation process has highlighted areas where further work is needed to inform system decisions regarding payment development. Further, this information has helped the system to explore the benefits and risks of core payment options in greater detail as well as understand the feasibility of introducing possible payment approaches.

Other health and care systems have addressed concerns about capitated payment by including a component of payment linked to outcomes, but we will need to consider what is right for our local circumstances. We will be taking all views into account when developing payment options.

Payment reform has not been tested at scale in any area within ELHCP. However, the Tower Hamlets Together Vanguard initiated work to consider options for payment reform. This work:

- (i) Looked at examples of how payment has been used in other health and care systems to support care improvement (NHS and international examples)
- (ii) considered different payment approaches and how they may work within a local context.

The thinking and learning from that work fed into thinking of the consultation, so the East London system could benefit from the work of the vanguard, but was able to shape next steps based on views and feedback from across the East London patch.

Further information about the 13 co-developed 'principles of payment' is attached as Appendix B.

### **Financial challenges across north east London**

Given the current financial position of the system as a whole the control total target for 2018/19 will not be a breakeven position. While we don't yet have the details of the overall control total it is not anticipated that it will be more challenging than a net deficit of £81m. This deficit will need to be gradually closed over the next few years through further efficiencies

In terms of making efficiency savings without compromising quality or reach of services, there is a sign off process required for CIPs to ensure that they do not impact on quality. CIPs can come from a number of different areas e.g. procurement efficiencies through reduced prices for consumables, drugs etc; reduction in levels of agency expenditure through improving recruitment and retention which actually improves quality and so on. The total budget across the STP footprint is in excess of £3bn so this represents only a small percentage of savings out of the total expenditure.

There is an established CCG risk share framework which has been in place for several years. Utilisation of the risk share requires sign off by the relevant boards and an objective financial analysis being undertaken to demonstrate the requirement and drivers for it.

The RAG assessment refers to unidentified QIPP, the level of unidentified QIPP is the difference between the level set out in the CCG operating plans as being required and the level of actual identified schemes which have supporting plans.

### **Deficits**

Barts Health has the highest deficit of all the providers and BHR CCGs have the highest deficit out of the CCGs. The bulk of the BHR CCGs costs relate to the contract with BHRUT and are not therefore related to the Barts financial position. Having deficits in these two areas is a challenge for ELHCP, and the drivers of each of them are different. Barts needs to identify additional efficiencies in order to operate within its income levels. There are also on-going legacy issues predating the merger in relation to a number of things including the additional costs associated with the PFI.

Within the BHR patch there is a need for the CCGs to identify alternative ways of providing services to reduce the level of expenditure required to service the healthcare needs of its population. The ability of the provider (BHRUT) to remove costs from its cost base also needs to be factored into these service redesign considerations to avoid it being left with stranded costs and the deficit then shifting from the CCGs to the provider instead of being resolved.

### **King George Hospital update**

The decision to replace the A&E with an Urgent Care Centre (UCC) was taken in 2011 and much has changed since then. Our east London population is growing and ageing, demand for NHS services continues to increase, and we face ever-increasing challenges as a healthcare system.

Following on from the recommendations in a strategic review undertaken recently by PWC, which is published on our [website](#), we now need to consider more options for the way we deliver urgent and emergency care across our communities. This will allow us to look at how this care is provided locally, taking these challenges into account.

It is important we consider how we deliver these services across both King George and Queen's hospitals to enable us to deliver care in the best way for patients. Exploring more options will enable us to do this.

This is now an opportunity for us to work with our clinicians, patients, partners and stakeholders to develop a plan to make it easier for people to access the right services, deliver care sustainably, and address the challenges such as an ageing population and increasing demand on A&E services. It is important we involve local authorities in this, and we will be inviting Barking and Dagenham, Havering, Redbridge, Newham and Waltham Forest councils to nominate representatives for this shortly.

The KGH strategic outline case is still being considered by NHS Improvement. We hope this will be concluded soon, allowing us to move to the next stage and the development of the new plan.

The model we adopt for KGH must provide excellent, safe patient care and meet the needs of local people now and well into the future, taking into account the expected growth in population. In the meantime, the existing A&E at King George Hospital will continue to operate as now.

## **Cancer**

You raise concerns about performance in Newham. Newham has its own local cancer taskforce with a variety of stakeholders represented including borough, CCG, ELHCP, charities, patients and community services. Out of this has developed the Newham CAN! (Cancer awareness network) who are very active locally. Since 2014 Community Links (a Newham-based charity organisation that delivers community projects) has been commissioned to call patients in Newham who have not returned their bowel kit. All practices in Newham used this service – except two, who call people themselves. This has shown a significant improvement in uptake to bowel screening from 35% to 45%. There are plans for this to continue. In planning both population awareness and education interventions and screening uptake interventions for 2018/19 a range of evidence is being reviewed to ensure they are effective.

Evidence published in 2016 shows four effective interventions to increase screening uptake in less well-served populations:

1. Pre-screening reminders
2. General practitioner endorsement
3. More personalised reminders for non-participants
4. More acceptable screening tests

The NHS bowel screening programme provides GP endorsed invitations in London, and is committed to introducing a simpler test using the faecal immunochemical test (FIT) instead of the faecal occult blood test (FOBt) in 2018/19 (Options 2 and 4). Options 1 and 3 can be introduced at a local level as part of plans for 2018/19.

There is currently no lung cancer screening programme in England. There may be a trial of this in 2018 where CCGs/boroughs with poor one-year survival will be encouraged to take part. Waltham Forest has the lowest rate in east London. We await further details on this as others may also fall in to this category. We have however been working with both the lung cancer and TB teams at Newham General Hospital to improve the very early part of the pathway to achieve a faster diagnosis.

