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City Integrated Commissioning Board

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

Hackney Integrated Commissioning Board

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

Joint Meeting on Wednesday 15 November 10am -12 noon
Tomlinson Centre, Queensbridge Road, E8 3ND

City ICB and Hackney ICB – Joint Session					
Item no.	**Item**	**Lead and action for boards**	**Documentation**	**Page No.**	**Time**
1.	Apologies/Introductions				10.00
2.	Declarations of Interest	*For noting*	2.1 City Register of Interests 2.2 Hackney Register or Interests	3 7	10.05
3.	Questions from the Public	Chair	Verbal	-	10.10
4.	Minutes of the Previous Meeting	Chair For approval by City ICB/for information to Hackney ICB *For approval by Hackney ICB/for information to City ICB* *For noting*	4.1 Minutes of City ICB Meeting 18 October 2017 4.2 Noting of decisions from 18 October City ICB 4.3 Minutes of Hackney Meeting18 October 2017 4.4 ICB Action Log	11 21 23 35	10.15
5.	Local Face to Face 111 model	Tracey Fletcher *For approval*	5.1 Options Appraisal for Local Response to NEL IUC model	36	10.25

6.	The City of London Plan, Section 256 Supporting Hospital discharge and the Better Care Fund	Neil Hounsell *For approval*	6.1 City of London Section 256 funding and Carried Forward BCF	65	10.40
7.	Co-production Charter	Emily Tullock *For approval*	7.1 Co-production Charter	83	10.55
8.	System Performance Management	Anna Garner *For approval*	8.1 Monitoring of Financial and Performance Risks Across the System	85	11.05
9.	Monthly Integrated Finance Report – Month 6	Philippa Lowe/Mark Jarvis *For noting*	9.1 Finance report	91	11.20
10.	School-based and Vulnerable Children's Health Services	Amy Wilkinson *For information*	10.1 Redesign and procurement of the School based and Vulnerable Children's Health Services	106	11.30
11.	Update from Transformation Board	Paul Haigh *For noting*	11.1 September Transformation Board meeting minutes	112	11.45
12.	Reflections on Meeting	Chair *For discussion*	Verbal		11.50
13.	AOB	Chair	Verbal		11.55

Integrated Commissioning
2017/18 City Members Register of Interests

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Paul	Haigh	23/03/2017	Transformation Board Member - CHCCG	City & Hackney CCG	Chief Officer	Pecuniary Interest
			CoLC ICB Member - CHCCG	NHS England	Spouse is Regional Director of People & Organisational Development (London)	Indirect interest
			LBH ICB Member - CHCCG	Hackney Health & Wellbeing Board	Board Member	Non-Pecuniary Interest
				City of London Health & Wellbeing Board	Board Member	Non-Pecuniary Interest
				NEL STP Board	Board Member	Non-Pecuniary Interest
				N/A	Resident of Westminster & Registered with Westminster GP	Non-Pecuniary Interest
Penny	Bevan	25/03/2017	Transformation Board Member - DPH, LBH & CoLC	London Borough of Hackney	Director of Public Health	Pecuniary Interest
				City of London Corporation	Director of Public Health	Pecuniary Interest
				Association of Directors of Public Health	Member	Non-Pecuniary Interest
				British Medical Association	Member	Non-Pecuniary Interest
				Faculty of Public Health	Member	Non-Pecuniary Interest
				National Trust	Member	Non-Pecuniary Interest
Neal	Hounsell	23/03/2017	Transformation Board Member - CoLC	City of London Corporation	Acting Director of Community and Children's Services	Pecuniary Interest
			CoLC ICB Member - CoLC	Hackney Volunteer & Befriending Service	Volunteer	Non-Pecuniary Interest
				n/a	Tenant - De Beauvoir Road, Hackney	Non-Pecuniary Interest
				n/a	Registered with the De Beauvoir Practice	Non-Pecuniary Interest
Janine	Adridge	30/03/2017	Transformation Board Member - Healthwatch City of London	Healthwatch City of London	Officer	Pecuniary Interest
				Royal College of Pathologists	Public Affairs Officer	Pecuniary Interest
Clare	Highton	23/12/2016	Transformation Board Member - CHCCG CoLC/CCG ICB Chair LBH ICB Member - CHCCG	City & Hackney CCG	Chair	Pecuniary Interest
				Body and Soul	Daughter in Law works for this HIV charity.	Indirect interest
				CHUHSE	Sorsby and Lower Clapton Group Practice's are members	Pecuniary Interest
				GP Confederation	Sorsby and Lower Clapton Group Practice's are members and shareholders	Pecuniary Interest
				Local residents	Myself and extended family are Hackney residents and registered at Hackney practices, 2 grandchildren attend a local school.	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				Lower Clapton Group Practice (CCG Member Practice)	Partner at a GMS and an APMS practices which provide a full range of services including all GP Confederation and the CCG's Clinical Commissioning and Engagement contracts, and in addition child health, drug, minor surgery and anticoagulation clinics. We host CAB, Family Action, physiotherapy, counselling, diabetes and other clinics. The buildings are leased from PropCo, and also house community health services. The practices are members of CHUHSE and the GP Confederation. Lower Clapton is a teaching, research and training practice, and I am a GP trainer. I am a member of the BMA and Unite. One partner is a member of the LMC.	Pecuniary Interest
				Sorsby Group Practice (CCG Member Practice)	Partner at a GMS and an APMS practices which provide a full range of services including all GP Confederation and the CCG's Clinical Commissioning and Engagement contracts, and in addition child health, drug, minor surgery and anticoagulation clinics. We host CAB, Family Action, physiotherapy, counselling, diabetes and other clinics. The buildings are leased from PropCo, and also house community health services. The practices are members of CHUHSE and the GP Confederation. Lower Clapton is a teaching, research and training practice, and I am a GP trainer. I am a member of the BMA and Unite. One partner is a member of the LMC.	Pecuniary Interest
				Tavistock and Portman NHS Trust	Husband is Medical Director of Tavistock and Portman NHS FT which is commissioned for some mental health services for C&H CCG.	Non-Pecuniary Interest
				N/A	Daughter is a trainee Psychiatrist, not within the City and Hackney area.	Non-Pecuniary Interest
Philippa	Lowe	22/12/2016	Transformation Board Member - CHCCG CoLC ICB Attendee - CHCCG LBH ICB Attendee - CHCCG	City & Hackney CCG	Joint Chief Finance Officer	Non-Pecuniary Interest
				GreenSquare Group	Board Member, Group Audit Chair and Finance Committee member for GreenSquare Group, a group of housing associations. Greensquare comprises a number of charitable and commercial companies which run with co-terminus Board.	Non-Pecuniary Interest
				NHS Oxford Radcliffe Hospital	Member of this Foundation Trust	Non-Pecuniary Interest
				PIQAS Ltd	Director at PIQAS Ltd, dormant company.	Non-Pecuniary Interest
Honor	Rhodes	05/04/2017	Member - City / Hackney Integrated Commissioning Boards	Tavistock Relationships	Director of Strategic Devleopment	Pecuniary Interest
				The School and Family Works, Social Enterprise	Special Advisor	Pecuniary Interest
				Oxleas NHS Foundation Trust	Spouse is Tri-Borough Consultant Family Therapist	Indirect interest
				Early Intervention Foundation	Trustee	Non-Pecuniary Interest
				n/a	Registered with Barton House NHS Practice, N16	Non-Pecuniary Interest
Gary	Marlowe	06/04/2017	GP Member of the City & Hackney CCG Governing Body	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				De Beauvoir Surgery	GP Partner	Pecuniary Interest
				City & Hackney CCG	Planned Care Lead	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				Hackney GP Confederation	Member	Pecuniary Interest
				British Medical Association	London Regional Chair	Non-Pecuniary Interest
				n/a	Homeowner - Casimir Road, E5	Non-Pecuniary Interest
				City of London Health & Wellbeing Board	Member	Non-Pecuniary Interest
				Local Medical Committee	Member	Non-Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				CHUHSE	Member	Non-Pecuniary Interest
Dhruv	Patel	28/04/2017	Chair - City of London Corporation Integrated Commissioning Sub-Committee	n/a	Landlord	Pecuniary Interest
				Clockwork Pharmacy Group SSAS, Amersham	Trustee; Member	Pecuniary Interest
				Clockwork Underwriting LLP, Lincolnshire	Partner	Pecuniary Interest
				Clockwork Retail Ltd, London	Company Secretary & Shareholder	Pecuniary Interest
				Clockwork Pharmacy Ltd	Company Secretary	Pecuniary Interest
				DP Facility Management Ltd	Director; Shareholder	Pecuniary Interest
				Clockwork Farms Ltd	Director; Shareholder	Pecuniary Interest
				Clockwork Hotels LLP	Partner	Pecuniary Interest
				Capital International Ltd	Employee	Pecuniary Interest
					Land Interests - 8/9 Ludgate Square 215-217 Victoria Park Road 236-238 Well Street 394-400 Mare Street 1-11 Dispensary Lane	Pecuniary Interest
					Securities - Fundsmith LLP Equity Fund Class Accumulation GBP	Pecuniary Interest
				East London NHS Foundation Trust	Governor	Non-Pecuniary Interest
				City of London Academies Trust	Director	Non-Pecuniary Interest
				The Lord Mayor's 800th Anniversary Awards Trust	Trustee	Non-Pecuniary Interest
				City Hindus Network	Director; Member	Non-Pecuniary Interest
				Aldgate Ward Club	Member	Non-Pecuniary Interest
				City & Guilds College Association	Life-Member	Non-Pecuniary Interest
				The Society of Young Freemen	Member	Non-Pecuniary Interest
				City Livery Club	Member and Treasurer of u40s section	Non-Pecuniary Interest
				The Clothworkers' Company	Liveryman; Member of the Property Committee	Non-Pecuniary Interest
				Diversity (UK)	Member	Non-Pecuniary Interest
				Chartered Association of Buidling Engineers	Member	Non-Pecuniary Interest
				Institution of Engineering and Technology	Member	Non-Pecuniary Interest
				City & Guilds of London Institute	Associate	Non-Pecuniary Interest
				Association of Lloyd's members	Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				High Premium Group	Member	Non-Pecuniary Interest
				Avanti Court Primary School	Chairman of Governors	Non-Pecuniary Interest
Joyce	Nash	06/04/2017	Member - City Integrated Commissioning Board	City of London Corporation	Deputy	Pecuniary Interest
				Neaman Practice	Registered Patient	Non-Pecuniary Interest
				Feltmakers Livery Company	Lifemember of Headteachers' Association	Non-Pecuniary Interest
Peter	Kane	12/05/2017	Attendee - City Integrated Commissioning Board	City of London Corporation	Chamberlain	Pecuniary Interest
Randall	Anderson	13/06/2017	Member - City Integrated Commissioning Board	City of London Corporation	Deputy Chair, Community and Children's Services Committee	Pecuniary Interest
				n/a	Self-employed Lawyer	Pecuniary Interest
				n/a	Renter of a flat from the City of London (Breton House, London)	Non-Pecuniary Interest
				City of London School for Girls	Member - Board of Governors	Non-Pecuniary Interest
				Neaman Practice	Registered Patient	Non-Pecuniary Interest
Andrew	Carter	05/06/2017	Attendee - City Integrated Commissioning Board	City of London Corporation	Director of Community & Children's Services	Pecuniary Interest
				n/a	Spouse works for FCA (fostering agency)	Indirect interest

Integrated Commissioning
2017/2018 Hackney Register of Interests

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Paul	Haigh	23/03/2017	Transformation Board Member - CHCCG CoLC ICB Member - CHCCG LBH ICB Member - CHCCG	City & Hackney CCG	Chief Officer	Pecuniary Interest
				NHS England	Spouse is Regional Director of People & Organisational Development (London)	Indirect interest
				Hackney Health & Wellbeing Board	Board Member	Non-Pecuniary Interest
				City of London Health & Wellbeing Board	Board Member	Non-Pecuniary Interest
				NEL STP Board	Board Member	Non-Pecuniary Interest
				N/A	Resident of Westminster & Registered with Westminster GP	Non-Pecuniary Interest
Jon	Williams	29/03/2017	Transformation Board Member - Healthwatch Hackney Attendee - Hackney Integrated Commisioning Board	Healthwatch Hackney	Director Hackney Council Core and Signposting Grant - CHCCG NHS One Hackney & City Patient Support Contract - CHCCG NHS Community Voice Contract - CHCCG Patient User Experience Group Contract - CHCCG Devolution Communications and Engagment Contract Hosted by Hackney CVS at the Adiaha Antigha Centre, 24-30 Dalston Lane	Pecuniary Interest
Penny	Bevan	25/03/2017	Transformation Board Member - DPH, LBH & CoLC	London Borough of Hackney	Director of Public Health	Pecuniary Interest
				City of London Corporation	Director of Public Health	Pecuniary Interest
				Association of Directors of Public Health	Member	Non-Pecuniary Interest
				British Medical Association	Member	Non-Pecuniary Interest
				Faculty of Public Health	Member	Non-Pecuniary Interest
				National Trust	Member	Non-Pecuniary Interest
Jake	Ferguson	31/03/2017	Transformation Board Member - Hackney CVS	Hackney Community & Voluntary Services	Chief Executive	Pecuniary Interest
Clare	Highton	23/12/2016	Transformation Board Member - CHCCG CoLC/CCG ICB Chair LBH ICB Member - CHCCG	City & Hackney CCG	Chair	Pecuniary Interest
				Body and Soul	Daughter in Law works for this HIV charity.	Indirect interest
				CHUHSE	Sorsby and Lower Clapton Group Practice's are members	Pecuniary Interest
				GP Confederation	Sorsby and Lower Clapton Group Practice's are members and shareholders	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				Local residents	Myself and extended family are Hackney residents and registered at Hackney practices, 2 grandchildren attend a local school.	Non-Pecuniary Interest
				Lower Clapton Group Practice (CCG Member Practice)	Partner at a GMS and an APMS practices which provide a full range of services including all GP Confederation and the CCG's Clinical Commissioning and Engagement contracts, and in addition child health, drug, minor surgery and anticoagulation clinics. We host CAB, Family Action, physiotherapy, counselling, diabetes and other clinics. The buildings are leased from PropCo, and also house community health services. The practices are members of CHUHSE and the GP Confederation. Lower Clapton is a teaching, research and training practice, and I am a GP trainer. I am a member of the BMA and Unite. One partner is a member of the LMC.	Pecuniary Interest
				Sorsby Group Practice (CCG Member Practice)	Partner at a GMS and an APMS practices which provide a full range of services including all GP Confederation and the CCG's Clinical Commissioning and Engagement contracts, and in addition child health, drug, minor surgery and anticoagulation clinics. We host CAB, Family Action, physiotherapy, counselling, diabetes and other clinics. The buildings are leased from PropCo, and also house community health services. The practices are members of CHUHSE and the GP Confederation. Lower Clapton is a teaching, research and training practice, and I am a GP trainer. I am a member of the BMA and Unite. One partner is a member of the LMC.	Pecuniary Interest
				Tavistock and Portman NHS Trust	Husband is Medical Director of Tavistock and Portman NHS FT which is commissioned for some mental health services for C&H CCG.	Non-Pecuniary Interest
				N/A	Daughter is a trainee Psychiatrist, not within the City and Hackney area.	Non-Pecuniary Interest
Philippa	Lowe	22/12/2016	Transformation Board Member - CHCCG CoLC ICB Attendee - CHCCG LBH ICB Attendee - CHCCG	City & Hackney CCG	Joint Chief Finance Officer	Non-Pecuniary Interest
				GreenSquare Group	Board Member, Group Audit Chair and Finance Committee member for GreenSquare Group, a group of housing associations. Greensquare comprises a number of charitable and commercial companies which run with co-terminus Board.	Non-Pecuniary Interest
				NHS Oxford Radcliffe Hospital	Member of this Foundation Trust	Non-Pecuniary Interest
				PIQAS Ltd	Director at PIQAS Ltd, dormant company.	Non-Pecuniary Interest
Ian	Williams	10/05/2017	Transformation Board Member - LBH Attendee - Hackney Integrated Commissioning Board	London Borough of Hackney	Group Director, Finance and Corporate Resources	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				n/a	Homeowner in Hackney	Pecuniary Interest
				Hackney Schools for the Future Ltd	Director	Pecuniary Interest
				NWLA Partnership Board	Joint Chair	Pecuniary Interest
				Chartered Institute of Public Finance and Accountancy	Member	Non-Pecuniary Interest
				Society of London Treasurers	Member	Non-Pecuniary Interest
				London Finance Advisory Committee	Member	Non-Pecuniary Interest
				Schools and Academy Funding Group	London Representative	Non-Pecuniary Interest
				London Pensions Investments Advisory Committee	Chair	Non-Pecuniary Interest
Anne	Canning	31/03/2017	Transformation Board Member - LBH LBC/CCG ICB Attendee - LBH	London Borough of Hackney	Group Director - Children, Adults & Community Health	Pecuniary Interest
				Petchey Academy & Hackney/Tower Hamlets College	Governing Body Member	Non-Pecuniary Interest
					Spouse works at Our Lady's Convent School, N16	Indirect interest
Honor	Rhodes	05/04/2017	Member - City / Hackney Integrated Commissioning Boards	Tavistock Relationships	Director of Strategic Devleopment	Pecuniary Interest
				The School and Family Works, Social Enterprise	Special Advisor	Pecuniary Interest
				Oxleas NHS Foundation Trust	Spouse is Tri-Borough Consultant Family Therapist	Indirect interest
				Early Intervention Foundation	Trustee	Non-Pecuniary Interest
				n/a	Registered with Barton House NHS Practice, N16	Non-Pecuniary Interest
Haren	Patel	10/04/2017	GP Member of the City & Hackney CCG Governing Body	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				Latimer Health Centre	Senior GP Partner Contract with CCG for carrying out GP services at Acorn Lodge Nursing Home Spouse is a GP Partner Owner (with spouse) of freehold of Latimer Health Centre	Pecuniary Interest
				Newcare Pharmacy, Willesden Green	Joint Director Spouse is Joint Director	Pecuniary Interest
				Klear Consortia	Prescribing Clinical Lead	Pecuniary Interest
				City & Hackney GP Confederation	Member	Pecuniary Interest
				Londonwide Local Medical Committee	Member	Non-Pecuniary Interest
				British Medical Association	Member	Non-Pecuniary Interest
Anntoinette	Bramble	28/04/2017	Deputy Mayor, Hackney Council	Hackney Council	Deputy Mayor	Pecuniary Interest
				Local Government Association	Member of the Children and Young Board	Pecuniary Interest
				HSFL (Ltd)		Non-Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				Urstwick School	Governor	Non-Pecuniary Interest
				City Academy	Governor	Non-Pecuniary Interest
				Hackney Play Bus (Charity)	Board Member	Non-Pecuniary Interest
				Local Government Association	Member	Non-Pecuniary Interest
				Lower Clapton Group Practice	Registered Patient	Non-pecuniary interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Jonathan	McShane	15/05/2017	Chair - Hackney Integrated Commissioning Board	London Borough of Hackney	Lead Member for Health, Social Care & Devolution	Pecuniary Interest
				Local Government Association		Pecuniary Interest
				Public Health England		Pecuniary Interest
				The Labour Party		Pecuniary Interest
				LGA General Assembly	Member	Non-Pecuniary Interest
				LGA Community Wellbring Board	Member	Non-Pecuniary Interest
				London Councils Grants Committee	Member	Non-Pecuniary Interest
				London Councils Transport and Environment Committee	Substitute Member	Non-Pecuniary Interest
				Shoreditch Town Hall Trust	Trustee	Non-Pecuniary Interest
				LGA Community Wellbeing Board	Member	Non-Pecuniary Interest
				Unite	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Community Trade union	Member	Non-Pecuniary Interest
				Action on Smoking and Health	Trustee	Non-Pecuniary Interest
				Public Health System Group	Chair	Non-Pecuniary Interest
				NHS Health Checks National Advisory Committee	Chair	Non-Pecuniary Interest
				Dementia Programme governance Board, Public Health England	Co-Chair	Non-Pecuniary Interest
				Pharmacy and Public Health Forum, Public Health England	Chair	Non-Pecuniary Interest
				Liver Advisory Group, NHS Blood and Transplant	Lay Member	Non-Pecuniary Interest
				n/a	Spouse is a Communications Consultant	Pecuniary Interest
Geoffrey	Taylor	26/04/2017	Member - Hackney Integrated Commissioning Board	London Borough of Hackney	Member	Pecuniary Interest
				The Labour Party	Member	Pecuniary Interest
				n/a	Homeowner - Meynell Gardens, E9	Pecuniary Interest
				n/a	Spouse is a Homeowner - Riverside Close, E5	Pecuniary Interest
				London Legacy Development Corporation	Member - Planning Committee	Non-Pecuniary Interest
				Hackney Parish Almshouse Charity	Memer	Non-Pecuniary Interest
				Hackney Parochial Charity	Member	Non-Pecuniary Interest
				The Fabian Society	Member	Non-Pecuniary Interest
				Elsdale Street Practice	Registered Patient	Non-Pecuniary Interest

Document 4.1

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

City Integrated Commissioning Board

Meeting of 18 October 2017

MEMBERS

Members of the City of London Corporation Integrated Commissioning Sub-Committee

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

Cllr Joyce Nash – Member, Community and Children's Services Committee, City of London Corporation

Members of City and Hackney CCG Integrated Commissioning Committee

Paul Haigh – Chief Officer, City & Hackney CCG

Clare Highton – Chair of the City & Hackney CCG Governing Body **(Chair)**

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

FORMALLY IN ATTENDANCE

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

Mark Jarvis, deputising for Peter Kane, Chamberlain, City of London Corporation

Sunil Thakker – Joint Chief Finance Officer, City and Hackney CCG

STANDING INVITEES

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

Geoffrey Rivett – Representative, City of London Healthwatch
Gary Marlowe – Governing Body GP Member, City and Hackney CCG

OFFICERS PRESENT

Anna Garner – Head of Performance and Alignment, City and Hackney CCG
Kate Heneghan – Public Health Strategist, London Borough of Hackney
David Maher – Deputy Chief Officer, City and Hackney CCG
Ellie Ward – Integration Programme Manager, City of London Corporation
Amy Wilkinson – Workstream Director, Children, Young People and Maternity Services
Devora Wolfson – Programme Director, Integrated Commissioning
Catherine Macadam – Chair, PPI, CCG

Jarlath O'Connell - Integrated Commissioning Governance Manager (*minutes*)

APOLOGIES

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

Officers
Neal Hounsell – Assistant Director of Commissioning and Partnerships, City of London Corporation
Philippa Lowe – Joint Chief Finance Officer, City & Hackney CCG

1. Apologies and Introductions

1.1 The Chair welcomed members and attendees to the meeting.

1.2 It was noted that CoLC integrated Commissioning Sub-Committee was not quorate according to CoLC Standing Orders which requires 3 Members to be in attendance.

1.3 Ellie Ward confirmed that Dhruv Patel's agreement on the items would be sought via email after the meeting.

2. Declarations of Interest

2.1 Clare Highton declared an interest as working as a GP in Hackney

3. Local System 2018/20 Financial Planning - PRIVATE ITEM

3.1 Sunil Thakker presented a paper to the ICB setting out proposals for financial planning as a local system over the next two years.

4.2 Sunil stated that we are working towards having a system control total for City and Hackney. The paper presented financial scenarios relating to the CCG and two Local Authority positions that were consolidated to give an indicative system position. The provider financial positions were included in the CCG spend, but there was a sensitivity around failing to deliver CIPs which would have an impact on the system control total.

3.3 A workshop for ICB and Transformation Board is to be held in November to discuss these scenarios and the paper presented to ICB will be refined for the workshop.

3.4 Sunil also outlined the issues relating to the NEL STP control total, in particular, the risk share framework and the NHSE ask of delivering additional in-year surplus in support of balancing the NEL system position. These were discussed further under item 6.

3.5 In response to a question from the Chair, Mark Jarvis confirmed that there were no other specific challenges or issues for the City of London Corporation other than those noted. It was also confirmed that the 2% savings are across the People's Directorate (which includes adult and children's social care)

3.6 The Integrated Commissioning Board:

- **AGREED** the proposals for the approach to 2018/19 financial planning as an integrated system.

4. Questions from the Public

4.1 There were no questions from the public.

5. Minutes from Previous Meeting

5.1 The Integrated Commissioning Board:

- **APPROVED** the minutes of the City of London Corporation ICB on 20 September 2017 as an accurate record
- **NOTED** the minutes of the Hackney ICB meeting on 20 September 2017
- **NOTED** progress on actions recorded on the action log
- **APPROVED** the minutes of the joint ICB meeting held on 2 August 2017 as an accurate record

6. Framework for Risk Sharing 2017/18

6.1 Sunil Thakker introduced the paper which set out the Framework for Risk Sharing across East London Health and Care Partnership CCGs.

6.2 The CCG Governing Body has been discussing potential arrangements for risk sharing across East London Health and Care Partnership CCGs. These views, plus those of the other CCGs have been taken into account and a framework agreement was submitted to the relevant CCG Governing Bodies in September 2017. The NHS City & Hackney CCG Governing Body agreed the proposals.

6.3 This paper has agreed by the NHS City & Hackney CCG Governing Body and is provided for information.

6.4 The Integrated Commissioning Board

- **NOTED** the report

7. Workstream Assurance Review Part 2

7.1 Devora Wolfson presented this report and the ICB was asked to note the progress being made by the workstreams against the assurance point 2 gateway and to endorse the system issues and next steps outlined.

7.2 The focus of Assurance Review Point 2 was on:

- Transformation Plans
- Virtual Teams
- Further budget pooling opportunities
- General OD issues

7.3 It was noted that in terms of next steps some work around organisational development needs to take place as this was an issue that came up across the workstreams.

7.4 It is also proposed that two pooled budgets will be trialed – one for CHC and residential care in the planned care workstream and all of the budgets in the prevention workstreams. Business cases will be worked up for this. These will be test cases to explore the process and the willingness of NHS England for further pooling. If this pooling goes ahead, further changes will need to be made to the integrated commissioning governance.

7.5 It was noted that a neighbourhood care model (integrated care at a local level) is being considered and there will be a further detailed discussion on this at Transformation Board in November.

7.6 The Integrated Commissioning Board

- **ENDORSED** the progress and next steps.

8. Prioritisation of Investment Request

8.1 Anna Garner introduced the paper which asked the ICB to consider proposals on the method for prioritising future investments and disinvestments (based

on their value to the City and to Hackney) and approve the paper for discussion at the seminar ICB / Transformation Board workshop in November.

8.2 Eight value criteria are proposed (encompassing all elements of value to the City and Hackney system):

- Physical health gain
- Mental health and wellbeing and quality of life gain
- Supports increasing focus on prevention (wide definition of prevention including wider determinants of health, primary prevention, secondary prevention, and preventing increased health and social care usage)
- Patient empowerment
- Reducing inequalities in health and care outcomes
- Social value
- Ensuring equity in access
- Supports financial sustainability

8.3 Proposals would then be scored against these criteria by members of a scoring group (scores then moderated for a number of factors and then converted to ranked list, incorporating funding required for the scheme). Scoring is labour intensive but converting value of widely varying schemes to a quantitative measure is the only robust way of comparing.

8.4 Scorers cannot be members of the ICB for governance reasons.

8.5 Andrew Carter asked how we would review whether the prioritisation was working correctly. Anna Garner suggested that if the prioritisation is trialed on a couple of workstream projects then it could be reviewed and refined if necessary.

8.6 Ellie Ward asked whether the issue if a service delivered statutory requirements also needed to be considered within the prioritisation. Anna Garner noted that this was considered in the previous process but that it will need to be considered for this process.

8.7 Geoffrey Rivett asked about patient involvement in this process. Catherine Macadam outlined the way patients had been fully involved.

8.8 The Integrated Commissioning Board

- **AGREED** the outline proposal and process, subject to consideration of how statutory services are considered within the prioritisation process.

8.9 **ACTION: CICB 1810-1:** Anna Garner to review how statutory services are considered within the prioritisation process after the initial phase of scoring is completed, assessing what is working and what could be improved.

9. **Children and Young People's Obesity and Physical Activity Services**

9.1 Amy Wilkinson introduced the item, outlining that it is a public health procurement supporting a wider agenda on reducing childhood obesity which sat across the Prevention and CYPMS work stream.

9.1 Kate Heneghan presented an outline of some recently commissioned obesity services for Children and Young People in City and Hackney which will commence in December 2017. Physical activity services, which are being recommissioned with a start of April 2019 are only for Hackney residents. However, the City of London Corporation's contract for physical activity services will also be coming to an end then too so there may be opportunities to discuss opportunities for joint commissioning on this service.

9.2 Gary Marlowe made the point that although there is a focus on exercise and activity in helping address obesity, reduction in calorie intake is more important. Kate Heneghan noted that part of the wider obesity work is about changing behaviour and understanding.

9.3 The Integrated Commissioning Board

- **ENDORSED** the report with the agreement for some conversations between City and Hackney about any opportunities around jointly commissioning some physical activity services

10. Co-production Charter

10.1 The ICB was asked to endorse and approval the co-production charter for health and social care in Hackney and the City.

10.2 A number of issues had been flagged up at the Transformation Board:

- The Charter should be framed in a way that recognises the different statutory responsibilities of partner organisations
- The Charter need to cover those who work in the City of London
- The Charter should be framed in a way that shows that co-production is our direction of travel and we will be using the coproduction principles identified.

10.3 The Integrated Commissioning Board

- **AGREED** the principles of the Co-production charter subject to the revisions above

10.4 Members of the City of London Corporation Integrated Commissioning Sub-Committee requested that the Charter came back to them when amended.

10.5 **ACTION: CICB 1810-2:** Updated charter to be brought back to City ICB.

11. Investment of PMS Premium

11.1 This paper set out the plans to use the Primary Medical Services Premium for a proactive care model across all GPs in City and Hackney. The funds will be used to fund a service for patients at risk of admission but who do not currently meet the criteria for the existing Frail Home Visiting Service.

11.2 The service will start in April 2018 and come under the umbrella of the Frail Home Visiting Contract. The specification for the new service will be brought to the CCG Contracts Committee in November 2017 for scrutiny.

11.3 The CCG Contracts Committee recommended that this service could be delivered through a variation to the 2017/18 Frail Home Visiting Contract.

11.4 Ellie Ward noted that it was important to ensure that any risk stratification used for proactive care fitted in with any emerging risk stratification in the work around neighbourhoods.

11.5 The Integrated Commissioning Board

- **ENDORSED** the recommendations for the service

12. Winter Readiness Plan

12.1 David Maher introduced the report on the Winter Readiness Plan for City and Hackney. The local A&E Delivery Board (part of the Unplanned Care Board) were required to submit the plan to NHSE in September.

12.2 Randall Anderson reflected that the plan was very Homerton centric and that it would be useful to see the similar plan for Royal London Hospital and UCH. David Maher to source these.

12.3 The Board noted that there is significant concern in the acute sector about the potential flu pandemic this winter and it was noted that local authorities need to build this into their resilience and emergency planning. AC to confirm the City of London Corporation lead on this.

12.4 The Integrated Commissioning Board:

- **NOTED** the report

12.5 **ACTION: CICB 1810-3:** David Maher to source Winter Readiness Plans from UCLH and Royal London hospitals

12.6 **ACTION: CICB 1810-4**: Andrew Carter to confirm the City of London Corporation lead for flu resilience

13. Finance Report Month 5

13.1 The Integrated Commissioning Board

- **NOTED** the report

14. National Ambulance Response Times Briefing for CCGs

14.1 The Integrated Commissioning Board

- **NOTED** the report

15. Reflection on ICB meetings

15.1 Honor Rhodes reflected back on some of the specific City of London Corporation issues raised in the meeting and noted the importance of considering City of London Corporation needs. Honor suggested that when meetings were held back to back it might be useful to have the City of London Corporation meeting first in order to ensure adequate energy and reflection of City needs.

16. Any Other Business

16.1 It was agreed that the next meeting will be a combined one of the two ICBs and that according to the Terms of Reference, the Chairs of the ICBs will rotate and that Dhruv Patel will chair the City ICB for the next 6 months.

16.2 Clare Highton was thanked by the Board for chairing the City ICB for the first 6 months.

Document 4.2

Title:	Record of decisions from inquorate August meeting
Date:	15 November 2017
Lead Officer:	Devora Wolfson
Author:	Ellie Ward
Committee(s):	City of London Integrated Commissioning Board - 18 October 2017
Public / Non-public	Public

Executive Summary:

The 18 October 2017 meeting of the City Integrated Commissioning Board was inquorate as the City of London integrated commissioning sub-committee only had 2 Members in attendance whereas the standing orders for any City of London Corporation sub-committees state that in order to be quorate, three Members have to be in attendance.

Any decisions or endorsements had to be agreed after the meeting by the third Member of the Sub-Committee who was not present at the meeting.

The full minutes are also included with this agenda item.

Recommendations:

The City of London Integrated Commissioning Board is asked to NOTE that the recommendations and endorsements made at the October meeting were agreed after the meeting by the third Member of the City of London Integrated Commissioning Sub-Committee.

The meeting had the two sub-committees meeting concurrently and the decisions were:

Item 3 : Local System 2018/20 Financial Planning.

The report sought approval to the approach to 2018/19 financial planning proposal as an integrated system as set out in the report.

AGREED. This will be discussed further at the ICB / TB Financial Seminar on 23 November 2017.

Item 7: Workstream Assurance Review Part 2

The ICB was asked to note the progress being made by the workstreams against the assurance point 2 gateway and to endorse the system issues and next steps outlined

System issues and next steps were ENDORSED

Item 8 : Prioritisation of Investment Requests.

The ICB was asked to consider the recommendations on the method for prioritisation for investments set out in the report, approve the methods and the timelines and approve the paper for

discussion at the seminar on 23 November.

The outline proposal and process was AGREED, subject to consideration of how we assess the process after it is trialled on a couple of projects and how statutory services are considered within this.

Item 10: Co-Production Charter.

The ICB was asked to endorse and approval the co-production charter for health and social care in Hackney and the City.

The underlying principles of the Charter were AGREED subject to some wording amendments to the charter which will be brought back to a future ICB

Item 11: Investment of PMS Premium

THE ICB was asked to endorse the recommendations of the CCG Contracts Committee (in relation to the use of the Primary Medical Services premium)

This was ENDORSED

These decisions were agreed by Dhruv Patel on 23 October 2017 by email.

Document 4.3

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

Hackney Integrated Commissioning Board

Meeting of 18 October 2017

MEMBERS

Hackney Integrated Commissioning Committee

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

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

City and Hackney CCG Integrated Commissioning Committee

Paul Haigh – Chief Officer, City & Hackney CCG

Clare Highton – Chair of the City & Hackney CCG Governing Body

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

FORMALLY IN ATTENDANCE

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

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

Sunil Thakker – Joint Chief Finance Officer, City & Hackney CCG

Jackie Moylan deputising for Ian Williams – Group Director, Finance and Resources, London Borough of Hackney

STANDING INVITEES

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

London Corporation
Jake Ferguson – Chief Executive, Hackney Council for Voluntary Services
Jon Williams – Director, Hackney Healthwatch

OFFICERS PRESENT

Devora Wolfson –Programme Director, Integrated COMMISSIONING
Amy Wilkinson – Workstream Director – Children, Young People and Maternity
Kate Heneghan – Public Heath Strategist (for item 9)
Jarlath O'Connell - Integrated Commissioning Governance Manager (minutes)
(*Minutes*)

APOLOGIES

Members

Cllr Geoffrey Taylor – Lead Member for Finance & Corporate Services, London Borough of Hackney

1. Apologies and Introductions

1.1. The Chair welcomed members and attendees to the meeting.

1.2 Councillor Taylor has stood down from position as member of ICB and LBH Cabinet Member because of ill health so LBH will be identifying their third member of the Hackney integrated Commissioning Committee

2. Declarations of Interest

2.1. Jake Ferguson declared an interest as a provider.

2.2 Haren Patel and Clare Highton declared an interest as GPs working in Hackney and therefore in agenda item 10

3. Local System 2018/19 Financial Planning – PRIVATE ITEM

3.1 Sunil Thakker took the ICB through the paper on behalf of the 3 commissioners which outlines a potential system control total for City and Hackney. The figures

presented included scenarios relating to the CCG and two LA positions that were consolidated to give an indicative system position. The Provider financial positions were included in the CCG spend, but there was a sensitivity on failing to deliver CIPs and would have an impact on the system control total. The paper highlighted known risks and was to be refined by the time of the scenario workshop. He also outlined the issues relating to the NEL STP control total, in particular, the risk share framework and the NHSE ask of delivering additional in-year surplus in support of balancing the NEL system position.

3.2 Jon Williams asked whether an equality impact assessment had been undertaken on the planned savings. It was clarified that equality impact assessments would be undertaken once proposals had been worked up by the workstreams. There are likely to be quite challenging assumptions made which will need public consultation

3.3 It was agreed that scenarios for a 3 year time period would be developed and that these will be shared at the financial scenario workshop on November 23rd The aim of the workshop is to share the assumptions and collectively design a process for the workstreams to identify what steps would need to be taken to achieve a system financial balance by the end of the 3 year period.

3.4 Jackie Moylan added that the scenarios will need to take account of the fact that there may be further savings to be made by LBH, for example, once the pay award has been agreed.

3.5 Cllr. Bramble suggested that savings proposals should take account of local or shared priorities. Paul Haigh stated that these were set out in the workstream asks.

3.6 **ACTION HICB 1810-1**: Sunil Thakker will work with the CFOs from LBH and CoLC to develop the 3 year scenarios.