A similar calling service has recently been introduced for women undergoing breast screening but there will be temporary suspension of this while the local breast screening services switches to new management. There is a national 'be clear on cancer' campaign currently running for breast cancer awareness.

As part of planning for 2018/19 we are working with screening commissioners and community links about methods to reach hard to reach groups. Team members are meeting with community voluntary services to look at opportunities to work in local communities.

### **Cancer education programmes**

We are planning a number of interventions to raise the awareness both of cancer signs and symptoms but also on lifestyle choices to reduce your risk of getting cancer:

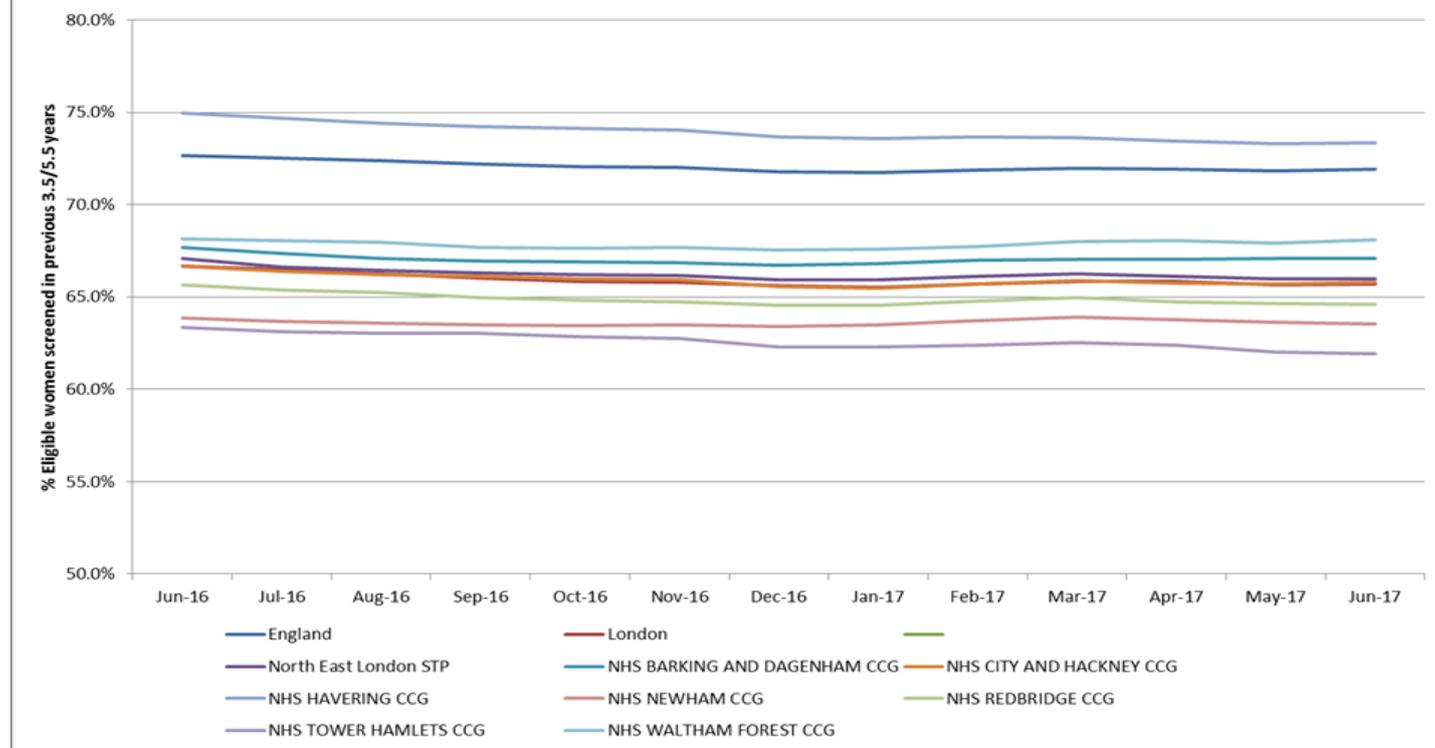
- Teachable moments: we are testing a proof of concept across the Barts and Homerton footprints throughout March 2018. Those invited have been referred on a cancer pathway but got the all clear so are invited to a healthy lifestyles event. There has been good uptake with positive feedback and more are planned.
- Using local pharmacies across City and Hackney to run awareness campaigns from April to June 2018. This will involve pharmacists and counter assistants having conversations to empower people to attend their GP if they are purchasing red flag medicines. They will be given training to do this. If successful further roll out will follow.
- Roll out of cancer research UK's "talk cancer" programme through community and voluntary services across east London. [www.cancerresearchuk.org/health-professional/awareness-and-prevention/talk-cancer](http://www.cancerresearchuk.org/health-professional/awareness-and-prevention/talk-cancer)
- Providing training and development to Community Links staff
- In discussions to make cancer a theme for the various east London summer festivals to enable awareness and encourage prevention messages and education.

In terms of how the pathway works for those who will go on to die from cancer, all people who receive a diagnosis are presented to a multi-disciplinary team (MDT) meeting where their treatment options are considered. If the prognosis is poor and the treatment decision is for best supportive care only their care will be picked up by the palliative care team who are core members of the MDT. They are also allocated a key worker to support them through their pathway irrespective of prognosis.

We recognise there is more work to do on end of life care across the system and are in the process of establishing a stand-alone palliative care workstream.