3.7 Jake Ferguson stated that it was important that Providers are aware of this work in terms of their contracts. This was agreed as a principle.

3.8 The ICB concluded that the approach set out in the paper, is it a sensible way forward and will encourage system thinking and will be taken forward at the financial scenario workshop on 23 November 2017.

3.9 The Integrated Commissioning Board

- **APPROVED** the approach to 2018/19 financial planning proposal as an integrated system as set out in the report.

4. Questions from the public

4.1 There were no questions from the public

5. Minutes of the Previous Meetings

5.1 The Integrated Commissioning Board:

- **APPROVED** the minutes of the Hackney ICB meeting on 20 September 2017
- N**OTED** the minutes of the City ICB meeting on 20 September 2017.
- **NOTED** progress on actions recorded on the action log
- **APPROVED** the minutes of the Joint ICB meetings held on 2 August 2017 as an accurate record.
- **RATIFIED** the decisions from the Hackney ICB on 2 August 2017

6. Framework for Risk Sharing 2017/18

6.1 Sunil Thakker introduced the paper for risk sharing across East London Health and Care Partnership CCGs.

6.2 The CCG Governing Body has been discussing potential arrangements for risk sharing across East London Health & Care Partnership CCGs. These views, plus those of the other CCGs have been taken account of, and a framework agreement was submitted to the CCGs Governing Bodies in September 2017. The NHS City & Hackney CCG Governing Body had agreed the document subject to proposals for how the risk share would be deployed being made to the GBs and the GBs receiving information on progress

6.3 The Integrated Commissioning Board

- **NOTED** the report

7. Workstream Assurance Review Pt. 2 for Planned Care, Unplanned Care and Prevention

7.1 Paul Haigh introduced the paper and explained that the focus of assurance Review Point 2 was on:

Transformation plans
Virtual teams
Further pooling opportunities
General OD issues

7.2 Paul Haigh outlined that all 3 workstreams are making good progress with their transformation plans and in understanding the current contractual arrangements that support each and outlined that the workstreams want to focus on how plans once agreed by the Transformation Board are embedded across the partner organisations by front line staff. One proposition was to pilot an “MOU” (memorandum of understanding) approach to defining organisational contributions to plans particularly where provider actions are not underpinned by formal contractual levers

7.3 It was noted that the Transformation Board will also consider the model for clinical leadership and engagement across integrated commissioning and how workstreams get system wide clinical support for their plans and ensure clinical and practitioner delivery.

7.4 It was noted that a neighbourhood model is being considered as the potential delivery vehicle for out of hospital services with further discussion about this concept at the Transformation Board in November 2017. If agreed the 3 commissioners will need to agree how to commission the providers to take this forward and how the providers will need to work together within the neighbourhood construct.

7.5 The ICB was informed that Workstream proposals for pooling are:

- All budgets assigned to prevention
- All budgets in planned care associated with continuing care and residential care

7.6 These will be test cases to explore process and willingness of NHSE/NEL for further pooling. Workstreams will be asked to develop mini business cases – once these are supported by the statutory organisations wider discussions can

commence. If approved further changes will be needed to integrated commissioning governance to reflect a further delegation of decision making and expansion of the s75 agreements.

7.7 The ICBs and TB have agreed to review the flow of business and the level of information being considered between workstreams and the TB by February 2018 and explore if further changes are needed to the operating model and governance.flows

7.8 It was agreed that assurance review point 3 will focus on financial planning for 2018/19 and beyond. This will involve the workstreams in developing plans to achieve financial balance and deliver system savings, against 3 scenarios and the TB agreeing system wide priorities. This will be a significant ask and it is proposed that the milestones which are developed for financial planning become the key elements of assurance review point 3.

7.9 In addition Review point 3 will focus on:

- Progress with the “big ticket” items across the system and providing assurance to the 2 HWBBs
- Alignment of all responsibilities and action plans to workstreams by April
- Development of “MOUs” within workstreams (to support implementation of plans), across workstreams (e.g. neighbourhoods, mental health) and across the system (what the workstreams are signing up to achieve).

7.10 Devora Wolfson stated that the Children and Young People’s workstream is making good progress and will be going through Assurance Point 1 in December 2017.

7.11 Jake Ferguson stated that it is being reported that not all of the workstreams are engaging with voluntary sector providers and that this needed to be addressed. Amy Wilkinson outlined her plan for engagement of the voluntary sector in children and young people’s workstream. Anne Canning explained that the voluntary sector are fully involved in all of the innovation projects within prevention.

7.12 Honor Rhodes commented that the development of MOUs will be very important so we have a shared understanding of expectations of the different organisations.

7.13 The Integrated Commissioning Board

- **NOTED** the progress being made by the workstreams against the assurance point 2 gateway
- **ENDORSED** the system issues and next steps outlined.

8. Prioritisation of investment requests

8.1 Anna Garner introduced the paper proposing a process for prioritising future investments and disinvestments based on their value to the City and Hackney system (following the outcome of the financial scenarios workshop in November).

8.2 Eight value criteria are proposed (encompassing all elements of value to the City and Hackney system):

- Physical health gain
- Mental health and wellbeing and quality of life gain
- Supports increasing focus on prevention (wide definition of prevention including wider determinants of health, primary prevention, secondary prevention, and preventing increased health and social care usage)
- Patient empowerment
- Reducing inequalities in health and care outcomes
- Social value
- Ensuring equity in access
- Supports financial sustainability

8.3 Proposals are then scored against these criteria by members of scoring group (scores then moderated for a number of factors and then converted to ranked list, incorporating funding required for the scheme). Scoring is labour intensive but converting value of widely varying schemes to a quantitative measure is the only robust way of comparing.

8.4 ICB members agreed that process was robust and supported the need for one system approach to prioritizing projects and investments 8.5 Scorers cannot be members of the ICB as they would be making the final recommendations so a separation of responsibilities was important in line with good governance principles. Haren Patel raised that scorers must score from a system perspective, trying not to be biased towards their particular organisation. Clare Highton suggested schemes should be negatively scored based on any harmful impact on residents/outcomes. Honor Rhodes asked about the recent research about Adverse Childhood Events.

8.6 David Maher asked for members to consider weighting proposed for value criteria in the paper. Members wanted higher weighting for financial sustainability.

8.7 **ACTION HICB 1810-2 Anna** Garner to email organisations to ask for nominations for people to be part of scoring process

8.8 ACTION **HICB 1810-3** All ICB members to provide nomination from their organisation.

8.9 **ACTION HICB 1810-4** Anna Garner to revise paper and include as part of financial scenarios workshop

8.10 The Integrated Commissioning Board

- **CONSIDERED** the recommendations on the method for prioritisation for investments set out in the report
- **APPROVED** the methods and timelines
- **APPROVED** the paper for discussion at the financial scenarios workshop for the ICB/TB in November

9. Children and Young People's Obesity and Physical Activity Services

9.1 Amy Wilkinson introduced the item, outlining that it is a public health procurement supporting a wider agenda on reducing childhood obesity which sat across the Prevention and CYPMS work stream.

9.2 Kate Heneghan presented the paper, explaining it briefly detailed the commissioning of a 0-5 (lot 1) and 5-19 (lot 2) children's healthy weight prevention and weight management service. The procurement has been successful and a recommendation to award will go to London Borough of Hackney Cabinet Procurement Committee in December. 9.3 The paper was also discussed at Transformation Board, with the additional information that the CCG may be looking at supporting a tier 3 children's healthy weight pilot for 2018/19. There was some discussion on the limited evidence base for reducing childhood obesity but KH is happy to circulate anything relevant. It was noted that a tier 3 proposal would need to be taken forward by the workstream as part of the system financial planning and prioritization work and that a pathway to show how all the services fit together was vital

9.4 There was some discussion around the fact that this paper did not take into account the wider obesity agenda across City and Hackney. Kate explained that this paper related to a very small procurement and there is a much wider scheme of work around reducing obesity, led by Tim Shields through the 'Obesity Strategic Partnership' that includes partners such as Planning, Housing, Young Hackney and transport. There was also some discussion that it would be useful to see some integrated work on a pre-conception (and onward) obesity pathway and this could be explored through the workstreams.

9.5 The Integrated Commissioning Board

- **NOTED** the report.

10. Co-production Charter

10.1Jon Williams introduced the charter by stating that co-production has been a stated goal of integrated commissioning (IC), linked to the ambition of creating a local health and social care system with people at the centre, who are involved in shaping the services they use The charter aims to enshrine the principles of co-production rather than be a set of rules

10.2 Devora Wolfson outlined the feedback from the Transformation Board namely: -

- The Charter should be framed in a way that recognises the different statutory responsibilities of partner organisations
- The Charter need to cover those who work in the City of London.
- The Charter should be framed in a way that shows that co-production is our direction of travel and we will be using the coproduction principles identified.

10.3 ACTION **HICB 1810-5** Jon Williams to revise the charter in light of the comments

10.4 The Integrated Commissioning Board

- **APPROVED** the Co-production Charter for Health and Social Care in Hackney and City subject to the amendments above.

11. Investment of PMS Premium: Proactive Care

11.1 Tracey Fletcher introduced the report and explained that PMS Premium will be used to fund a service for patients at risk of admission but who do not currently meet the criteria for the existing Frail Home Visiting service. The service, titled Proactive Care, will start in April 2018 and come under the umbrella of the FHV Contract. The specification for the new service will be brought to CCG Contracts Committee in November 2017 for scrutiny

11.2 The CCG Contracts Committee recommended a variation to the 2017/18 FHV Contract to allow the 2017/18 PMS Premium money to be used to fund GP practices between November 17 – March 18 to identify patients who are at risk of admission and meet the service criteria, and create a practice register ready for the service to begin in April 2018.

11.3 The Board welcomed the initiative and suggested that this was linked with the neighbourhood model when this is developed. It was noted that the service had been supported by the Transformation Board

11.4 The Integrated Commissioning Board

- **ENDORSED** the recommendations of the CCG Contracts Committee.

12. Winter Readiness Plan

12.1 Tracey Fletcher introduced the report. City & Hackney A&E Delivery Board (i.e. the Unplanned Care Board) were required to submit the Winter Plan to the NHSE and NHSI teams on Friday 8th September 2017. The Unplanned Care Board reviewed and signed off the Winter Plan and provided input from a system perspective.

12.2 The Board noted that Hackney's DTOC performance was of concern although performance has improved slightly. The Board discussed the importance of DTOC as 'system', and not focusing on whether specific DTOCs related to health or to social care. It was agreed that a robust system should be in place to manage DTOCs over the winter and it was noted that a recovery plan would come to the Transformation Board in December 2017 along with the proposals to initiate a discharge to assess pilot scheme

12.3 Clare Highton stated that we needed to work to maximise staff flu vaccinations. Tracey Fletched commented that this is happening across HUHFT.

12.4 Honor Rhodes asked if the Brexit impact has been logged on to the risk register and Tracey Fletched confirmed it had been at HUHFT.

12.5 The ICB noted the plan and thanked Tracey for the work which had been put into it, noting that the system usually performed well over the winter

12.6 The TB had discussed the plan and had

- asked that consideration be given to patient communications about local service availability
- recommended that a system overview was needed about the alignment and coherence of the individual organizational plans relating to flu pandemic

12.7 It was agreed that the latter function should be coordinated and overseen by the 2 local authorities who would be asked to provide assurance to the ICBs and unplanned care board on the local plans

12.8 The Integrated Commissioning Board

- **NOTED** the C&H Winter Plan.

13. Finance Report Month 5

13.1 Sunil Thakker introduced the report and explained that it reports on finance (income & expenditure) performance for the period from April to August 2017 across the CoLC, LBH and CCG Integrated Commissioning Funds.

13.2 The forecast as at month 5 is £4.4m adverse relating to the LBH position which is being driven by Learning Disabilities commissioned care packages. The risks to the position have been flagged in the risk schedule which will be updated and reported on monthly basis.

13.3 Anne Canning explained that Hackney Budget Board is actively monitoring the spend on a regular basis.

13.4 The Integrated Commissioning Board

- **NOTED** the report.

14. National Ambulance Responses Times Briefing for the CCG

14.1 Paul Haigh introduced this report.by explaining that the briefing was issued by NHSE to update members of Clinical Commissioning Group (CCG) Governing Bodies (GB) across London on the new national ambulance response times and the London Ambulance Service (LAS) readiness for the introduction of the new response time standards.

14.2 The Integrated Commissioning Board

- **NOTED** the information.

15. Reflections on ICB Meetings

15.1 There was a view that it was not always clear why reports were coming to the ICBs and that report authors should be asked to confirm this.

16. AOB

16.1 It was noted that the chair of the Hackney ICB would rotate from Cllr McShane to Clare Highton for the coming 6 month period as set out in the ICB terms of reference

16.2 Cllr McShane was thanked for his 6 month tenure as chair of the Hackney ICB.

16.3 It was noted that the November ICB meetings would be joint meetings between the City ICB and the Hackney ICB.

Ref No	Action	Assigned to	Assigned from	Assigned date	Due date	Status	Update	Update provided by
CICB 1810 -1	To review how statutory services are considered within the prioritisation process after the initial phase of scoring is completed, assessing what is working and what could be done better.	Anna Garner	City Integrated Commissioning Board	18/10/2017	30/11/2017	Open		
CICB 1810-2	Updated Coproduction Charter to be brought back to City ICB	Jon Williams	City Integrated Commissioning Board	18/10/2017	15/11/2017	Closed		
CICB 1810-3	Source Winter Readiness Plans from UCLH and Royal London hospitals	Dave Maher	City Integrated Commissioning Board	18/10/2017	30/11/2017	Open		
CICB 1810-4	Confirm City of London Corporation Lead for flu resilience	Andrew Carter	City Integrated Commissioning Board	18/10/2017	30/11/2017	Closed		
CICB 1709-1	To examine securing more City level data on cancer performance.	Neal Hounsell/ Siobhan Harper	City Integrated Commissioning Board	20/09/2017	30/11/2017	Open		
CICB 1709-2	To refer the issues of increased pressure for GP appointments and in particualr for Neaman Practice to the CCG's Local GP Provider Contracts Committee	Paul Haigh	City Integrated Commissioning Board	20/09/2017	30/11/2017	Open		
CICB1706-5	To bring a paper to the ICB for decision outlining further proposals for pooled budgets in support of the Integrated Commissioning Programme.	Paul Haigh / Devora Wolfson	City and Hackney Integrated Commissioning Boards	28/06/2017	13/12/2017	Closed	Svcheduled for December ICB	Devora Wolfson
CICB1705-1	To invite the CoLC Social Value Panel to discuss their work, alongside a wider discussion about how to procure to acieve social value	Ellie Ward/David Maher	City and Hackney Integrated Commissioning Boards	23/05/2017	31/12/2017	Open	Planned for January 2018	Devora Wolfson/Ellie Ward
HICB 1810-1	To work with the CFOs from LBH and CoLC to develop the 3 year scenarios.	Sunil Thakker	Hackney Integrated Commissioning Board	18/10/2017	20/11/2017	Open	Workshop planned for 23 November 2017	
HICB 1810-2	To email organisations to ask for nominations for people to be part of scoring process for prioritisation of investment requests	Anna Garner	Hackney Integrated Commissioning Board	18/10/2017	10/11/2017	in progress	Email sent awaiting responses	
HICB 1810-3	All ICB members to provide a nomination from their organisation to participate in the scoring of prioritsation of investment requests	All	Hackney Integrated Commissioning Board	18/10/2017	30/11/2017	Open		
HICB 1810 4	To revise paper on prioritisation of investment and include as part of financial scenarios workshop	Anna Garner	Hackney Integrated Commissioning Board	18/10/2017	03/11/2017	Closed	Incorporated into papers for the Finacial scenario workshop on 23 November	
HICB 1810 -5	To revise Co-production Charter in light of the comments from the ICB	Jon Williams	Hackney Integrated Commissioning Board	18/10/2017	01/11/2017	Closed	Being considered at November ICB meeting	
HICB 1709-1	To present an analysis of the impact of Universal Creadit introducition to a future ICB.	Ian Williams	Hackney Integrated Commissioning Board	20/09/2017		Open	To be scheduled for TB and ICB following further guidance on the timeline for furthe roll out	
HICB 1709-2	Report template to be amended to include a section on equality impacts	Devora Wolfson/ Jarlath O'Connell	Hackney Integrated Commissioning Board	20/09/2017		Closed	A revised report template will be used from the Nov meetings onwards	
HICB 1709-3	To organise a joint workship for ICB and TB Members in November to focus on financial planning for 2018/19	Devora Wolfson/ Jarlath O'Connell	Hackney Integrated Commissioning Board	20/09/2017		Closed	This will be held on 23 November 2017	

Title:	*Options Appraisal for Local Response to NEL IUC*
Date:	15th November 2017
Lead Officer:	Tracey Fletcher
Author:	Anna Hanbury
Committee(s):	Unplanned Care Workstream Board – for recommendation, 27th October 2017 Transformation Board – for recommendation, 10th November 2017 Integrating Commissioning Boards – for recommendation, 15th November 2017 Contracts Committee - 24th November 2017 Governing Body – 24th November 2017
Public / Non-public	N/A

Executive Summary:

Introduction

The NHS Five Year Forward View highlights the importance of delivering a functionally integrated urgent care service (IUC) to address the fragmented nature of out of hospital services. In line with this, C&H are procuring a new Integrated Urgent Care Service in collaboration with 6 other CCGs across North East London (NEL IUC) which is due to go live in March 2018.

The introduction of the NEL IUC fragments the current GPOOH service in City and Hackney and requires development of a new clinical (and service) model for managing referrals from the NEL IUC for urgent face-to-face primary care consultations (including base and home visits) in the out of hours period.

Purpose

The paper outlines the requirements of the new model and describes all the options that have been identified and discussed together with their relative advantages and disadvantages in terms of quality and cost.

Options

1) **Do nothing**

2) **Extend Primary Urgent Care Centre (PUCC) to be a 24 hour service -** integrate GP Out of Hours (GPOOH) activity into it extended PUCC service.

3) **Mixed Model –** Split the GP OOH activity between Extended Access Hubs when they are open and PUCC during the overnight period.

4) **Stand-alone model –** GP OOH remains a stand-alone service with a range of provider options including; CHUHSE, Homerton and GP Confederation.

Proposal and Commitment to Developing an Integrated Solution

The paper concludes that the long term solution / new model should be one that is integrated with existing services providing a similar function (i.e. urgent primary care),

enables providers to work together and minimises system costs. However, it is recommended that the current GP out of hours contract should be extended as a stand-alone service for a fixed period until March 2019 whilst an integrated solution is fully developed. Whilst this is not the most cost-effective option, the Unplanned Care Board agreed that it was the safest and highest quality solution given the current time-frames and real risks related to a scarce GP work-force.

Questions for the Transformation Board

The Transformation Board are asked to consider the models described in the paper and make a recommendation to the Integrated Commissioning Board whether or not to approve the proposal for an interim stand-alone solution whilst and integrated solution is fully developed.

Issues from Transformation Board for the Integrated Commissioning Boards

A verbal update from the Transformation Board will given to the Integrated Commissioning Boards

Recommendations:

The Integrated Commissioning Board is asked to:

- Approve the proposal to commission a standalone face to face service as an interim solution once the telephone advice and triage transfers to NEL IUC up until March 2019.
- Approve the selection of CHUHSE as the preferred provider with Homerton as the 2nd choice if legal advice indicates that the procurement risk associated with CHUHSE extension is too high.
- Approve additional funding required as set out in the report.
- Endorse the unplanned care programme's commitment to develop an integrated solution:
    - Proposed programme structure to be presented to the Integrated Commissioning Board in January 2018.
    - Implementation of plan by March 2019.

Links to Key Priorities:

The immediate proposal supports the STP goal of Reducing Hospital Admissions

The long term solution will support other key priorities:

- Improve the health and wellbeing of local people with a focus on prevention and public health, providing care closer to home, outside institutional settings where appropriate, and meeting the aspirations and priorities of the 2 Health and

Wellbeing strategies;
- Ensure we maintain financial balance as a system and can achieve our financial plans;

Specific implications for City and Hackney

The proposal to continue with CHUHSE as an interim solution will minimise the change locally when NEL IUC is introduced. The home visiting service will continue to visit City patients who are unable to access the Homerton for a base visit.

Improving access for City patients will be a key consideration in development of the long term integrated solution.

Patient and Public Involvement and Impact:

The options have been developed in consultation with patient representatives from the steering group with oversight of this work and the Unplanned Care Board.

The recommendation for preferred option takes into account the positive patient feedback on CHUHSE.

Further engagement with all sections of the community is planned via the Patient and User Experience Group and the Patient and Public Involvement Committee.

Clinical/practitioner input and engagement:

The options have been developed in consultation with the CCG Clinical Commissioning Lead for Unplanned Care, Homerton Clinical Lead in Emergency Medicine and GP's from the GP Confederation and Primary Care Quality Board.

Impact on / Overlap with Existing Services:

The preferred option provides continuity of an existing service and will help mitigate the potential impact of the introduction of the NEL IUC on other urgent and emergency services.

Supporting Papers and Evidence:

Appendix 1: Letter from CCG to Dylan Jones in response to specific questions related to the local response model including predicted number of onward referrals in out of hours
Appendix 2: Current CHUHSE and predicted face demand profile
Appendix 3: Detailed breakdown of costs for each option

Sign-off:

[Papers for approval by the ICBs must be signed off by the appropriate senior officers. Any paper with financial implications must be signed by the Members of the Finance Economy Group.
If there are any legal implications which require consultation with legal counsel, please make reference to that below.
Please ensure you have appropriate sign off for your report, along with the papers. Papers which have not been signed-off by the appropriate officers will not be considered by the Committee.]

Workstream SRO _____[Tracey Fletcher, CEO Homerton]_____

London Borough of Hackney _____[Ann Canning]_____

City of London Corporation _____[Neal Hounsell]_____

City & Hackney CCG _____[Paul Haigh]_____

Main Report

Options Appraisal for Local Response to NEL IUC

1. Introduction

The NHS Five Year Forward View highlights the importance of delivering a functionally integrated urgent care service (IUC) to address the fragmented nature of out of hospital services. In line with this, C&H are procuring a new Integrated Urgent Care Service in collaboration with 6 other CCGs across North East London (NEL IUC) which is due to go live in March 2018.

The introduction of the NEL IUC fragments the current GPOOH service in City and Hackney and requires development of a new clinical (and service) model for managing referrals from the NEL IUC for urgent face-to-face primary care consultations (including base and home visits) in the out of hours period.

The following options appraisal was presented to the Unplanned Care Programme Board in October. The recommendation from this group is that the current GP out of hours contract should be extended as a stand-alone service for a fixed period of 12 months whilst an integrated solution is fully developed. This is not the most cost-effective option, but the board agreed that it was the safest and highest quality solution given the current time-frames and real risks related to a scarce GP work-force.

2. Background and Overview of the new model

City and Hackney Urgent Healthcare Social Enterprise (CHUHSE) currently holds the contract for local Out of Hours (GPOOH) primary care services. In its entirety, this includes call handling, GP clinical triage, GP face-to-face clinical appointments and home visits.

The new IUC service being procured across NEL incorporates the current NHS 111 call handling **and** the telephone elements of current GPOOH services (triage/assessment and advice/treatment) via a new multidisciplinary clinical advice service (CAS). The aim of the new service is to provide the single telephony access point into a functionally integrated urgent care system.

Patients, after phoning 111, will have their needs assessed either with a clinical decision support system (algorithm e.g. Pathways), directly by a clinician, or a combination of both. Patients who are assessed as needing a face-to-face consultation will be referred into the most appropriate local service to do this. NHSE's IUC Service Specification states that all onward referral for GP face-to-face consultations in the out of hours period must be directly booked[1].

The novelty of the new NEL IUC model, specifically the introduction of the CAS, makes it very difficult to predict the onward referral activity in any detail or certainty. An estimated range of annual face to face

[1] https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf

activity has been developed based on the NEL IUC modelling together with assumptions about the efficacy of the CAS in comparison to current GPOOH telephone assessment outcomes[2].

Table 1. Predicted onward referral from NEL IUC in 2018/19 (with different levels of CAS efficacy) in comparison with current CHUHSE.

Scenario	Total GPOOH dispositions (from IUC modelling)	% call closure by CAS	No. call closure by CAS	Predicted total onward referral for F2F	Predicted base consultation (90%[3])	Predicted home visit (10%[4])
Successful CAS	16716	33 % closure by CAS	5516	11200	10080	1120
CAS failure	16716	No closure by CAS	None	16716	15044	1672
Current CHUHSE (2015/16)	n/a	n/a	n/a	11455	10337	1118

In the absence of a detailed profile (hour of day/ day of week) for onward referrals from the NEL IUC it is reasonable to assume a similar *pattern* of activity as currently seen by CHUHSE with volumes adjusted in proportion to the estimated total annual referrals (see appendix 2 for current CHUHSE and predicted face demand profile).

The contract for the current provider of OOH services, CHUHSE has been extended to December 2018 to mitigate against any slippage in the IUC start date but with an expectation that this will be terminated by mutual agreement at the point the IUC goes live and cannot be used as mitigation for the implementation of a face to face model. In short as soon as the telephone advice and triage moves to the NEL IUS service the new model for delivery for urgent out of hours face to face primary care will be required and their start dates MUST be aligned.

3. Engagement

The following stakeholders were consulted in the process of developing this options appraisal, on advance of presentation at the Unplanned Care Programme Board:

Name	Role
Laura Sharpe	CEO GP Confederation

[2] Appendix1: letter from CCG to Dylan Jones in response to specific questions related to the local response model including predicted number of onward referrals in out of hours.
[3] The predicted % of base visit vs home visit has been modelled on current activity in CHUHSE
[4] As above

Nigel Wylie	CEO CHUHSE
May Cahill	GP Clinical Lead, CCG
Emma Rowland	Clinical Lead in Emergency Medicine, Homerton
Osian Powell	Divisional Operations Director
Joyce Hartzenburg	General Manager IMRS Homerton
Extended Access / GPOOH / 111	Working group

4. Options Appraisal

The following section describes all the options that have been identified and discussed and outlines their relative advantages and disadvantages. Section 5 presents a summary of the benefits and risks of each including costs.

Option One – Do Nothing

The NEL IUC service is due to commence by 31st March 2018. As set out above, the introduction of this new service fragments the existing GPOOH clinical and service model in such a way that it cannot continue and deliver a safe and effective service to patients within its existing contract. Commissioners are therefore required to develop a new model that will receive referrals from the NEL IUC for face-to-face primary care in the OOH period.

Option Two - GPOOH activity picked up within PUCC contract - PUCC service extended to 24 hours

The Primary Urgent Care Centre (PUCC) currently manages those patients who attend A&E with urgent primary care needs and is staffed by a mixture of GP's s and ENP's and is open 16 hours a day.

The PUCC opening hours would be extended to 24/7 and referrals for face-to-face GP consultations would be directly booked into it during periods when GP surgeries and extended access services are not open (including protected learning time).

Advantages (benefits)

- Consuming the activity within an existing contract avoids the need for procurement.
- Economies of scale achieved by combining two services with similar activity.
- Existing skill mix in PUCC would facilitate effective use of scarce GP resource.
- Existing infrastructure and premises would help reduce costs.
- 24 hour streaming would be available for walk in patients enabling ED to focus on higher acuity patients at all times.
- The Homerton is a large organisation and therefore in a better position to manage risk associated with uncertainty about activity.

Risks (disadvantages)

- An Urgent Treatment Centre (UTC) co-located with A&E and managed by an acute trust is likely to be more risk averse than a primary care led service (potential for increased A&E conversions / admissions).

- Failure to fill GP shifts more likely to be managed by shifting activity into ED rather than finding a primary care solution. This presents a risk to operational and clinical service delivery in ED.
- IT systems will likely have to be changed to enable direct booking from IUC (although UTC's will be expected to do this irrespective of GPOOH).
- Lack of local GP buy in – local GP's are very keen for service to be primary care lead.
- Impact on 4 hour target from any new activity going through ED and from the risk of current PUCC staff having to cover any gaps in the GP out of hours rota.
- It would be very difficult to guarantee that this service is in place by March 2018

Option Three - GP OOH activity picked up by PUCC and Extended access contracts

From November 2017 a primary care hub will be open in a GP surgery to deliver extended access pre bookable and on the day appointments. The Hub will be open from 18.30 for a minimum of 1 ½ hour to 20.00 Monday to Friday and 08.00 – 20.00 Saturday, Sunday and Bank Holidays. This Hub will be based in the North of the Borough.

In order to be able to recruit Drs to cover the extended access sessions Monday to Friday it is expected to open the hubs for a full session (being approx. 4 hours, 10mins which potentially could be from 18.30 – 22.30. Additional GP capacity could be provided within the hubs to manage urgent referrals for primary care consultations during the hours that they are open.

The PUCC could be pick up the activity for the overnight period once the hubs are closed.

Advantages (benefits)

- Delivering primary care in primary care setting would help to reinforce the message for patients to avoid A&E for primary care complaints.
- There would be potential to offer better access for city patients during certain hours. However this would only be the case if the south hub was used and equity of access would only be achieved if both hubs were used (this would be cost prohibitive). The South Hub will not be opening until April 2018.
- More likely to achieve GP buy with an element of provision being primary care led in a primary care setting.

Risks (disadvantages)

- Expensive –
    - It would not be possible to rely on the extended access GP to 6.30-8pm therefore there is minimal opportunity for sharing resources. Sufficient additional capacity to manage all the predicted OOH activity would be required.
    - As the activity is split between two providers, both would incur associated organisational costs.
- The contractual mechanisms for extended access have not yet been agreed therefore it is uncertain whether urgent unplanned GP activity could be added to it.
- There may be security issues related to having OOH patients attending a GP practice for late appointments. There are no security mechanisms in place at a GP surgery.

- Potential complications with different indemnity requirements – previously OOH required additional indemnity due to its unplanned nature. This would need to be explored as it might change with direct booking from IUC.
- Substantial additional regulatory activity would need to be undertaken e.g. CQC compliance for OOH services, application for controlled drug license, medicines management etc.
- Changing the location of provision at different times of the day could be confusing for patients.
- Equity of access would be difficult to achieve unless a centrally located hub is introduced (as above).

Option Four - GP OOH remains stand-alone service – range of provider and procurement options

The urgency to find a solution comes mainly from the financial pressure that CHUHSE will face within their existing contract once the telephone activity and associated funds are transferred to the NEL IUC in March 2018.

The face-to-face element of GPOOH could continue as a stand-alone service with a range of provider options. Although this might not be a sustainable long term solution it could be sensible interim solution which:

- Allows for a transition phase (rather than attempting to manage multiple changes at one time)
- Provides the opportunity to assess the impact of new IUC & the pattern of onward referrals
- Allow extended access hubs / model to embed
- Allows time for an integrated long term solution to be developed

The contract could be awarded to a range of providers:

- Homerton
- Confederation
- CHUHSE
- Alliance
- Other

The exact clinical / service model would depend on the provider each with its own advantages and disadvantages.

The procurement requirements depend on the approach to this option and whether it is managed through a variation to an existing contract or award of a new one.

Award of a new contract would require issue of a 'Prior Information Notice' which would indicate the intention to award the contract to a specific provider with an explanation of the rationale for doing so. Should the notice generate interest from an alternative qualified provider then a competitive tender would be required.

Alternatively, the face to face activity could be commissioned through a variation to and existing contract if the service is very similar and the value added less than 50% of the original contract. Care needs be taken to ensure that the variation fits within these procurement rules to minimise risk of challenge.

Advantages (benefits)

- It would be easy to maintain the current IT systems (Adastra) which enables simplified data transfer from CHUHSE and easy transfer of data and electronic direct booking from IUC (also uses Adastra).

- Keeps activity separate – easy to monitor impact of new IUC service.
- Keeping a separate contract avoids the issue of mixing different cohorts of patients e.g. Walk in / booked in PUCC (& 4 hour target) / Planned and unplanned with extended access
- Provides short term solution that allows evaluation of impact of IUC before making decision about long term solution.

Provider specific advantages:

Homerton
- As for option 2
- Potential to avoid procurement via a variation to the Community Health Services Contract.

Confederation
- As for option 3 (primary care related)
- Potential to avoid procurement via a variation to the GP Clinical Services Contract.

CHUHSE
- Potential to avoid procurement through extension and variation of existing contract.
- Retain provider expertise and workforce. CHUHSE have effectively provided high quality GP out of hours services to date and have a successful track record of filling GP shifts.
- Retain current provider ability to manage patients within service, minimising impact on A&E
- Public / Patient loyalty to CHUHSE.
- Minimal disruption / change from current provision.

Other
- Depends on provider but potential for economies of scale / cross border STP working.

Risks (disadvantages)

- Expensive – reduced opportunity for economies of scale and flexibility of workforce.
- Missed opportunity for integration.
- Depending on the approach taken - potential requirement for competitive tender with insufficient time to complete by March 2018 and possible private sector interest.

Provider specific disadvantages:

Homerton
- As for option 2
- No experience providing GP OOH service

Confederation
- No experience in directly (i.e. not via practices) providing urgent primary care or providing an overnight service.
- Minimal existing infrastructure to support the contract.
- Premises – the nature of the risk depends on the choice of location for the service :
    - HUB: Practices are not set up for holding medicines or being open overnight. The risks associated with both would need to be addressed and would likely require additional security personnel.
    - Homerton site: Non primary care setting and cost for rental.
- Financial risk for small organisation to take on new service with uncertain demand.

CHUHSE

- Most expensive option – no shared overheads.

Other

- Loss of local involvement and reduced opportunity for integration.
- Patient / public dissatisfaction.

Appendix 1

Dear Dylan,

RE: Local response to new NEL 111 Model

Please find enclosed the information requested in Tracey's letter, dated 2nd April, regarding this issue.

The information provided is as accurate and detailed as possible but should be caveated with the following:

- Predicted activity is indicative and based on the NEL IUC modelling together with current activity patterns within 111 and GPOOH. Although robust assumptions have been used it is very difficult to predict how people will react to the new model
- The national standards and metrics for IUC and related services are still in development and are likely to emerge / be refined over time

A small change to the clinical model has been introduced following the NHSE gateway which might have a minor impact on predicted activity but this is very unlikely to extend beyond the ranges out lined below. Any significant changes will be shared as soon as the re-modelling is complete.

We will keep you updated in any developments in guidance or evidence from pilots that might have impact on the local model.

1. **The predicted number and percentage of GP dispositions which will be closed directly by the new IUC Clinical Assessment Service (CAS);**

The new NEL IUC contract reporting requirements include a measure (number and percentage) of calls closed as self-care by:

- Call handlers
- Clinician
- Pharmacist

The *threshold for a cumulative measure of over the reporting month has been set at 33%.* It is reasonable to assume that this percentage closure can be applied to GP dispositions managed by clinicians in the CAS.

Year	Total IH GP dispositions (from IUC modelling)	Predicted closed by CAS (33% KPI)
2018/19	4950	1634
2019/20	4991	1647
2021/21	5031	1660

Year	Total GPOOH dispositions (from IUC modelling)	Predicted GPOOH dispositions closed by CAS (33% KPI)
2018/19	16716	5516
2019/20	16939	5590

2021/21	17159	5662

2. **The predicted number of calls that will be transferred from the IUC Clinical Assessment Service to in hour's general practice;**

Year	Total IH GP dispositions (from IUC modelling)	Predicted closed by CAS (33% KPI threshold)	Predicted onward referral for F2F
2018/19	4950	1634	3317
2019/20	4991	1647	3344
2021/21	5031	1660	3371

Given the novelty of the IUC it would be advisable to plan for a range of activity between total GP IH dispositions and predicted onward referral i.e. 2018/19: 3317 – 4950 / year

3. The predicted number of face-to-face clinic appointments for the out of hours period

4. The predicted number of home visits for the out of hours period;

Year	Total GPOOH dispositions (from IUC modelling)	Predicted GPOOH dispositions closed by CAS (33%)	Predicted total onward referral for F2F	Predicted base consultation (90%[5])	Predicted home visit (10%[6])
2018/19	16716	5516	11200	10080	1120
2019/20	16939	5590	11349	10214	1135
2021/21	17159	5662	11497	10347	1150

Assuming CAS does not close any calls:

Year	Total GPOOH dispositions	Predicted base consultation (90%)	Predicted home visit (10%)
2018/19	16716	15044	1672
2019/20	16939	15245	1694
2021/21	17159	15443	1716

As with GPIH disposition it would be advisable to model service on range of activity for base and home visits between that predicted with no CAS closure and 33% closure:

2018/19 base visits: 10080 – 15044

2018/19 home visits: 1120 – 1672

5. The Key Performance Indicators and any relevant mandated requirements local providers will have to deliver for activity received from the IUC Clinic Assessment Service during both the in hours and out of hours period, covering all relevant dispositions;

[5] The predicted % of base visit vs home visit has been modelled on current activity in CHUHSE
[6] As above

The Integrated Urgent Care Commissioning standards set out the full range of requirements for delivering a functionally integrated 24/7 urgent care system including onward referral to other services. These standards can be found at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf

The national IUC metrics are intended to measure performance across the entire integrated urgent care pathway (including referral on to face to face consultations). Standards for these metrics have not yet been set and will be defined once sufficient data has been collected from providers.

The latest national IUC metrics can be found at:

https://www.england.nhs.uk/wp-content/uploads/2016/11/iuc-kpi-nov16.pdf

At present, no specific requirements have been released for delivering activity received from the IUC Clinical Assessment Service. In their absence, it would be advisable to follow response times detailed in the GP Out of Hours National Quality Requirements (NQR's attached appendix 1).