## Cancer statistics

### Cervical Screening Coverage in women aged 25 - 64 by CCG: June 2016 - June 2017

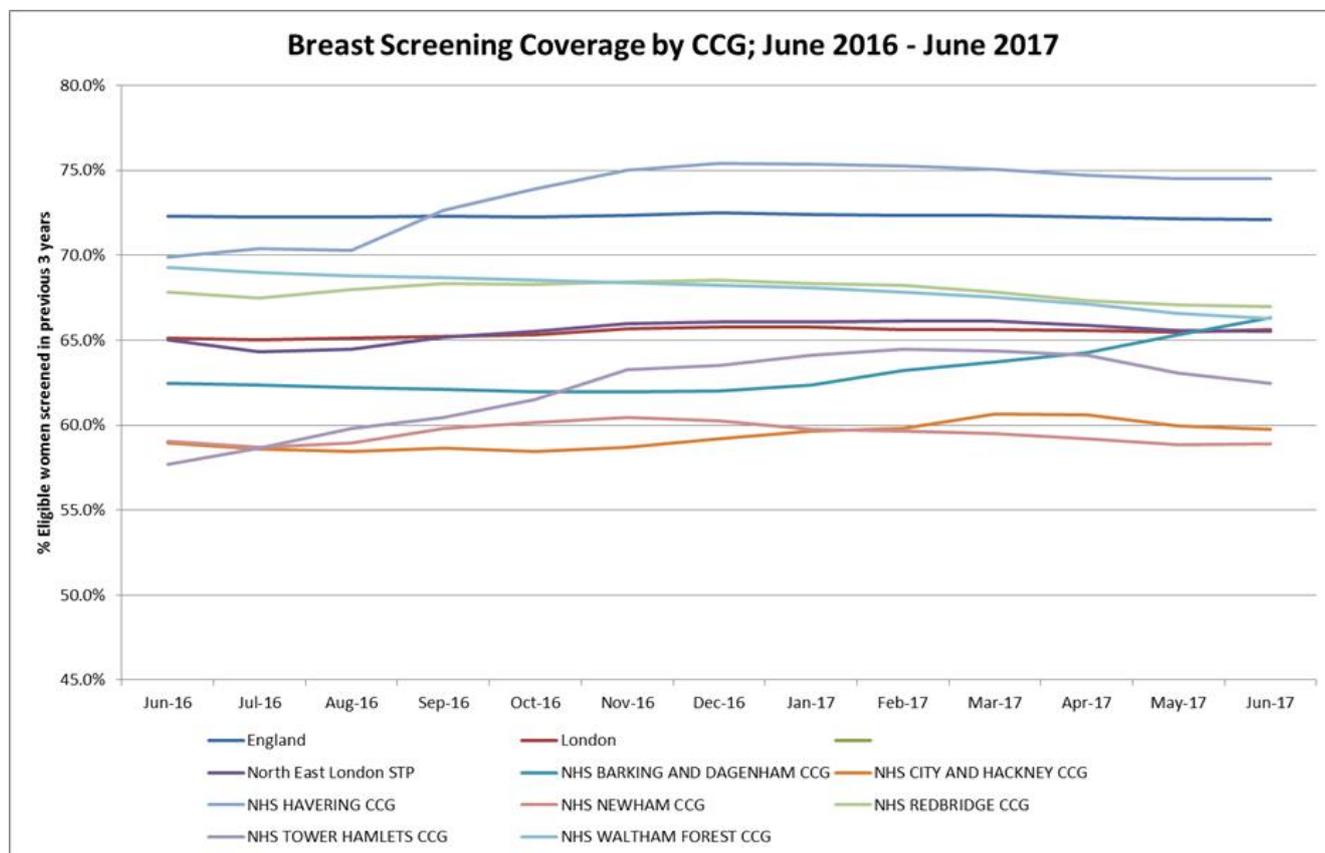


Cervical Cancer Target Age (25-64) 3.5/5.5Y Coverage	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
England	72.7%	72.5%	72.4%	72.2%	72.1%	72.0%	71.8%	71.7%	71.9%	72.0%	71.9%	71.8%	71.9%
London	66.7%	66.5%	66.3%	66.0%	65.9%	65.8%	65.6%	65.5%	65.7%	65.8%	65.8%	65.7%	65.7%
<b>North East London STP</b>	67.1%	66.6%	66.5%	66.3%	66.2%	66.2%	65.9%	65.9%	66.1%	66.2%	66.1%	66.0%	66.0%
NHS BARKING AND DAGENHAM CCG	67.7%	67.4%	67.1%	66.9%	66.9%	66.9%	66.7%	66.8%	67.0%	67.0%	67.0%	67.1%	67.1%
NHS CITY AND HACKNEY CCG	66.7%	66.4%	66.2%	66.1%	66.0%	65.9%	65.6%	65.5%	65.7%	65.9%	65.8%	65.7%	65.8%
NHS HAVERING CCG	75.0%	74.7%	74.4%	74.2%	74.1%	74.0%	73.7%	73.6%	73.7%	73.6%	73.4%	73.3%	73.3%
NHS NEWHAM CCG	63.8%	63.7%	63.6%	63.5%	63.4%	63.5%	63.4%	63.5%	63.7%	63.9%	63.8%	63.6%	63.5%
NHS REDBRIDGE CCG	65.7%	65.4%	65.2%	65.0%	64.8%	64.7%	64.6%	64.5%	64.8%	65.0%	64.7%	64.6%	64.6%
NHS TOWER HAMLETS CCG	63.3%	63.1%	63.0%	63.0%	62.8%	62.7%	62.3%	62.3%	62.4%	62.5%	62.4%	62.0%	61.9%
NHS WALTHAM FOREST CCG	68.2%	68.0%	67.9%	67.7%	67.6%	67.7%	67.6%	67.6%	67.7%	68.0%	68.0%	67.9%	68.1%