Patients referred from the IUC Clinical Assessment service will have spoken to a clinician who will assess the urgency of the call. Modelling to predict volumes of different urgencies has not been undertaken.

7. Any specific information with regard to the way (or ways) in which the IUC Clinical Assessment Service is expected (or mandated) to interface with local in hours and out of hours responses;

The recent update on the UEC 5 year forward delivery plan (March 2017) includes the following standards for level of direct booking from IUC (111/CAS):

Offer area	16/17	17/18	18/19	Notes
Level of booked appointments in-hours	5%	10%	30%	Callers will be able to have an appointment booked with GP practice or GP/primary care service
Level of booked appointment out of hours	70%	90%	95%	Callers will be able to have an appointment booked in primary care service

- Maybe interoperability standards

Work is underway at the London level to develop the interface between urgent and emergency care and primary care. No formal guidance has been issued but key elements are being discussed and are outlined in the presentation attached (appendix 3).

6. Any specific information with regard to which clinical staff can undertake out of hours activity;

Patients that are referred onward from the CAS will have spoken to a clinician who will decide whether they need a face to face consultation with a specific clinician e.g. GP.

The potential GP OOH / IH activity has been modelled from existing 'GP' pathways dispositions and guidance notes for these acknowledge that other primary care physicians might be appropriate (Clarification of terms used in NHS pathways dispositions attached in appendix 2).

8. The expected timeline for implementing a local out of hours response.

The new IUC service is due to go live between 1st March and 1st April 2018. The local face to face model for both in and out of hours response needs to align with this timeline.

9. **Fully confirmed activity and cost figures for the current elements of provision presented at the work-shop and considered to be relevant to out of hours provision and the contractual and recurrent/non-recurrent status of these services at present.**

The table below details the current services considered relevant to the local face to face response over the 24 hour period. The relevance of each to the in or out of hours response is open for discussion. The new response model could have less distinction between the two providing a 24 hour service with a clinical capability and capacity that changes to match the pattern of demand over the 24 hour period.

Service	Workforce	Service Model	Activity p/a	Funding
PUCC	**Nurse Practitioners + GPs at various times**	**Face to face**	**22, 394**	**£1, 073m (R)**
HOPS	**1 GP**	**Face to face**	**Not recorded**	**£176, 000 (NR)**
	22.00 – 03.00 (35hrs)			
CHAPS	**1 GP (41hrs)**	**Face to face**	**Not recorded**	**£182, 400 (NR)**
Duty Doctor	**GPs in all practices**	**Telephone, face to face, home visits**	**160, 628 telephone**	**£1.5m (R)**
			67, 464 appointments	
			11, 244 home visits	
GP OOH (CHUHSE)	**2xGP, 1xGP standby, 1x drive, 1x call handler**	**Telephone, face to face, home visits**	**25, 407 telephone**	**£2, 105m (R)**
			10, 337 base	
			1, 118 home visits	
Paradoc (divert scheme)	**1xGP, 1xparamedic**	**Face to face and home visits**	**6/day**	**£600, 000 (R)**

New London model	**Local practices**	**GP Practices and hubs**	**New service**	**2017/18: £272k subject to NHSE/HLPs approval of local plan**
Extended Hours in Primary Care				**2018/19 and beyond: TBC Jan 2018**

10. The total available recurrent financial envelope confirmed

The non-recurrent funding detailed above will cease on 31st March 2018 and £947,213 of the existing CHUHSE budget will be transferred to the NEL IUC contract from 1st March 2018. The potential money from NHSE for extended access has will not be confirmed until January 2018.

Therefore the total confirmed envelope available is £3,731,303 (this included duty doctor funding but excludes potential NHSE money for extended access).

I hope this provides sufficient information for you to progress with development of the local model and propose a timescale for the work including a date for presentation to the Transformation Board.

Please let me know if you have any queries or require any further information in the meantime.

Yours sincerely,

5. Costs, Benefits and Risks of the different options

The table below provides a summary of estimated costs, benefits and risks for option 2, 3 and 4. The assumptions and methodology underlying the costing are outlined in the list below and detailed breakdown of costs are provided in Appendix 3.

Cost type	Option 2: expand PUCC	Option 3: Mixed model (5 hours @ hub, overnight @ PUCC)	Option 4 stand-alone - HUH	Option 4 stand-alone - Confed	Option 4 Stand-alone – CHUHSE
Operational	Detailed costing of this option requires further development of the proposed model	£603,324	£477,756	£ £577,763 - £638,375 (different premises cost)	£677,511
Clinical		818,706 - £957,526	£818,706 - £957,526	£818,706 - £957,526	£818,706 - £957,526
Total	2016/17 C&H PUCC activity was 19352 @ contract value of <£1.1M. The top end of predicted annual F2F activity is 16716 therefore it is reasonable to assume additional activity could be managed within £1.1.	**£1,422,030 – 1,560,850**	**£1,296,462 - £1,435,282**	**£1,396,469 - £1,595,901**	**£1,496,217 - £1,635,037**
Benefits	> Maximal efficiency through integration with existing similar service > Large organisation better placed to manage risk associated with uncertain activity	> Collaborative approach including primary and secondary care > Partial provision in primary care setting	> Efficiencies delivered through the opportunity to share existing operational resources and infrastructure > Large organisation better placed to manage risk from uncertain activity	> Operational costs higher than Homerton as the Confederation has less existing management resource > Significant cost and risk associated with premises	> Continuity of robust, quality service in context of significant system change > Established relationship with GP Locums – most likely to successfully fill shifts > GP & Public support to CHUHSE
Risks	> Requires revision of PUCC clinical / operational model – difficult to achieve within timescales > Difficulty recruiting & retaining additional substantive posts - unfilled shifts adding pressure on existing staff and / or A&E > Operational challenges: Existing IT	> High cost - 2 organisations have associated operational costs - Minimal opportunity to share clinical resource during busiest period (evening shift) > Challenges associated with operating from GP practice / hub	> No experience running GPOOH – managing new systems (Adastra, Rotamaster) > Difficulty filling shifts – GP locums less likely to accept shifts with new provider. Unfilled shifts likely to cause increase in A&E activity	> Operational costs higher than Homerton as the Confederation has less existing management resource > Cost and risk associated with premises (Homerton or Hub) > No experience running GPOOH – managing new systems (Adastra,	Operational costs highest as operational costs include Executive Board and no opportunity for shared resources

	system not directly bookable from Adastra > Lack of primary care support – secondary care provider managing a primary care service	> Extended access hubs not yet established	> Lack of primary care support	Rotamaster) > Difficulty filling shifts – GP locums less likely to accept shifts with new provider. Unfilled shifts likely to cause increase in A&E activity	

Assumptions, methodology and limitations

- Estimated operating costs are based on the existing CHUHSE operational costs with proposed reductions in as many areas as possible (e.g. from shared resource).
- Estimated direct clinical costs are based on the range of predicted activity and proposed clinical requirements and working pattern (Appendix 3).
- The low clinical cost reflects the rota required to manage current levels of activity and the high clinical cost reflects the rota required to manage the potential increase in activity that would be seen if the CAS is unsuccessful in closing calls.
- A variable hourly payment rate has been applied based on benchmarking across different providers and taking account of proposed Extended Access payments.
- Limitations:

  The clinical costs calculated do not apply to the option of merging activity with PUCC. It is likely that clinical costs could be reduced with this option but further analysis of predicted activity together with current PUCC activity and clinical capacity would be required to confirm this.

- For each of the stand-alone provider options, the estimated direct clinical costs are the same. However, in terms of total cost of service, the Homerton is the lowest due to the potential for shared operational resources and infrastructure. CHUHSE is the highest due to Executive Board costs and the lack of opportunity to share fixed operational costs and the GP Confederation is between the two.

6. Summary of Cost / Benefit / Risk Analysis

- **None** of the costed options fit within the proposed budget of £1.1M and create a cost pressure.
- Full integration with PUCC is likely to be the most efficient option and therefore it is possible that it could fit within the £1.1M. However, further analysis is required to cost this option. In addition, it is associated with a number of risks /challenges.
- The mixed model is one of the higher cost options and would be challenging to implement with current proposed hub model (i.e. 1 x hub north & south).
- The stand-alone options are less efficient than full integration with PUCC but offer a number of advantages (ease of transfer, transition phase - time to measure impact of NEL IUC & for extended access hubs to be established) that make it an attractive short term option.
- Each of the provider options for the stand alone model have different benefits and risks which need to be considered together with their cost as part of the evaluation.
- The success of any of these options relies of the ability to fill shifts from the scarce GP resource. Option 4 – CHUHSE is likely to be the best equipped to fill shifts.

7. Proposal and Commitment to Developing an Integrated Solution

The long term solution / new model should be one that is integrated with existing services providing a similar function (i.e. urgent primary care), enables providers to work together and minimises system costs. However, given the current risks, this paper proposes that option 4 (CHUHSE) is taken forward as an interim option, alongside a commitment to develop an integrated solution. A proposal for the programme structure and plan to develop the integrated solution will be brought to the Transformation Board in January 2018.

All viable interim options create a non-recurrent cost pressure for the CCG in the region of £200,000 - £400,000 but are the safest and highest quality solution given the current time-frames and real risks related to a scarce GP work-force. One of the aims of the long term integrated solution will be to reduce this cost pressures and contribute to achieving financial balance across the system.

All stand-alone options miss the opportunity to better align parallel services and are unsustainable in the long term both in terms of overall cost and scarce GP workforce. However, as an interim option for an agreed period of time whilst an integrated long term solution is developed, they are a pragmatic choice.

The additional time would allow the impact of the NEL IUC to be evaluated providing more accurate demand profiles on which to model the new service. In addition, it would allow extended access hubs to become established so that their potential contribution to the integrated solution can be better understood. It also provides the opportunity to review and streamline all urgent primary care services across the 24 hour period rather than focusing on the OOH period alone.

For robust assessment of each of these developments, an interim arrangement would in place for 12 - 18 months from go live of the NEL IUC. The extended access hub pilot is due to finish in March 2019 which coincides with the end of contract for PUCC and Paradoc therefore it would be logical and sensible for implementation of the integrated model to align with these.

Despite being the highest cost, CHUHSE has a number of important non-financial benefits. CHUHSE currently provides a valued high quality service, consistently delivering all National Quality Requirements and receiving excellent feedback from patients and recent CQC inspection. The impact from introduction of the NEL IUC is difficult to predict and therefore having a robust face to face service in place to receive onward referrals will be key to ensuring patients continue to receive quality care. Commissioning CHUHSE to provide the face to face service would provide this assurance.

There are risks associated with the transfer of any service to new provider and it would be difficult to have confidence in a new provider to deliver the same quality of service immediately. Therefore, a decision to transfer the face to face activity to a new provider at the same time as the NEL IUC is introduced would be high risk. In addition, if it is agreed that a long term integrated solution should be in place by March 2019 it would better have one transition rather than two.

One of the biggest challenges that GPOOH providers face is filling shifts from the scare GP resource available. CHUHSE has an established relationship with a bank of GPs who regularly work these shifts and is experienced in managing their requirements.

A new provider, with no experience of managing a GPOOH service, is more likely to have difficulty filling these shifts in the competitive market that exists. The introduction of the NEL IUC and extended access hubs will increase the demand on GPs and therefore the ability to attract GPs will become even more important. Unfilled GPOOH shifts have the potential to increase cost in the system through increased A&E activity or increased hourly rate required to secure GPs. In addition, an increased demand on A&E is likely to have a negative impact on the 4 hour target.

In terms of system costs, CHUHSE have a proven track record of managing patients within the service, closing 53% of calls with telephone advice and referring only 6% to A&E. A new provider might offer a lower cost service but be less effective and therefore increase system costs through an increased onward referral to A&E. Although CHUHSE is the highest cost service, it effectively manages potential cost to the system and with a possible increased

demand resulting from the introduction of NEL IUC it could easily prove to be the lowest cost to the system as a whole.

From a procurement perspective, direct award of a new contract (for a standalone) service would require a Prior Information Notice to be issued which has a significant risk of attracting qualified interest from an external provider and subsequent requirement for competitive tender. It is likely possible to avoid procurement if a contract variation is used. This could be the case for any of the standalone options as all of these providers (CHUHSE, Homerton Community Health Services and the GP confederation) hold current contracts for similar services where the total service value is less than 50% of the existing contract value. However each are also associated with some risk as they are close to the limits of contract variation allowable within procurement rules.

Setting aside the procurement issues, there are clear advantages associated with selecting CHUHSE to provide the interim solution that have been outlined above. It is felt that these are worth the additional cost for the short term making it the preferred provider option.

If, however the procurement risk associated with extending the CHUHSE contract is unreasonably high then the Homerton, as the lowest cost provider, would become the preferred option.

Legal advice on the procurement risks has been sought but is not available at the time of writing this paper. This will be confirmed verbally at the Transformation Board meeting.

8. Recommendation

It is recommended that the Transformation Board:

- Endorse the proposal to commission a standalone F2F service as an interim solution (with the preferred provider being determined by the legal advice received)
- Endorse the request for additional funding required (circa. £200,000 - £400,000 dependent on preferred provider)
- Endorse the unplanned care programme's commitment to develop an integrated solution:
    - Proposed programme structure to be presented to the Transformation Board in January 2018.
    - Implementation of plan by March 2019.

9. Assurance process / timetable

Date	Board / Committee	Function
27th October	Unplanned Care Board	Agree preferred option
10th November	Transformation Board	Endorsement
15th November	Integrated Commissioning Board	Endorsement
24th November	Contracts Committee	Contractual arrangements
24th November	Governing Body	Approval
29th November	Finance and Performance Committee	Financial arrangements / implications
30th November	Patient and Public involvement	Patient engagement
7th December	Clinical Commissioning Forum	GP engagement
13th December	Clinical Executive	GP engagement

		Average Face-to-face Demand by Hour of Day Over 3 Previous Years																						
Day of Week	Average by Day Of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	18	1	1	2	1	1	0	1	1											0	1	3	2	2	2
Saturday	73	1	2	0	0	1	1	1	1	2	4	5	5	4	4	5	4	5	2	2	3	4	3	7	7
Sunday	85	3	1	1	0	2	0	1	1	3	4	6	5	6	6	4	5	6	5	6	4	6	4	4	2
Monday (Summer Bank Holiday)	88	3	1	1	1	1	0	0	1	2	4	7	7	7	4	6	4	4	5	6	5	5	5	5	4
Tuesday	18	2	1	0	0	2	0	0	0											0	2	3	4	2	2
Wednesday	17	0	1	1	0	1	1	1	1											0	2	2	2	4	1

		Average Base Visit Demand by Hour of Day Over 3 Previous Years																						
Day of Week	Average by Day Of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	17	1	1	1	1	1	0	1	1											0	1	3	2	2	2
Saturday	61	1	1	0	0	1	1	0	1	1	3	4	4	4	4	3	3	4	2	2	3	4	3	6	6
Sunday	69	3	1	1	0	1	0	1	0	2	3	4	4	5	5	4	4	5	4	4	4	5	3	4	2
Monday (Summer Bank Holiday)	78	3	1	1	1	1	0	0	1	2	3	6	6	6	4	5	4	4	5	4	4	5	4	4	4
Tuesday	14	2	1	0	0	1	0	0	0											0	1	2	3	2	2
Wednesday	13	0	1	0	0	0	1	1	1											0	1	2	2	3	1

		Average Home Visit Demand by Hour of Day Over 3 Previous Years																						
Day of Week	Average by Day Of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	1	0	0	1	0	0	0	0	0											0	0	0	0	0	0
Saturday	12	0	1	0	0	0	0	1	0	1	1	1	1	0	0	2	1	1	0	0	0	0	0	1	1
Sunday	16	0	0	0	0	1	0	0	1	1	1	2	1	1	1	0	1	1	1	2	0	1	1	0	0
Monday (Summer Bank Holiday)	10	0	0	0	0	0	0	0	0	0	1	1	1	1	0	1	0	0	0	2	1	0	1	1	0
Tuesday	4	0	0	0	0	1	0	0	0											0	1	1	1	0	0
Wednesday	4	0	0	1	0	1	0	0	0											0	1	0	0	1	0

Predicted hourly demand - based on predicted annual onward referral for F2F consultations if the CAS fails to close any calls (1.5 x current CHUHSE annual F2F activty)

Day of the week	Predicted face to face demand by hour of day																							
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	1.5	1.5	3	1.5	1.5	0	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	1.5	4.5	3	3	3
Saturday	1.5	3	0	0	1.5	1.5	1.5	1.5	3	6	7.5	7.5	6	6	7.5	6	7.5	3	3	4.5	6	4.5	10.5	10.5
Sunday	4.5	1.5	1.5	0	3	0	1.5	1.5	4.5	6	9	7.5	9	9	6	7.5	9	7.5	9	6	9	6	6	3
Monday (Summer Bank Holiday)	4.5	1.5	1.5	1.5	1.5	0	0	1.5	3	6	10.5	10.5	10.5	6	9	6	6	7.5	9	7.5	7.5	7.5	7.5	6
Tuesday	3	1.5	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4.5	6	3	3
Wednesday	0	1.5	1.5	0	1.5	1.5	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	3	3	3	6	1.5

Day of Week	Predicted Base Visit Demand by Hour of Day																							
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	1.5	1.5	1.5	1.5	1.5	0	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	1.5	4.5	3	3	3
Saturday	1.5	1.5	0	0	1.5	1.5	0	1.5	1.5	4.5	6	6	6	6	4.5	4.5	6	3	3	4.5	6	4.5	9	9
Sunday	4.5	1.5	1.5	0	1.5	0	1.5	0	3	4.5	6	6	7.5	7.5	6	6	7.5	6	6	6	7.5	4.5	6	3
Monday (Summer Bank Holiday)	4.5	1.5	1.5	1.5	1.5	0	0	1.5	3	4.5	9	9	9	6	7.5	6	6	7.5	6	6	7.5	6	6	6
Tuesday	3	1.5	0	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.5	3	4.5	3	3
Wednesday	0	1.5	0	0	0	1.5	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	1.5	3	3	4.5	1.5

Day of Week	Predicted Home Visit Demand by Hour of Day																							
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Saturday	0	1.5	0	0	0	0	1.5	0	1.5	1.5	1.5	1.5	0	0	3	1.5	1.5	0	0	0	0	0	1.5	1.5
Sunday	0	0	0	0	1.5	0	0	1.5	1.5	1.5	3	1.5	1.5	1.5	0	1.5	1.5	1.5	3	0	1.5	1.5	0	0
Monday (Summer Bank Holiday)	0	0	0	0	0	0	0	0	0	1.5	1.5	1.5	1.5	0	1.5	0	0	0	3	1.5	0	1.5	1.5	0
Tuesday	0	0	0	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.5	1.5	1.5	0	0
Wednesday	0	0	1.5	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.5	0	0	1.5	0

Predicted GP requirement to manage high level demand (CAS fails to close calls) based on 4 appointments / hour

Day of week	Predicted GP requriement to manage face to face demand profile (based on 15 min appt)																							
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0.4	0.4	0.8	0.4	0.4	0.0	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	1.1	0.8	0.8	0.8
Saturday	0.4	0.8	0.0	0.0	0.4	0.4	0.4	0.4	0.8	1.5	1.9	1.9	1.5	1.5	1.9	1.5	1.9	0.8	0.8	1.1	1.5	1.1	2.6	2.6
Sunday	1.1	0.4	0.4	0.0	0.8	0.0	0.4	0.4	1.1	1.5	2.3	1.9	2.3	2.3	1.5	1.9	2.3	1.9	2.3	1.5	2.3	1.5	1.5	0.8
Monday (Summer Bank Holiday)	1.1	0.4	0.4	0.4	0.4	0.0	0.0	0.4	0.8	1.5	2.6	2.6	2.6	1.5	2.3	1.5	1.5	1.9	2.3	1.9	1.9	1.9	1.9	1.5
Tuesday	0.8	0.4	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	1.1	1.5	0.8	0.8
Wednesday	0.0	0.4	0.4	0.0	0.4	0.4	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.8	0.8	1.5	0.4

Day of week	Predicted GP requriement to manage base visit demand profile (based on 15 min appt)																							
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0.4	0.4	0.4	0.4	0.4	0.0	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	1.1	0.8	0.8	0.8
Saturday	0.4	0.4	0.0	0.0	0.4	0.4	0.0	0.4	0.4	1.1	1.5	1.5	1.5	1.5	1.1	1.1	1.5	0.8	0.8	1.1	1.5	1.1	2.3	2.3
Sunday	1.1	0.4	0.4	0.0	0.4	0.0	0.4	0.0	0.8	1.1	1.5	1.5	1.9	1.9	1.5	1.5	1.9	1.5	1.5	1.5	1.9	1.1	1.5	0.8
Monday (Summer Bank Holiday)	1.1	0.4	0.4	0.4	0.4	0.0	0.0	0.4	0.8	1.1	2.3	2.3	2.3	1.5	1.9	1.5	1.5	1.9	1.5	1.5	1.9	1.5	1.5	1.5
Tuesday	0.8	0.4	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.8	1.1	0.8	0.8
Wednesday	0.0	0.4	0.0	0.0	0.0	0.4	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.8	0.8	1.1	0.4

Day of week	Predicted GP requriement to manage home visit demand profile (based on 45 min appt)																							
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0.0	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Saturday	0.0	0.4	0.0	0.0	0.0	0.0	1.1	0.0	1.1	1.1	1.1	1.1	0.0	0.0	2.3	1.1	1.1	0.0	0.0	0.0	0.0	0.0	1.1	1.1
Sunday	0.0	0.0	0.0	0.0	1.1	0.0	0.0	1.1	1.1	1.1	2.3	1.1	1.1	1.1	0.0	1.1	1.1	1.1	2.3	0.0	1.1	1.1	0.0	0.0
Monday (Summer Bank Holiday)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.1	1.1	1.1	0.0	1.1	0.0	0.0	0.0	2.3	1.1	0.0	1.1	1.1	0.0
Tuesday	0.0	0.0	0.0	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.1	1.1	0.0	0.0
Wednesday	0.0	0.0	1.1	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	1.1	0.0

Proposed rota: current & increased activity

Item	Shift timing	Hours	Number of GPs - existing rota	Number of GPs - increased demand *
Week day evening shift	1830-2330	5	2	2
Week day night shift	2300-0800	9	1	1
W/end (& BH) morning	0800-1300/0900-1400	5	2	3
W/end (& BH) afternoon	1300-1800/1400-1900	5	2	3
W/end (& BH) evening	1800-2300/1900-0000	5	2	3
W/end (&BH) night	2300-0800	9	1	1

*** GP requirement modelled based on predicted hourly demand assuming 4 appointments / hour base vist and 45 minutes per home visit (including GP on rota if =/ >0.5 GP required (e.g. requirement = 1.4 then only 1 GP on rota, requrment for 1.6 = 2 GPs rota'd)**

Clinical cost - current and increased activity

Shift	Rate p/h	Hours Per week	Hours Per Year	Cost for single GP	Number of GP - amended CHUHSE rota (current activity)	Total rota hours	Total rota cost	Number of GP - high level demand	Total rota hours	Total rota cost	Split provision - option 3: high cost		Split provision - option 3: low cost	
											Confed cost	HuH cost	Confed cost	HuH cost
Mon - Thu evening Rate	£80	20	1042	£83,392	2	2085	£166,784	2	2085	£166,784	£166,784.00		£166,784	
Mon - Thu Night Rate	£95	36	1876	£178,250	1	1876	£178,250	1	1876	£178,250		£178,250.40		£178,250
Friday evening	£90	5	261	£23,454	2	521	£46,908	2	521	£46,908	£46,908.00		£46,908	
Friday Night	£100	9	469	£46,908	1	469	£46,908	1	469	£46,908		£46,908.00		£46,908
Weekend Day	£80	20	922	£73,792	2	1845	£147,584	3	2767	£221,376	£221,376.00		£147,584	
Weekend Evening	£90	10	461	£41,508	2	922	£83,016	3	1384	£124,524	£124,524.00		£83,016	
Weekend Night	£100	18	830	£83,016	1	830	£83,016	1	830	£83,016		£83,016.00		£83,016
B Hol Weekend Day	£100	32	192	£19,200	2	384	£38,400	3	576	£57,600	57600		£38,400	
B Hol Weekend Night	£125	16	96	£12,000	1	96	£12,000	1	96	£12,000		£12,000.00		£12,000
B Hol Mon Day	£120	6	36	£4,320	2	72	£8,640	3	108	£12,960	£12,960.00		£8,640	
B Hol Mon Night	£150	8	48	£7,200	1	48	£7,200	1	48	£7,200		£7,200.00		£7,200
Total		180	6234	£573,040		**9149**	**£818,706**		**10760**	**£957,526**				
Average P/H				£92		**£89**			**£89**					
											£630,152.00	**£327,374.40**	**£491,332**	**£327,374**

CHUHSE ACTIVITY 2017

PREDICTED HIGH LEVEL ACTIVITY (CAS CLOSES 0% GPOOH DISPOSITIONS) - TOTAL ANNUAL ACTIVITY 1.5 X CURRENT

GP REQUIREMENT TO MANAGE HIGH LEVEL ACTIVITY BASED ON 4 APPOINTMENTS / HOUR

Average Face-to-face Demand by Hour of Day Over 3 Previous Years

Day of Week	Average by Day Of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	18	1	1	2	1	1	0	1	1											0	1	3	2	2	2
Saturday	73	1	2	0	0	1	1	1	1	2	4	5	5	4	4	5	4	5	2	2	3	4	3	7	7
Sunday	85	3	1	1	0	2	0	1	1	3	4	6	5	6	6	4	5	6	5	6	4	6	4	4	2
Monday (Summer Bank Holiday)	88	3	1	1	1	1	0	0	1	2	4	7	7	7	4	6	4	4	5	6	5	5	5	5	4
Tuesday	18	2	1	0	0	2	0	0	0											0	2	3	4	2	2
Wednesday	17	0	1	1	0	1	1	1	1											0	2	2	2	4	1

Predicted face to face demand by hour of day for top end of range of onward referrals from NEL IUC (i.e. 1.5 x current annual total demand)

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	1.5	1.5	3	1.5	1.5	0	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	1.5	4.5	3	3	3
Saturday	1.5	3	0	0	1.5	1.5	1.5	3	6	7.5	7.5	6	6	7.5	6	7.5	3	3	4.5	6	4.5	10.5	10.5	
Sunday	4.5	1.5	1.5	0	3	0	1.5	1.5	4.5	6	9	7.5	9	9	6	7.5	9	7.5	9	6	9	6	6	3
Monday (Summer Bank Holiday)	4.5	1.5	1.5	1.5	1.5	0	0	1.5	3	6	10.5	10.5	10.5	6	9	6	6	7.5	9	7.5	7.5	7.5	7.5	6
Tuesday	3	1.5	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4.5	6	3	3
Wednesday	0	1.5	1.5	0	1.5	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	0	3	3	3	6	1.5

Predicted GP requriement to manage face to face demand profile (based on 15 min appt)

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0.4	0.4	0.8	0.4	0.4	0.0	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	1.1	0.8	0.8	0.8
Saturday	0.4	0.8	0.0	0.0	0.4	0.4	0.4	0.8	1.5	1.9	1.9	1.5	1.5	1.9	1.5	1.9	1.9	1.9	0.8	0.8	1.1	1.5	1.1	2.6
Sunday	1.1	0.4	0.4	0.0	0.8	0.0	0.4	0.4	1.1	1.5	2.3	1.9	2.3	2.3	1.5	1.9	2.3	1.9	2.3	1.5	2.3	1.5	1.9	0.8
Monday (Summer Bank Holiday)	1.1	0.4	0.4	0.4	0.4	0.0	0.0	0.4	0.8	1.5	2.6	2.6	2.6	1.5	2.3	1.5	1.5	1.9	2.3	1.9	1.9	1.9	1.9	1.5
Tuesday	0.8	0.4	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	1.1	1.5	0.8	0.8
Wednesday	0.0	0.4	0.4	0.0	0.4	0.4	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.8	1.5	0.4

Average Base Visit Demand by Hour of Day Over 3 Previous Years

Day of Week	Average by Day Of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	17	1	1	1	1	0	1	1												0	1	3	2	2	2
Saturday	61	1	1	0	0	1	1	0	1	1	3	4	4	4	4	3	3	4	2	2	3	4	3	6	6
Sunday	69	3	1	1	0	1	0	1	0	2	3	4	4	5	5	4	4	5	4	4	4	5	3	4	2
Monday (Summer Bank Holiday)	78	3	1	1	1	1	0	0	1	2	3	6	6	6	4	5	4	4	5	4	4	5	4	4	4
Tuesday	14	2	1	0	0	1	0	0	0											0	1	2	3	2	2
Wednesday	13	0	1	0	0	0	1	1	1											0	1	2	2	3	1

Predicted Base Visit Demand by Hour of Day

Day of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	1.5	1.5	1.5	1.5	1.5	0	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	1.5	4.5	3	3	3
Saturday	1.5	1.5	0	0	1.5	1.5	0	1.5	1.5	4.5	6	6	6	6	4.5	4.5	6	3	3	4.5	6	4.5	9	9
Sunday	4.5	1.5	1.5	0	1.5	0	1.5	0	3	4.5	6	6	7.5	7.5	6	6	7.5	6	6	6	7.5	4.5	6	3
Monday (Summer Bank Holiday)	4.5	1.5	1.5	1.5	1.5	0	0	1.5	3	4.5	9	9	9	6	7.5	6	6	7.5	6	6	7.5	6	6	6
Tuesday	3	1.5	0	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.5	3	4.5	3	3
Wednesday	0	1.5	0	0	0	1.5	1.5	1.5	0	0	0	0	0	0	0	0	0	0	0	1.5	3	3	4.5	1.5

Predicted GP requriement to manage base visit demand profile (based on 15 min appt)

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0.4	0.4	0.4	0.4	0.4	0.0	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	1.1	0.8	0.8	0.8
Saturday	0.4	0.4	0.0	0.0	0.4	0.4	0.0	0.4	0.4	1.1	1.5	1.5	1.5	1.1	1.1	1.5	0.8	0.8	1.1	1.5	1.1	2.3	2.3	
Sunday	1.1	0.4	0.4	0.0	0.4	0.0	0.4	0.0	0.8	1.1	1.5	1.5	1.9	1.9	1.5	1.5	1.9	1.5	1.5	1.9	1.1	1.5	1.5	0.8
Monday (Summer Bank Holiday)	1.1	0.4	0.4	0.4	0.4	0.0	0.0	0.4	0.8	1.1	2.3	2.3	2.3	1.5	1.9	1.5	1.5	1.9	1.5	1.5	1.9	1.5	1.5	1.5
Tuesday	0.8	0.4	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.8	1.1	0.8
Wednesday	0.0	0.4	0.0	0.0	0.0	0.4	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.8	0.8	1.1

Average Home Visit Demand by Hour of Day Over 3 Previous Years

Day of Week	Average by Day Of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	1	0	0	1	0	0	0	0	0											0	0	0	0	0	0
Saturday	12	0	1	0	0	0	0	1	0	1	1	1	1	0	0	2	1	1	0	0	0	0	0	1	1
Sunday	16	0	0	0	0	1	0	0	1	1	1	2	1	1	1	0	1	1	1	2	0	1	1	0	0
Monday (Summer Bank Holiday)	10	0	0	0	0	0	0	0	0	0	1	1	1	1	0	1	0	0	0	2	1	0	1	1	0
Tuesday	4	0	0	0	0	1	0	0	0											0	1	1	0	0	
Wednesday	4	0	0	1	0	1	0	0	0											0	1	0	0	1	0

Predicted Home Visit Demand by Hour of Day

Day of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Saturday	0	1.5	0	0	0	1.5	0	1.5	1.5	1.5	1.5	1.5	0	0	3	1.5	1.5	0	0	0	0	0	1.5	1.5
Sunday	0	0	0	0	1.5	0	0	1.5	1.5	1.5	3	1.5	1.5	1.5	0	1.5	1.5	1.5	3	0	1.5	1.5	0	0
Monday (Summer Bank Holiday)	0	0	0	0	0	0	0	0	0	1.5	1.5	1.5	1.5	0	1.5	0	0	0	3	1.5	0	1.5	1.5	0
Tuesday	0	0	0	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.5	1.5	1.5	0	0
Wednesday	0	0	1.5	0	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.5	0	0	1.5	0

Predicted GP requriement to manage home visit demand profile (45 mins)

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Friday	0.0	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Saturday	0.0	0.4	0.0	0.0	0.0	0.0	1.1	0.0	1.1	1.1	1.1	1.1	0.0	0.0	2.3	1.1	1.1	0.0	0.0	0.0	0.0	0.0	1.1	1.1
Sunday	0.0	0.0	0.0	0.0	1.1	0.0	0.0	1.1	1.1	1.1	2.3	1.1	1.1	1.1	0.0	1.1	1.1	1.1	2.3	0.0	1.1	1.1	0.0	0.0
Monday (Summer Bank Holiday)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.1	1.1	1.1	0.0	1.1	0.0	0.0	0.0	2.3	1.1	0.0	1.1	1.1	0.0
Tuesday	0.0	0.0	0.0	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.1	1.1	0.0	0.0
Wednesday	0.0	0.0	1.1	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	1.1	0.0

Options comparsion - low cost (current activity & low premesis cost for Confederation)

Cost type	Option 2: expand PUCC	Option 3: Mixed model (5 hours @ hub, overnight @ PUCC)		Option 4 stand alone - HUH	Option 4 stand alone - Confed	Option 4 stand alone - CHUHSE
Operational		Confed	£356,752	£477,756	£577,763	£677,511
		Homerton	£246,572			
Clinical		Confed	£491,332	£818,706	£818,706	£818,706
		Homerton	£327,374			
Total	2016/17 C&H PUCC activity was 19352 @ contract value of <£1.1M. The top end of predicted F2F activity is 16716 therefore it is reasonable to assume additional activity could be managed within £1.1.		**£1,422,030**	**£1,296,462**	**£1,396,469**	**£1,496,217**
Comment	> Maximum opportunity for efficiency via shared clinical and operational BUT > Primary care push back > IT issues with direct booking > Costing needs to be confirmed		Minimum opportunity for efficiency: > 2 organisations have operational costs > Minimal opportunity to share clinical resource during busiest period (evening shift)	> Organisational cost efficiences - shared management resources and no additional premesis costs > minimal opportunity to share clnical resources with PUCC (different IT systems etc) therefore clinical costs high	> Operational costs higher as the Confederation has less existing management resource > Also cost and risk associated with premises	> Operational costs highest as operational costs include Executive Board and no opportunity for shared resources > Benefits from existing expertise (and workforce) > Minimal disrption > Public loyalty

Options comparsion - high cost (increased activity & high premesis cost for Confederation)

Cost type	Option 2: expand PUCC	Option 3: Mixed model (5 hours @ hub, overnight @		Option 4 stand alone - HUH	Option 4 stand alone - Confed	Option 4 stand alone - CHUHSE
Operational		Confed	£356,752	£477,756	£638,375	£677,511
		Homerton	£246,572			
Clinical		Confed	£505,628	£957,526	£957,526	£957,526
		Homerton	£451,898			
Total	2016/17 C&H PUCC activity was 19352 @ contract value of <£1.1M. The top end of predicted F2F activity is 16716 therefore it is reasonable to assume additional activity could be managed within £1.1.		**£1,560,850**	**£1,435,282**	**£1,595,901**	**£1,635,037**

Document 6.1

Title:	City of London Section 256 funding and carried forward BCF
Date:	15 November 2017
Lead Officer:	Ellie Ward Integration Programme Manager
Author:	Ellie Ward Integration Programme Manager
Committee(s):	City of London Integrated Commissioning Board for approval
Public / Non-public	Public

Executive Summary:

Section 256 (S256) funding is health funding transferred to local authorities for services which have a health gain. The City of London Corporation received two lots of Section 256 (S256) funding in 2016.

Each of these was for £250,000 and were designated for the following:

- Supporting hospital discharge and admission avoidance
- Delivering the Locality Plan

To date, £112,000 has been spent, as agreed by the former Integrated Care Programme Board and the CCG Governing Board, on schemes to avoid admission and support hospital discharge.

With the creation of the new integrated commissioning governance structures, the plans for the remaining S256 funding for supporting hospital discharge and admission avoidance and the whole of the funding for delivering the locality plan will now need to be agreed by the Integrated Commissioning Board.

There is also £30,000 remaining from the 2016/17 City of London Better Care Fund. Plans for this also need to be approved by the Integrated Commissioning Board.

This report sets out the proposed plans for use of the S256 funding and the BCF underspend.

Questions for the Transformation Board

N/A

Issues from Transformation Board for the Integrated Commissioning Boards

N/A

Recommendations:

The Integrated Commissioning Board is asked:

- To **APPROVE** the plans for use of the City of London Corporation S256 funding agreements and the remaining money from BCF 2016/17

Links to Key Priorities:

These plans for use of the S256 and the remaining BCF money are proposed in the context of a number of strategic plans and priorities:

- City and Hackney Locality Plan and workstream priorities
- City of London Corporation Joint Health and Wellbeing Strategy
- City of London Corporation Social Wellbeing Strategy and Action Plan
- Community and Children's Departmental Business Plan
- Community and Children's Departmental Adult Commissioning Prospectus

Specific implications for City and Hackney

These plans, the BCF funding and the S256 funding arrangements relate specifically to the City of London Corporation.

Patient and Public Involvement and Impact:

Existing schemes and pieces of work have had service user and public involvement and for schemes going forward, the City of London Corporation is seeking to embed a co-production approach.