Cervical Cancer Higher Age (50-64) 5.5Y Coverage	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
England	78.0%	77.9%	77.8%	77.7%	77.6%	77.5%	77.3%	77.2%	77.2%	77.2%	77.2%	77.0%	77.0%
London	76.3%	76.2%	76.0%	75.8%	75.7%	75.6%	75.4%	75.3%	75.3%	75.3%	75.3%	75.1%	75.1%
<b>North East London STP</b>	78.4%	78.2%	78.0%	77.8%	77.8%	77.7%	77.5%	77.4%	77.4%	77.4%	77.3%	77.2%	77.2%
NHS BARKING AND DAGENHAM CCG	76.0%	75.8%	75.7%	75.9%	75.5%	75.3%	75.2%	75.2%	75.3%	75.2%	75.2%	75.3%	75.4%
NHS CITY AND HACKNEY CCG	76.3%	76.2%	76.1%	75.9%	75.9%	75.7%	75.4%	75.3%	75.3%	75.3%	75.3%	75.3%	75.4%
NHS HAVERING CCG	79.8%	79.7%	79.4%	79.4%	79.4%	79.4%	79.2%	79.2%	79.2%	79.1%	79.1%	79.0%	79.0%
NHS NEWHAM CCG	78.7%	78.7%	78.5%	78.2%	78.1%	78.1%	77.9%	77.8%	77.7%	77.7%	77.6%	77.4%	77.2%
NHS REDBRIDGE CCG	78.4%	78.2%	78.1%	78.0%	77.8%	77.6%	77.4%	77.4%	77.4%	77.5%	77.4%	77.2%	77.2%
NHS TOWER HAMLETS CCG	77.7%	77.6%	77.5%	77.4%	77.3%	77.2%	76.7%	76.7%	76.7%	76.7%	76.6%	76.4%	76.2%
NHS WALTHAM FOREST CCG	79.5%	79.5%	79.4%	79.2%	79.1%	79.0%	78.9%	78.9%	78.9%	78.9%	78.9%	78.7%	78.8%

Cervical Cancer Lower Age (25-49) 3.5Y Coverage	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
England	70.2%	70.0%	69.8%	69.6%	69.5%	69.4%	69.2%	69.2%	69.4%	69.5%	69.5%	69.4%	69.5%
London	63.6%	63.3%	63.1%	62.8%	62.6%	62.6%	62.4%	62.3%	62.5%	62.7%	62.7%	62.6%	62.6%
<b>North East London STP</b>	63.8%	63.2%	63.1%	62.9%	62.8%	62.8%	62.5%	62.5%	62.8%	63.0%	62.8%	62.7%	62.7%
NHS BARKING AND DAGENHAM CCG	65.2%	64.8%	64.5%	64.4%	64.3%	64.3%	64.1%	64.2%	64.5%	64.6%	64.5%	64.6%	64.5%
NHS CITY AND HACKNEY CCG	64.3%	63.9%	63.7%	63.7%	63.5%	63.5%	63.1%	63.0%	63.3%	63.5%	63.3%	63.3%	63.4%
NHS HAVERING CCG	72.6%	72.3%	72.0%	71.7%	71.5%	71.4%	71.0%	70.8%	71.0%	70.9%	70.6%	70.5%	70.6%
NHS NEWHAM CCG	60.0%	59.8%	59.7%	59.6%	59.6%	59.7%	59.6%	59.7%	60.0%	60.3%	60.2%	60.0%	59.9%
NHS REDBRIDGE CCG	61.3%	60.9%	60.8%	60.5%	60.4%	60.3%	60.1%	60.1%	60.4%	60.6%	60.3%	60.3%	60.2%
NHS TOWER HAMLETS CCG	60.9%	60.7%	60.5%	60.5%	60.3%	60.3%	59.8%	59.8%	59.9%	60.1%	60.0%	59.6%	59.5%
NHS WALTHAM FOREST CCG	64.5%	64.3%	64.2%	64.0%	63.9%	64.0%	63.9%	63.9%	64.1%	64.4%	64.5%	64.4%	64.6%

### Breast Screening Coverage by CCG; June 2016 - June 2017



Breast Cancer Standard Age (50-70) 36M Coverage	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
England	72.3%	72.2%	72.3%	72.3%	72.2%	72.4%	72.5%	72.4%	72.4%	72.3%	72.2%	72.2%	72.1%
London	65.1%	65.0%	65.1%	65.2%	65.3%	65.7%	65.8%	65.8%	65.6%	65.7%	65.8%	65.5%	65.6%
North East London STP	65.0%	64.3%	64.5%	65.2%	65.5%	66.0%	66.1%	66.1%	66.2%	66.1%	65.9%	65.6%	65.5%
NHS BARKING AND DAGENHAM CCG	62.4%	62.4%	62.2%	62.2%	62.0%	62.0%	62.0%	62.3%	63.2%	63.7%	64.3%	65.3%	66.3%
NHS CITY AND HACKNEY CCG	58.9%	58.6%	58.5%	58.6%	58.4%	58.7%	59.2%	59.6%	59.8%	60.6%	60.6%	60.0%	59.7%
NHS HAVERING CCG	69.9%	70.4%	70.3%	72.6%	73.9%	75.0%	75.4%	75.3%	75.3%	75.1%	74.7%	74.5%	74.5%
NHS NEWHAM CCG	59.1%	58.7%	59.0%	59.8%	60.1%	60.5%	60.3%	59.8%	59.6%	59.5%	59.2%	58.9%	58.9%
NHS REDBRIDGE CCG	67.8%	67.5%	68.0%	68.3%	68.3%	68.5%	68.5%	68.4%	68.2%	67.8%	67.3%	67.1%	67.0%
NHS TOWER HAMLETS CCG	57.7%	58.6%	59.8%	60.5%	61.5%	63.3%	63.5%	64.1%	64.5%	64.4%	64.1%	63.1%	62.5%
NHS WALTHAM FOREST CCG	69.3%	69.0%	68.8%	68.7%	68.6%	68.4%	68.2%	68.1%	67.8%	67.5%	67.1%	66.6%	66.3%

Note: The source of all figures and tables is NHS Digital.

You reference using Hackney’s Migrant Health Needs Assessment when designing services. The ELHCP cancer team are engaged with the work of the Hackney public health team and have provided support and content for the development and review of the JSNA. The team is currently developing a programme of interventions to improve uptake to all screening programmes and are looking at interventions to raise awareness in the population of east London and are in the planning phase for 2018/19. In addition C&H CCG are currently running a number of focus groups with local people to help inform what key messages resonate with the local population.

It is a priority for ELHCP to deliver a number of interventions for those living with and beyond cancer. From April 2018 all providers in east London will have a Macmillan-funded “recovery package” project manager to provide the four aspects of the recovery package for cancer patients in east London. The four key interventions are:

- a holistic needs assessment at key points in the pathway
- a health and well-being event
- treatment summaries
- care plans

A proportion of cancer transformation money in 2018/19 is set aside to deliver a project to give people more choice about where they access a health and wellbeing event at the end of their active treatment.

We are currently using cancer transformation funding to test the concept of teachable moments for those referred on a cancer pathway who don't have cancer. Three events for INEL patients took place in March 2018, providing education on living well and cancer prevention. There has been good take up with positive feedback and more events planned.

Some patients across east London are now being followed up on supported self-management programmes with further roll out planned.

### **Update on reconfiguration of urology cancer services**

The reconfiguration of urology services was expected to have an impact on reducing complications and reducing some of the long term side effects of the surgery for example incontinence, leaks and erectile dysfunction.

Survival rates for cancer are not published until 18 months after a year end as someone diagnosed on 31 December will need to survive a year before data is produced for that year therefore it is too early to see a survival benefit.

In December 2017 the UCLH urology team reported the following outcomes:

- Length of stay in line with national average
- Fewer radical procedures on low risk prostate cancer (There was acceptance that too many people were being operated on nationally)
- Higher per cent of radical surgical treatment on high risk cases
- Lower complication rate than national average
- Lower transfusion rate than national average

However it should be noted that there have not been improvements in 62-day cancer waiting time urology pathway performance and the pathway overall for men with prostate cancer in east London remains challenged.

### **Workforce**

In December 2017 Health Education England (HEE) published a Cancer Workforce Plan to support delivery of the cancer programme, developed in partnership with NHS England and Five Year Forward View partners.

The plan sets out actions to ensure the NHS in England has the right numbers of skilled staff to provide high quality care and services to cancer patients at each stage in their care – from accurate early diagnosis and treatment to living with cancer and end of life care.

Phase 1 of the plan targets six key professional groups. Work is currently underway with HEE locally, the local cancer Alliance and ELHCP workforce leads, to develop our local contribution to the plan and the first submission is due at the end of March.

In 2018/19 we are looking at new roles to support people on supported self-management in the community. We are also funding some places for development for example, reporting radiographers.

There is considerable work going on across ELHCP to recruit and retain clinicians and staff across whole spectrum of health and care. Councils are actively involved. This work includes initiatives such as a central web-portal that will not only bring together information and contacts about jobs and career development in one central place, but promote east London as a place to live. This will include the provision and promotion of key worker accommodation across the area.

## **Estates**

Please see Appendix C for an update on progress to date. The first meeting of the ELHCP's newly-formed Estates Board is on 10 April 2017. All of the east London local authorities have been invited and most, if not all, are attending. We are happy to send a representative to talk to the committee about estates in more detail – please advise regarding a suitable date.

## **Integrated care systems update**

In terms of accountable care systems, these are now referred to as Integrated Care Systems (ICS) and there are individual borough based systems developing across the WEL footprint. Each has similar priorities but with a distinct borough based focus to their development. It is important that we do not duplicate or lose any learning from the system and therefore it is proposed that the borough leads work collectively to identify areas where a single approach across WEL would be beneficial.

ELHCP will continue its focus on voluntary efforts to coordinate services and build partnerships between established health and care organisations, whose legal duties remain unchanged.

The Alliance is happy to ask individual CCGs to provide an update on progress for the JHOSC. Please let me know if you would like this information.

A member of the public asked for the position of the INEL JHOSC on these developments – it would be helpful if the committee shared its response with this Alliance.

I hope this detailed response provides additional reassurance to the committee.

Yours sincerely



Jane Milligan

**Accountable Officer, NHS North East London Commissioning Alliance  
Executive Lead, East London Health and Care Partnership**

cc: Alwen Williams, Chief Executive, Barts Health  
Managing directors, NEL CCGs

## Appendix A

2017-18 QIPPs and CIPs-£m														
Org.	STP Work Stream	B&D	BARTS	BHRUT	C&H	ELFT	Havering	HUH	NELFT	Newham CCG	Redbridge	TH CCG	Waltham Forest	Grand Total
CCG QIPPs	Cancer											0		0
	Clinical Productivity	3,022			480		5,998				4,506	105		14,111
	Further info required	4,740			1,032		4,687			1,100	6,672	787	2,700	21,717
	Infrastructure	187					825			1,000			250	2,262
	LD											-100		-100
	Meds Optimisation	1,360			505		2,010			1,300	1,696	0	1,000	7,870
	Mental Health				1,435					1,100		-932	1,100	2,703
	None				650		250			2,200		4,580	1,690	9,370
	Planned Care	1,563			535		2,759			3,005	1,429	4,260	1,680	15,232
	Planned Care / Primary Care									700				700
	Prevention											-21		-21
	Primary Care				160							-9		151
	Primary Care / Infrastructure											220	300	520
	Productivity	63			213					900				1,176
	Spec Comms										273	63		336
	UEC	430					603			1,100	439	2,028	500	5,100
	UEC / Planned Care												1,400	1,400
	UEC / Primary Care												200	200
<b>CCG Total</b>		<b>11,364</b>			<b>5,010</b>		<b>17,132</b>			<b>12,405</b>	<b>15,014</b>	<b>10,982</b>	<b>10,820</b>	<b>82,728</b>
<b>Trust CIPS</b>	Total		66,658	28,000		9,050		10,106	16,000					129,814
<b>Trust Total</b>			<b>66,658</b>	<b>28,000</b>		<b>9,050</b>		<b>10,106</b>	<b>16,000</b>					<b>129,814</b>
<b>Grand Total</b>		<b>11,364</b>	<b>66,658</b>	<b>28,000</b>	<b>5,010</b>	<b>9,050</b>	<b>17,132</b>	<b>10,106</b>	<b>16,000</b>	<b>12,405</b>	<b>15,014</b>	<b>10,982</b>	<b>10,820</b>	<b>212,542</b>