Clinical/practitioner input and engagement:

Adult Social Care staff at the City of London Corporation have helped shape these proposals in conjunction with the Senior Commissioning Manager and the Integration Programme Manager.

Workstream Directors have also been consulted on these proposals and have agreed that these proposals align with wider plans and priorities.

Impact on / Overlap with Existing Services:

Many of these schemes inter-connect with each other and complement each other and will support health services.

Main Report

Background and Current Position

Section 256 (S256) funding is health funding transferred to local authorities for services which have a health gain. The City of London Corporation received two lots of Section 256 (S256) funding in 2016.

Each of these was for £250,000 and were designated for the following:

- Supporting hospital discharge and admission avoidance
- Delivering the Locality Plan

To date, £112,000 has been spent, as agreed by the former Integrated Care Programme Board and the CCG Governing Board, on schemes to avoid admission and support hospital discharge.

With the creation of the new integrated commissioning governance structures, the plans for the remaining S256 funding for supporting hospital discharge and admission avoidance and the whole of the funding for delivering the locality plan will now need to be agreed by the Integrated Commissioning Board.

There is also £30,000 remaining from the 2016/17 City of London Better Care Fund. Plans for this also need to be approved by the Integrated Commissioning Board.

This report sets out the proposed plans for use of the S256 funding and the BCF underspend for the approval of ICB.

These have been discussed with and agreed by the Workstream Directors in terms of aligning with the wider plans and priorities.

Options

The proposals for the use of S256 and the BCF underspend are mainly based on new schemes or pieces of work.

These are non-recurrent and low risk but have potential significant benefits in the long term.

One issue that will need to be considered is where schemes are showing significant benefit and there is scope for them to continue or where new areas of work arise, how these can be funded.

Equalities and other Implications:

Existing schemes have been subject to Tests of Relevance for equalities and full impact assessments where appropriate. For those that are yet to develop, Tests of Relevance will be undertaken.

Proposals

The full proposals are set out below.

Ref	Scheme	Summary	Outcomes	Amount	Workstream
S1.1	Feasibility study for care hub (carried forward from agreement at CCG GB)	Undertake feasibility study for development of a care hub in the City of London. Many City residents are single people living in studio and one bedroom flats which make providing short-term more intensive care within people's homes difficult. The Corporation does not have consistent access to short-term extra care and we have to spot purchase at high cost. It has been agreed that one of the ground floor two-bedroom flats in a proposed redevelopment on one of the Corporation's estates can be designated as an extra care property, allowing the possibility of live-in care as required. The provision would meet the following objectives: • Avoiding hospital admission • Providing additional support after a period of poor health or hospitalisation until the individual can move back home • When individuals are awaiting crucial adaptations to their home • Respite opportunities for families, when	Clarity on feasibility of developing a care hub in the City of London. The development of a care hub would deliver the following outcomes: • Reduction in hospital admissions • Increase in number of hospital safe and supported earlier discharge • Maintenance of performance on Adult Social Care Delayed Transfers of Care • Maintenance of care within the community and close to home	19,500	Unplanned Care

		an informal carers needs a break or is taken ill • When an individual's needs are being assessed for permanent care and / or they are awaiting a suitable residential or nursing home to become available (discharge to assess and placement without prejudice) • Where an individual is terminally ill and requires palliative care in their community The feasibility study will consider: • Opportunities for consultation and communication regarding the proposal • A more detailed scope of need • Clarification on requirements of registration, licensing and insurances • Cost benefit analysis and income generation • Options for care provision within the delivery model	• Carers' wellbeing supported • Reduced reliance on costly placements as short term measures		
S1.2	Shopping Service	This new preventative service will deliver a Shopping Service for City of London Corporation Residents. It aims to reduce social isolation, the risk of falls, malnutrition and other poor health outcomes. This will involve working with the Adult's Social Care Team and other providers of care	• independence of service users promoted • Service users supported to engage with community	20,000	Prevention

		and health and wellbeing services. This Service will be offered to those who require short term support and assistance. The shopping service will have three broad categories – escorted services, home delivery services and internet shopping services.	services • Services users supported and encouraged to participate in their community to use community resources and facilities • Service users supported to improve and maintain their health and wellbeing • healthy eating and hydration promoted • Service users supported to alleviate loneliness and isolation • Service that assists service users to gain/re-gain confidence provided • Reduction in		

			number of unplanned admissions to hospital • Safe and timely discharge of patients from hospital support		
S1.3	Befriending scheme	On-going scheme to enable service users to: • Become less socially isolated and be enabled to reduce their social isolation • Develop self-confidence and emotional growth • Enhance skills to form and maintain relationships with others • Develop greater resilience • Increase their wellbeing • Feel supported The service model includes befriending for those with dementia and low level mental health difficulties, carers and those who are lonely.	• People with care and support needs will have more choice and an enhanced quality of life • People with support and care needs will be supported in a way that prevents deterioration, delaying dependency and supporting recovery • People with support and care needs will confirm they	60,000	Prevention

			have had a positive experience of care and / or support • People with support and care needs will be protected from avoidable harm and their care will take place in a safe environment • Volunteers will confirm that they have benefitted positively from their befriending role		
S1.4	IT for social isolation and enabling self-activation	New scheme to use digital inclusion to reduce social isolation and loneliness and ensure people have the relationships and support they need. Reducing loneliness can be shown to improve health and wellbeing, lowering healthcare costs, delaying the onset of social care needs, and reducing an individual's risk of abuse or neglect.	• Reduction in isolation and loneliness by enabling participants to form new social connections using digital means • Reduction in isolation and	30,000	Prevention

		A number of recent projects in the Square Mile have sought to improve the digital skills of older people. While these have had encouraging results, there is still potential for further improvement, especially amongst older people who are socially isolated or find it difficult to attend classes due to limited mobility. These older people are missing out on opportunities to learn valuable digital skills, enabling them to stay connected with family and friends, feel part of a supportive community and manage some of their health conditions. The scheme will include a sessional Digital and Social Coordinator who will recruit and manage a team of DBS-checked volunteers, supporting people to get online through home visits and local sessions for which transport will be provided.	loneliness by enabling participants to strengthen their existing relationships using digital means • Participants enabled to maintain their independence and manage their own health and care by using digital means		
S1.5	Review DFGs and other adaptations to use these more flexibly to support hospital discharge	Undertake review of our DFG process and adaptations to ensure we are making the most efficient use of them to facilitate hospital discharge	• New DFG and adaptation policies and processes to ensure best use is made of these within hospital discharge	8,000	Unplanned Care
	Total			**137,500**	

S256 Delivering the Locality Plan

Ref	Scheme	Summary	Proposed Outcomes	Amount	Workstream
S2.1	Co-production resource	To provide resources and capacity to progress co-production, embedding it across social care and building City of London resident capacity and representation to play a role in integrated commissioning arrangements.	• City of London resident and service users play a role in integrated commissioning and the transformation of services • Transformation of services recognises and addresses specific City of London needs	20,000	TBC
S2.2	Care hub phase 2	To follow from the feasibility study above.	To be confirmed	30,000	Unplanned care
S2.3	Continuing Healthcare / Residential Care	To provide capacity to support the work around CHC and res care pooling.	• Work on CHC and Res care pooling is taken forward with adequate capacity	20,000	Planned care
S2.4	CHS – performance / contract monitoring for City	Resource to have greater input into performance and contract monitoring of the Community Health Services Contract	• Greater understanding of City of London	30,000	Planned care

		to ensure that City of London resident needs are met.	use and experience of Community Health Services • Increased appropriate access and use of Community Health Services by City residents		
S2.5	Employment support for people with Learning Disabilities	Specialist commissioned resource to support cohort of existing clients with learning disabilities into employment where they wish and are able to do so. This will be short term intensive piece of work with an existing cohort. Going forward this work may be part of the work and health programme. The scheme will provide targeted support to individuals to explore volunteering, skills and employment opportunities with individuals who wish to gain employment. Employment / volunteering has an overall positive effect on health and wellbeing and is also beneficial to the economy.	• Aspirations raised amongst clients with learning disabilities with regard to employment • Clients with learning disabilities assisted into work where appropriate • Health and wellbeing of clients with learning disabilities increased	30,000	Prevention
S2.6	Early Intervention / Prevention Project	The Community and Children's Services Commissioning Team have been working	Outcome from this piece of work	30,000	Prevention

		with colleagues across the Department to understand the scope of current service provision that offers early intervention and on-going support (including assistive technology and equipment) to adults in their own home and the wider community, reduces hospital admissions and delivers effective and timely hospital discharge. Many of these contracts are up for renewal over the next couple of years. The potential for this review and commissioning exercise is to develop a comprehensive service specification, or set of specifications, which will be used to invite the provider market to demonstrate how they can deliver a fully integrated service system offering early intervention and on-going support for communities.	would be the completion of review and development of specification. Longitudinal outcomes would include: • Improved health and wellbeing • Prevention and delay of health and social care needs • Maintenance of independence		
S2.7	Health Services for Rough Sleepers - audit	Long term rough sleepers have limited life expectancy. The current model of healthcare is not delivering fully to the needs of those sleeping rough in the City of London whose long term homelessness is characterised by "tri-morbidity". It is proposed an audit is undertaken to assess the reach of services against the	• Improved health • Homelessness alleviated • Reduced unplanned admissions • Reduced A&E attendances	20,000	Prevention

		commitments of the Health London Partnership's commissioning guidance for "Health care & people who are homeless". The aim would be to propose service models that improve health care delivery to this group.			
S2.8	TBC once workstream priorities are agreed. There are likely to be City of London emerging projects related to a new Children and Young People's Plan and work around SEND	TBC	TBC	70,000	Children, Young People and Maternity Services
	Total			**250,000**	

BCF funding

Ref	Scheme	Summary	Proposed Outcomes	Amount	Workstream
BCF1	Social Wellbeing Support	To use an asset based approach to reduce social isolation and loneliness and ensure people have the relationships and support they need. Reducing loneliness can be shown to improve health and wellbeing, lowering healthcare costs, delaying the onset of social care needs, and reducing an individual's risk of abuse or neglect. The project has three interrelated elements - Community Connectors, Assertive Outreach and City Over 50s Guide All three aim to prevent or resolve isolation by providing timely support and utilising the assets already present within the wider City of London community.	• Reduction in social isolation and loneliness • Residents with low / no needs are more easily able to find social and community activities relevant to their interests reducing the risk of social isolation • Delayed onset of care needs	30,000	Prevention

Conclusion

This report sets out proposals for use of S256 funding and some remaining money from BCF 2016/17 in the City of London.

The ICB is asked to approve these plans.

Supporting Papers and Evidence:

None

Sign-off:

[Papers for approval by the ICBs must be signed off by the appropriate senior officers. Any paper with financial implications must be signed by the Members of the Finance Economy Group. If there are any legal implications which require consultation with legal counsel, please make reference to that below. Copies of email sign-off should be sent to the Secretariat (jarlath.o'connell@nhs.net) along with the papers. Papers which have not been signed-off by the appropriate officers will not be considered by the Committee.] City of London Corporation _____Neil Hounsell_____ City & Hackney CCG _____Paul Haigh_____

Title:	Co-production Charter for Health and Social Care in Hackney and City
Date:	01-11-17
Lead Officer:	Jon Williams, Director, Healthwatch Hackney Catherine Macadam, CCG PPI lay member
Author:	Emily Tullock, Healthwatch Hackney, Communications & Engagement Manager – Transformation
Committee(s):	Integrated Commissioning Engagement Enabler Group – for feedback – July and Sept 2017 CCG Patient & Public Involvement Committee – for feedback – 28 Sept 2017 Transformation Board – endorsed– 13 Oct 2017 Hackney Integrated Commissioning Board – endorsed – 17 Oct 2017 City Integrated Commissioning Board –for endorsement – 17 Oct 2017 and revised for 15 Nov 2017
Public / Non-public	Public

Executive Summary:

The Co-production Charter for Health and Social Care in Hackney and City was endorsed by the Transformation Board (13 Oct 2017) and Hackney Integrated Commissioning Board (17 Oct 2017) as the direction of travel for integrated commissioning and in line with the NHS Five Year Forward View.

This final version incorporates feedback that the charter should:

- include workers using health and social care services in the area
- include children and young people.
- acknowledge that co-production can't override an organisation's democratic decision-making processes or statutory responsibilities to service users
- acknowledge that people who use services and representatives of organisations have different responsibilities and resources so they cannot be truly equal but should be equally valued.

The City Integrated Commissioning Board is requested to endorse the revised version of the Co-production Charter to ensure co-production is embedded equally in Hackney and the City.

Questions for the Transformation Board

n/a

Issues from Transformation Board for the Integrated Commissioning Boards

n/a

Recommendations:

The City Integrated Commissioning Board is asked to:

- To **APPROVE** the Co-production Charter for Health and Social Care in Hackney and City

Links to Key Priorities:

- NHS Five Year Forward View goal to engage with communities and citizens in new ways,

involving them directly in decisions about the future of health and care services. - Hackney Health & Wellbeing Strategy drive towards person-centred integrated care and support. - City Health & Wellbeing Strategy focus on listening to the views of service users.

Specific implications for City and Hackney

This charter has been jointly developed by Healthwatch Hackney and Healthwatch City of London. Both Hackney and City residents were involved in developing this charter. The charter has been endorsed by the Transformation Board and Hackney ICB.

Patient and Public Involvement and Impact:

- Over 70 residents developed the principles for the Co-production Charter at a local Healthwatch conference in July - Public consultation and feedback on charter (advertised in Hackney Today and through Healthwatch Hackney and Healthwatch City channels) - Patient User Experience Group (PUEG) and CCG PPI committee feedback in Sept 2017

Clinical/practitioner input and engagement:

Clinicians and practitioners in care workstreams who pilot co-productive ways of working will be offered co-production training and support by the Engagement Enabler Workstream

Impact on / Overlap with Existing Services:

Supporting Papers and Evidence:

Appendix 1: Revised Co-production Charter for Health and Social Care in Hackney and City

Sign-off:

Workstream SRO _____[*insert name and title*]_____ London Borough of Hackney _____[*insert name and title*]_____ City of London Corporation _____[*insert name and title*]_____ City & Hackney CCG _____[*insert name and title*]_____

CO-PRODUCTION CHARTER FOR HEALTH AND SOCIAL CARE

HACKNEY AND CITY

PURPOSE:

Co-production is defined as designing, reshaping or delivering services in equal partnership with the people who use them in order to create better services and outcomes. This charter sets out the rights people[1] can expect for the co-production of health and social care services in Hackney and the City of London. It also sets out the responsibilities of people taking part in co-producing services. Integrated commissioning partners in Hackney and City will be asked to sign-up to the charter.

This charter aims to capture the principles of co-production rather than be a set of rules. These principles are intended to guide actions to achieve the vision of people as equal partners in health and care. The principles of co-production in no way replace any organisation's democratic processes or statutory duties, including consultation on service change.

The charter signals the direction of travel for integrated commissioning in City and Hackney.

This charter has been developed in partnership with local people. It is a living document and will be subject to annual review and change.

PEOPLE HAVE A RIGHT TO:

- Be included from the start in the design or redesign of health and social care services that affect them.
- Be treated and taken seriously as an equally valued voice, asset and partner.
- Transparency. Involves organisations setting out all the information on what is being co-produced (including any limitations) from the start and feeding back the result of co-production.
- Honesty. Involves acknowledging differences in power and resources between those taking part.
- Access to all the relevant information to understand and take part in decision-making.
- Receive something back for their contribution. This could include training, acknowledgement, new skills, time credit vouchers, or payment.
- Accessibility so everyone has an equal opportunity to participate. This includes accessibility of venues, location, translation into different languages, British sign language (BSL) interpreters, understandable language (in line with the Accessible Information Standards) , variety of times and formats (including easy read).
- Stable and consistent structures and people (as much as possible).
- Freely give feedback and make their voice heard.

[1] Inclusive of all Hackney and City residents, citizens, service users, patients, carers, experts by experience, workers using local health and social care services, children and young people, and other self-nominated identifiers.

PEOPLE ENGAGED IN CO-PRODUCTION HAVE A RESPONSIBILITY TO:

- Encourage a partnership based on mutual trust and respect. For example by listening to each other and answering questions respectfully.
- Build connections and be answerable to wider communities and groups. This recognises that no one individual can represent everyone.
- Share information with wider communities and groups and feedback their concerns.
- Commit to ongoing involvement to keep momentum going.
- Commit to working together towards shared goals.

AS HEALTH AND SOCIAL CARE ORGANISATIONS, WE COMMIT TO MAKING CO-PRODUCTION A REALITY BY:

- Signing up to this Co-production Charter, reporting against it annually and making steps to improve how we implement its principles.
- Service user involvement throughout including on senior strategic and partnership boards.
- Co-production championed all through our organisations, from strategic board level down to managers and frontline staff.
- Training and capacity building for all health and care staff on co-production.
- Training and capacity building for people and groups to encourage diverse involvement.
- Explore new and different ways of working to remove barriers to diverse people taking part equally.
- Dedicating resources and funding for co-production to ensure it continues.
- Committing to continuous learning and improvement including by building in feedback and review to see if co-production is having an impact.
- Committing to individual and organisational cultural change.
- Building on existing processes for involvement and engagement.

Document 8.1

Title:	Monitoring Financial and Performance Risks Across the System
Date:	15 November 2017
Lead Officer:	Anna Garner, Head of Performance and Alignment, CCG
Author:	Anna Garner, Head of Performance and Alignment, CCG
Committee(s):	Integrated Commissioning Board – 15 November 2017 (decision) CCG Governing Body – 24 November 2017 LB Hackney Management Team – 28 November 2017 CoLC Departmental Leadership Team –date tbc Transformation Board – 8 December 2017
Public / Non-public	Public

Recommendations:

The Integrated Commissioning Board is asked:

- To **CONSIDER** the recommendations on the method for monitoring of performance and financial risks
- To **APPROVE** the methods and timelines
- To **APPROVE** revisions to TORs, starting discussions with performance teams and other impacts of process

Executive Summary:

Proposal for how to identify and monitor performance and financial risks across City and Hackney system, managed via the Integrated Commissioning governance.

Questions for the Transformation Board

- Process/flow of business acceptable?
- What is the role of ICB in scrutiny of finance and performance data, underlying trends/risks and appropriateness/fullness/likely impact of any recovery plans? What capacity available in ICB to do this?
- Timelines acceptable?
- Who is responsible for drafting performance and financial reports?
- How we identify current risks and then how new risks added?
- What is needed within recovery plans? What needed to assure committees of delivery/recovery?