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## Thirteen principles of payment

In July 2017 the ELHCP published a consultation on payment development to support transformation in care and ways of working across East London. The consultation document provided an overview of different payment approaches, outlined benefits and risks of each and highlighted other 'enablers' of change that are needed to support system development.

The consultation process sought and received views on what individuals and organisations within East London wanted to achieve with the payment system and what payment reform should deliver for the health and care system as a whole. There was wide involvement in the consultation process and rich feedback was received in both written and verbal forms. The ELHCP held six workshops for payment development for ELHCP stakeholders including nearly 100 health and care representatives covering all 20 ELHCP partner organisations as well as other providers within East London. 54 members of the public attended the first workshop, representing a mix of individuals, health conditions and backgrounds across the ELHCP footprint. ELHCP colleagues also attended local authority governance and scrutiny committees. This process also enabled ELHCP partners to kick off a discussion across ELHCP about how they can work together differently to serve our population better.

Feedback from the Consultation suggested a number of 'principles for payment'. The ELHCP Board agreed this set of principles, and that they should apply to payment approaches developed within East London. If a single approach to payment was not taken across East London, local authorities or integrated care systems within this footprint could still adhere to a common set of principles.

Principles are not presented in a specific hierarchy.

Payment should:

1. enable and incentivise providers and commissioners to focus on achieving good quality care and the right outcomes for patients and our population;
2. include metrics that allow agreed outcomes to be linked to transactional payments;
3. allocate resources to get the balance of services right for our population, and to achieve value for money in regard to the location, model and method of care delivery;
4. support early intervention, prevention and condition management;
5. align organisational and system objectives, including measurements and targets;
6. ensure that payment within the system supports, and works within, the system-wide control total;
7. incentivise providers and commissioners to cooperate and provide coordinated care;
8. facilitate innovation and transformation at all levels within system, including making the most of the ideas and energy of clinicians, care professionals and front line staff;
9. facilitate, and create incentives for, delivery of the clinical strategy agreed for East London;
10. share risk in a way that is fair and creates incentives that support ELHCP objectives - ensure that overall system risk is lowered and financial risk is aligned to those parts most able to influence/manage the risk;
11. offer longer contract cycles to provide stability and incentivise investment;
12. ensure an approach that is transparent and simple for all in the system to understand
13. minimise administrative burdens and transaction costs associated with payment, including streamlining 'key performance indicators' and targets.

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## **Infrastructure Work Stream**

**JHOSC update February 2018**

## Memorandum of Understanding (MoU)

Since the London Devolution MoU was signed mid-November 2017, the estates work stream has moved to the next gateway requiring London partners to complete a robust London Capital Plan by end of March 2018. This requires STPs to:

Page 54

1. Establish a governance structure and set up an Estates Board
2. Complete an STP wide Strategic Estates Plan (SEP)
3. Produce a detailed, prioritised pipeline of projects
4. Compile an STP Capital plan to feed into the London Capital Plan

The completion of this work requires each ACS to produce local level information to feed into the STP Plan. This document forms the BHR Integrated Care Partnership contribution to the ELCHP STP Plan.

## Devolution Opportunities

A new national £2.6bn capital fund was announced in the budget with the first 10% being given to the most mature STP plans.

Future access to this fund will be via a single STP estates strategy and capital plan. Individual organisations will not be allowed to bid for money for individual schemes.

The STP capital plan must demonstrate an outline clinical strategy and outline all available disposal opportunities.

**Devolution offers the opportunity to argue for capital receipts to be recycled locally, noting that London will expect all receipts to be recycled within London as part of the agreement.**

# Phase 2 Devolution functions and what this means for NEL

## Phase 2 Functions

Continue to provide **single forum for NHS estates** discussions and enable whole system strategic estates planning, building a London view from local and sub-regional estates strategies

Support local and sub-regional areas **to develop clear estates strategies** aligned to clear commissioning strategies.

Develop a **clear capital plan for London**, drawing from local and sub-regional estates strategies and ETTF bids. Supported by a clear list and status of **prioritised capital cases** under development.

Develop a prioritisation framework for decisions.

Develop a **robust and professional business case support function** within the LEDU to support local and sub-regional areas.

Support sub-regional and pilot estates boards to take on **robust governance and accountability** functions to a sufficient standard to enable delegations and devolutions from national partners to be made to sub-regional level.

Consider **the recommendations of a London report on NHS estate utilisation**.

Work with **national partners** to explore how **incentives** for the health and care system to release surplus land can be optimised.

**Work with DH, NHSPS and CHP** to develop an approach for NHSPS and CHP investments and sales, which balances national and London needs and priorities.

Work with DH and sub-regional areas to ensure that when **surplus NHS sites are released**, this is done with due consideration of wider local health economy and public sector opportunities.

## Phase 3 Gateway Criteria

Established business case support function



Clear local and sub-regional estates strategies aligned to commissioning strategies



Clear capital plan for London



Pipeline of sites and agreed prioritisation framework



Agreement from national partners for the LEB to commence shadow running.



Evidenced collaborative working



Agreed governance and key appointments



Signed MoU relating to internal delegations.



LEB membership review



## Requirements of NEL to enable progress to Phase 3

The LEDU is working with STPs to assess the resourcing need to support business plan development. As part of this, practitioner training has been proposed for all Steering Group members. NEL to continue to support this work as required, and commit relevant NEL representatives to attend training.

NEL to review local estates strategies holistically to ensure that they are in alignment relevant commissioning strategies.

NEL to continue to work to produce a strategic estates plan, built up from a clear clinical strategy, which will feed into the London capital plan.

NEL working to prepare a complete prioritised pipeline of sites, using a standardised prioritisation methodology as agreed with the LEDU.

NEL continuing to work collaboratively with the LEDU, LEB and London and national partners on estates matters, to focus on how they can work together to unlock site-related issues and deliver progress.

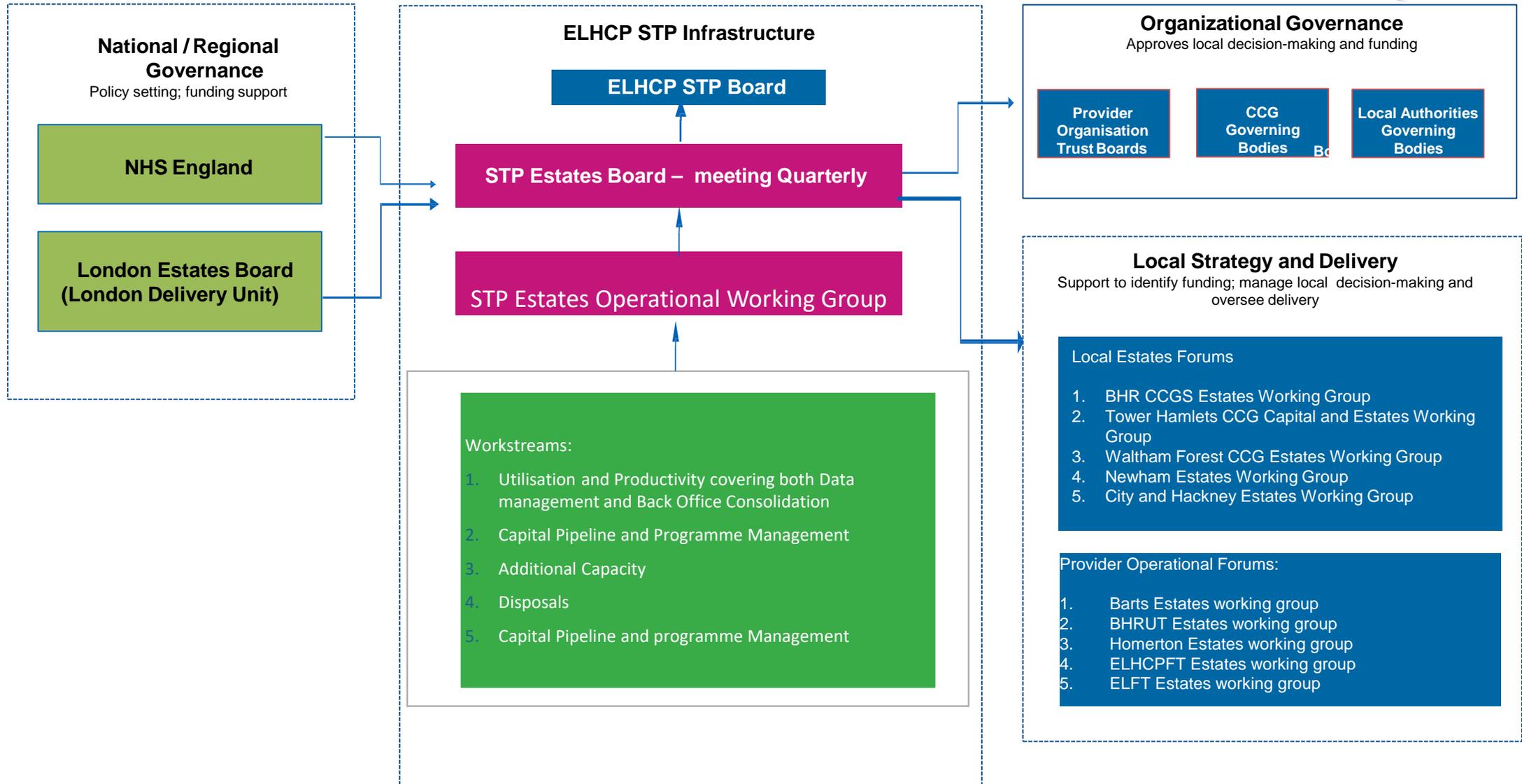
NEL agreeing a strong and established governance structure which brings together CCGs as well as Trusts, including the appointment of key roles.

# Governance Model

## ELHCP Infrastructure

- MoU requires specific governance arrangements to be put in place for each STP to ensure appropriate, transparent and robust decision-making authority within ELHCP.
- We need to establish an **ELHCP Estates Board** to link to London Estates Board and STP governance arrangements.
- The Estates Board aims to facilitate more joined-up strategic decision-making for NEL and to enhance effectiveness, efficiency, quality and transparency of process and decisions
- ELHCP Estates board will work alongside ACS local estate forums to ensure adherence with the principles of subsidiarity fulfilling the below functions:
  - **Strategic** – in relation to oversight of the STP strategy for estates. We have already developed a set of principles setting out what activities should be considered at what level
  - **Bringing partners together** – to provide greater co-ordination and easier escalation to tackle barriers which can be addressed through improved local joint working
- Project delivery and day to day operational management will remain at an ACS level.
- Trusts and Local Authorities will continue to make decisions through their own governance structures.
- Core Members may be asked to delegate responsibility to individuals to allow decisions to be made ‘**in the room**’ for example in relation to prioritisation within an agreed framework.