Issues from Transformation Board for the Integrated Commissioning Boards

N/A

Links to Key Priorities:

N/A

Specific implications for City and Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Impact on / Overlap with Existing Services:

N/A

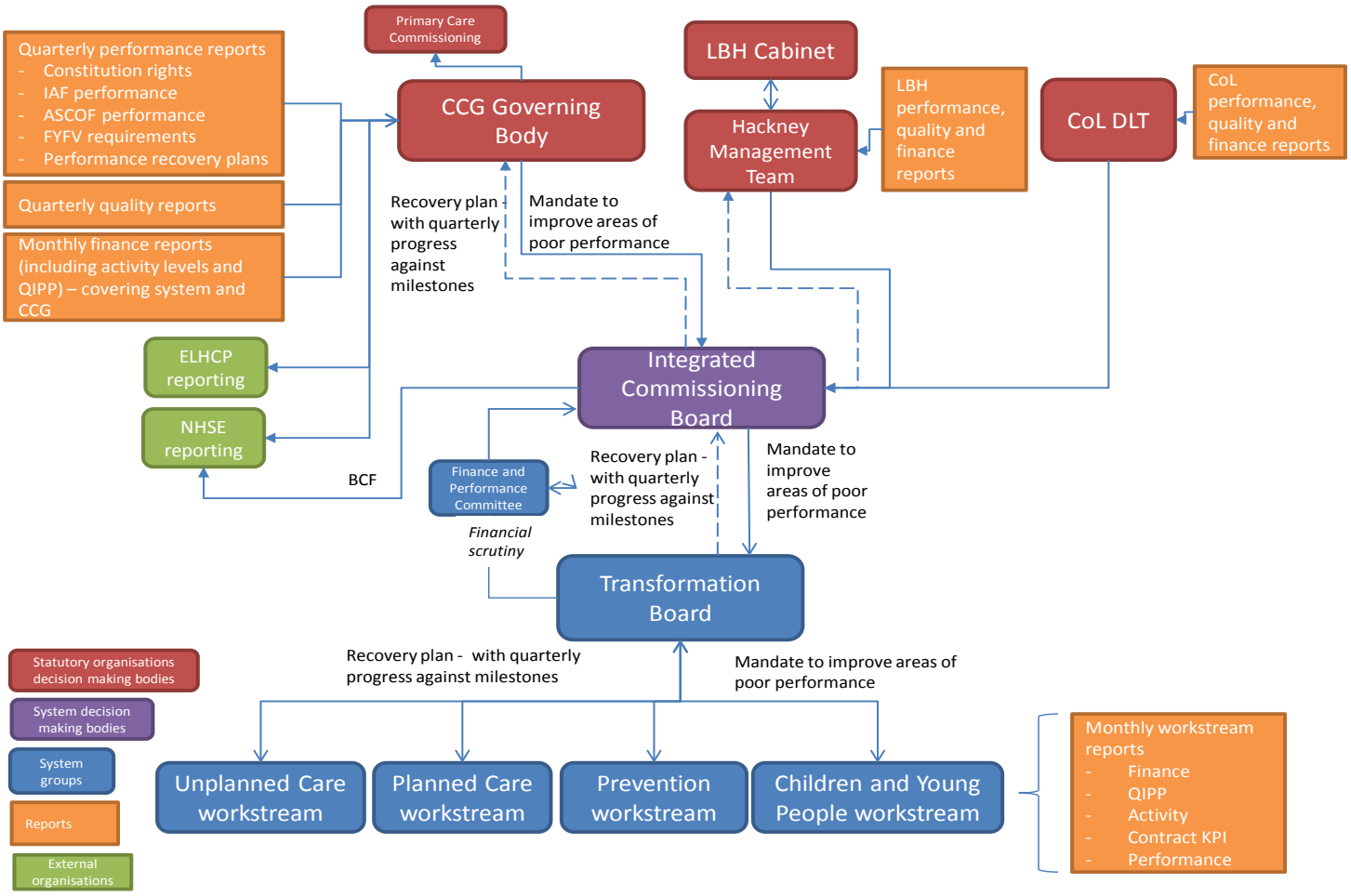
Main Report

How to monitor financial and performance risks across the system

Need

1. Identification of risks across the different organisations and their impact across the system
2. Ensuring that appropriate action is taken to mitigate these risks, including recovery plans drafted and delivered by workstreams
3. Monitoring progress against these plans and ensuring expected impact on performance/financial balance

Proposed process



Considerations (and recommendations)

- Format of reports to ICB, including:
  - Mandated performance data for LAs and CCG
  - Financial run rate and outturn against activity based contracts
  - Identification of current risks and any deteriorating performance suggesting future risks
  - Workstream narrative on above
- Role of ICB in scrutiny of finance and performance data, underlying trends/risks and appropriateness/fullness/likely impact of any recovery plans. What capacity available in ICB to do this. Recommendation:
  - Form a dedicated group – CCG Finance and Performance Committee could be

reconstituted with additional members to provide this function for the ICB

- Flow of business through the integrated commissioning governance (and timing of that, including impact on speed of response)
- Revisions to committee TOR
- Timelines for the above. Recommendation:
    - Agreement of process: Nov/Dec
    - Plan for flow of business through IC governance (initial risks): Nov/Dec
    - Workstreams to develop recovery plans: Dec-March
    - Recovery plans through IC governance for initial approval: Apr-Jun
    - Reports on progress: quarterly via performance reports to ICB
- Who is responsible for drafting performance and financial reports, who has inputted before ICB receive reports. Recommendation:
    - 3x organisation performance teams (CCG and LA) develop streamlined process utilising capacity and skills in each team for collating data and drafting report, and then incorporating workstream narrative (engagement from all partners needed, mandate to move towards greater joint working alongside capacity in teams to do this)
- How we identify current risks and then how new risks added. How this is recorded. How mandate to draft recovery plan flows to TB and then ICB from this (roles and responsibilities of staff teams within this). Suggested criteria for risks *(divide by workstream, ensure none fall outside of workstreams):*
    - Poor/deteriorating performance on IAF/ASCOF
    - External regulator concerns (CQC inspection etc)
    - Poor quality measures
    - Increasing/unwarranted activity linked spend
    - Risks to delivery of NHS FYFV (unassured workstream delivery plans – plans due October 2017)
    - Risks to financing of NHS FYFV requirements
- What is needed within recovery plans. What needed to assure committees of delivery/recovery. Suggested:
    - System plans to improve performance
    - Requirements from each provider – contribution, roles, responsibilities, behaviours
    - Contracts/other mechanisms
    - Outcome trajectories
    - Milestones

<u>Current risks for CCG</u>

<u>IAF</u>
DTOCs
A&E 4hr target
62 day cancer wait
Cancer rating (survival, early diagnosis patient experience)
Childhood obesity

Achievement of diabetes triple target
Personal health budgets
People feeling supported to manage their LTCs
Workforce race inequality standard
Cancer patient experience
IAPT recovery rate
CQC rating score for adult social care

Financial
Out of area contracts
Continuing healthcare spend
Non-elective admissions spend
FYFV funding gaps

CCG Board Assurance Framework risks
Homerton Maternity services
CAMHS services and CYP crisis demand
Anticoagulation service
Primary care staffing
111 service

Transition risks
?

Sign-off:

[Papers for approval by the ICBs must be signed off by the appropriate senior officers. Any paper with financial implications must be signed by the Members of the Finance Economy Group.
If there are any legal implications which require consultation with legal counsel, please make reference to that below.
Copies of email sign-off should be sent to the Secretariat (jarlath.o'connell@nhs.net) along with the papers. Papers which have not been signed-off by the appropriate officers will not be considered by the Committee.]

London Borough of Hackney _____[*insert name and title*]___Anne Canning, Group Director_____

City of London Corporation _____[*insert name and title*]____Neil Hounsell_, Assistant Director__

City & Hackney CCG Paul Haigh, CO

Document 9.1

Title:	Consolidated Finance (income & expenditure) report as at August 2017 - Month 6
Date:	15th November 2017
Lead Officer:	Anne Canning, London Borough of Hackney (LBH) Paul Haigh, City & Hackney Clinical Commissioning Group (CCG) Neal Hounsell, City of London Corporation (CoLC)
Author:	Integrated Finance Task & Finish Group CCG: Dilani Russell, Deputy Chief Finance Officer CoLC: Mark Jarvis, Head of Finance, Citizens' Services LBH: Jackie Moylan, Director – Children's, Adults' and Community Health Finance
Committee(s):	Transformation Board – 10th November City Integrated Commissioning Board – 15th November 2017 Hackney Integrated Commissioning Board – 15th November 2017
Public / Non-public	Public

Executive Summary:

This reports on finance (income & expenditure) performance for the period from April to September 2017 across the CoLC, LBH and CCG Integrated Commissioning Funds.

The forecast variance for the Integrated Commissioning Fund as at Month 06 (September) is £5.2m adverse. This an adverse movement of £0.8m from the reported forecast variance at month 5. This relates to the LBH position which is being driven by Learning Disabilities commissioned care packages (outlined within the report). The risks to the position have been flagged in the risk schedule which will be updated and reported on monthly basis.

Questions for the Transformation Board

N/A

Issues from Transformation Board for the Integrated Commissioning Boards

Comments from TB to be provided verbally at meeting.

Recommendations:

The Integrated Commissioning Board is asked:

1. *To **NOTE** the report;*

Links to Key Priorities:

N/A

Specific implications for City and Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Impact on / Overlap with Existing Services:

N/A

Main Report

Background and Current Position

N/A

Options

N/A

Equalities and other Implications:

N/A

Proposals

N/A

Conclusion

N/A

Supporting Papers and Evidence:

N/A

Sign-off:

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

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

Integrated Commissioning Fund
Financial Performance Report

Month 06 Year to date cumulative position

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Consolidated summary of Integrated Commissioning Budgets

	Organisation	Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend £000's	Forecast Fcast Variance £000's	Forecast Prior Mth Variance £000's
Pooled Budgets	City and Hackney CCG	24,947	12,473	12,473	-	24,947	-	-
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	283	53	32	21	277	6	6
Total		25,230	12,526	12,505	21	25,224	6	6
Aligned	City and Hackney CCG	363,659	178,747	178,747	0	363,659	(0)	-
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	5,957	2,491	2,794	(303)	6,271	(314)	(318)
Total		369,616	181,238	181,541	(302)	369,930	(314)	(318)
ICF	City and Hackney CCG	388,606	191,221	191,221	0	388,606	(0)	(0)
	London Borough of Hackney Council	102,127	51,064	58,752	(7,689)	106,979	(4,852)	(4,084)
	City of London Corporation	6,240	2,544	2,825	(282)	6,548	(308)	(312)
Total		496,973	244,828	252,798	(7,971)	502,133	(5,160)	(4,396)
CCG Primary Care co-commissioning		44,183	21,097	21,097	(0)	44,183	-	-
Total		44,183	21,097	21,097	(0)	44,183	-	-

Notes:

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

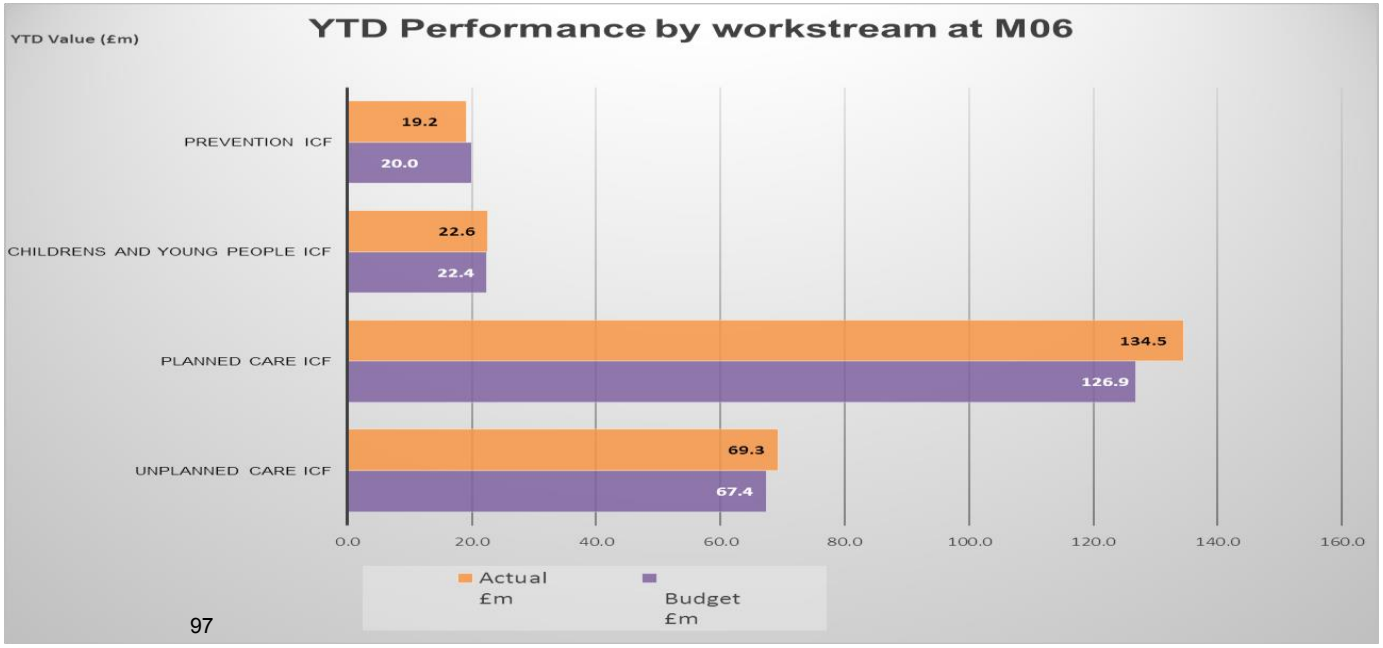
Summary Position at Month 06

- The forecast variance for the Integrated Commissioning Fund as at Month 06 (September) is £5.2m adverse. This an adverse movement of £0.8m from the reported forecast variance at month 5.
- Driving the adverse forecast outturn (FOT) position is the London Borough of Hackney, which is forecasting a £4.9m over spend for the year, a deterioration of £0.8m from last month's reported FOT. The adverse position relates to Learning Disabilities commissioned care packages.
- The City of London forecasts over spend of £0.3m against the annual plan. The over spend is expected to be met by a request for additional Adult Social Care funding and Public Health reserves.
- The CCG is forecasting breakeven position in line with the annual plan.
- The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF) including the Integrated Independence Team (IIT) and Learning Disabilities. There is a £6k under spend against Pooled budgets.
- At present London Borough of Hackney budgets are not split between pooled and aligned due to the fact that pooled funds are contributing to towards the services in aligned funds.
- The CCG took on Primary Care Co- commissioning on 1 April 2017. At M06 these budgets are break even with a forecast break even position at year end.

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

Integrated Commissioning Budgets – Performance by workstream

WORKSTREAM	Annual Budget £m	YTD Performance Budget £m	YTD Performance Actual £m	YTD Performance Variance £m	Forecast Fcast Spend £000's	Forecast Fcast Variance £m	Forecast Prior Mth Variance £000's
Unplanned Care ICF	134.9	67.4	69.3	(1.9)	134.8	0.2	1.0
Planned Care ICF	254.8	126.9	134.5	(7.6)	260.8	(6.0)	(5.9)
Childrens and Young People ICF	44.8	22.4	22.6	(0.2)	45.1	(0.3)	(0.1)
Prevention ICF	40.8	20.0	19.2	0.8	41.0	(0.2)	(0.1)
All workstreams	**475.4**	**236.7**	**245.5**	**(8.8)**	**481.7**	**(6.3)**	**(5.2)**
Corporate services	20.6	7.6	6.7	0.9	19.4	1.2	0.9
L ocal Authorities (DFG Capital and CoL income)	1.0	0.5	0.6	(0.1)	1.1	(0.1)	(0.1)
Not attributed to Workstreams	**21.6**	**8.1**	**7.3**	**0.8**	**20.5**	**1.1**	**0.8**
Grand Total	**497.0**	**244.8**	**252.8**	**(8.0)**	**502.1**	**(5.2)**	**(4.4)**



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Performance by Workstream.

- The report by workstream combines 'Pooled' and 'Aligned' services but excludes chargeable income .CCG corporate services is also shown separately as they are not attributable to any work streams.
- The combined position for the workstreams for month 6 is an over spend of £8.8m, and £6.3m forecast over spend for the year.
- Across the CCG, LBH and CoL,
  - Unplanned care workstream forecasts £0.2m underspend against the annual budget. This is an adverse movement of £0.6m against the forecast reported last month. This is mainly attributable to forecast CCG Acute over spends outlined in the next slide.
  - Planned care workstream reports forecast outturn (FOT) of £6m adverse. This position reflects LBH Learning disabilities overspend which is driven by activity increases (transition from adolescent to adult care & new referrals) and increase in care needs.

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

City and Hackney CCG – Position Summary at Month 6

	ORG	WORKSTREAM	Annual Budget	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend	Forecast Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Commissioned	Unplanned Care	18,735	9,367	9,367	0	18,735	0	0
		Planned Care	6,202	3,101	3,101	0	6,202	0	0
		Prevention	10	5	5	0	10	0	0
		Childrens and Young People	0	0	0	0	0	0	0
	Pooled Budgets Grand total		24,947	12,473	12,473	0	24,947	0	0

	ORG	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Aligned	Commissioned	Unplanned Care	110,464	55,232	55,635	(403)	111,279	(814)	99
		Planned Care	184,022	91,607	91,967	(361)	184,103	(81)	(891)
		Prevention	3,761	1,881	1,881	(0)	3,762	(0)	(0)
		Childrens and Young People	44,849	22,424	22,603	(179)	45,145	(297)	(63)
		Corporate and Reserves	20,563	7,604	6,661	943	19,371	1,192	855
	Aligned Budgets Grand total		363,659	178,747	178,747	0	363,659	(0)	(0)
Subtotal of Pooled and Aligned			**388,606**	**191,221**	**191,221**	**0**	**388,606**	**(0)**	**(0)**

In Collab	Primary Care Co-commissioning		44,183	21,097	21,097	(0)	44,183	0	0
Grand Total of including Primary Care Co-commissioning			**432,789**	**212,318**	**212,318**	**(0)**	**432,789**	**(0)**	**(0)**

- Corporate (Running Cost Allowance - RCA) underspends and reserve funding are off setting overspends at an organisational level. However, workstream YTD budgets and FOT are adverse.
- Primary Care Co- commissioning services passed on to the CCG on 1 April 2017 with a budget of £43.9m. At M05 this increase to £44.1m and the position is forecasting to break even at year end.
- At Month 06, the budgets are based on 1st April 2017 list sizes. Work is currently underway to estimate the additional costs in property charges (included as a potential financial risk in risk slide). Any variation to plan will be factored into the forecast outturn position once quantified.
- *Continuing Health Care

- At Month 06 the CCG reports break even position .
- **Pooled budgets** reflect pre-existing integrated services of the Better Care Fund (BCF), Integrated Independence Team (IIT), Learning Disabilities and are break even.
- **Aligned budgets**: The Unplanned Care workstream is over spent by £0.4m YTD with £0.8m forecast over spend. Driving the adverse variances are Acute over spends with UCLH being the largest due to Adult A&E +NEL activity. London Ambulance Service (LAS) and NHS 111 service are also over spent against budget.
- The Planned