# Proposed Governance for Estates



Page 57



# Infrastructure Workstream Structure

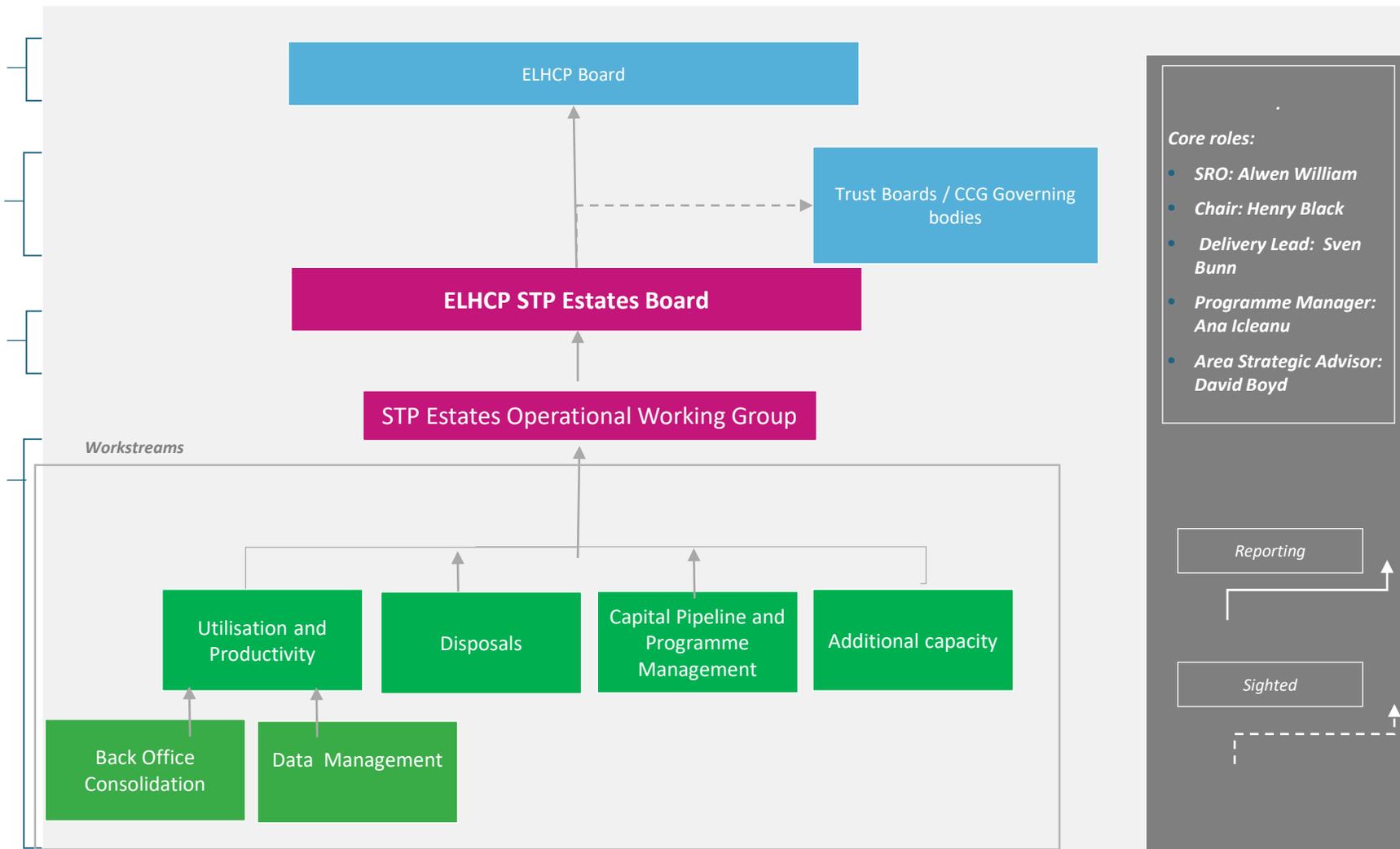
Trust boards will sign off ultimate proposals and plans recommended to them by their representatives on the Infrastructure Steering Group, with additional support as needed

The ELHCP STP Board is sighted on plans, making sure they are coherent with the overall plans across the STP

A ELHCP Estates Board with:

1. Formal oversight and approval of ELHCP System Estates strategy and delivery
2. Make recommendations on the use of capital receipts
3. Make other delegated decisions (e.g. changes to increase utilisation).

Workstreams do the detailed work and make recommendations to the Productivity Steering Group. Workstreams include wider group of stakeholders, including Directors of Estates, Strategy Directors etc.



**Core roles:**

- SRO: Alwen William
- Chair: Henry Black
- Delivery Lead: Sven Bunn
- Programme Manager: Ana Icleanu
- Area Strategic Advisor: David Boyd

Reporting

Sighted

# Next Steps

## January to March 2018

### January

- Set up STP Estates Board and associated governance
- Set up STP Estates Team
- Detailed Delivery Plan and resources to complete work by end of March
- Prioritised list of projects to feed into London capital pipeline
- Each ACS to update local Strategic Estates Plans

### February

- Summarise clinical model
- Finalise STP wide Strategic Estates Plan
- Develop detailed by year programme for delivery of strategic estates plan
- Produce capital investment plan with detailed requirements for years 1-3
- Start working on OPE Phase 7 bids due in April

### March

- Detailed delivery plan and associated resources for 18/19
- Confirm resources required at STP vs local level
- OPE Phase 7 bids to be finalised for April

# High Level Plan

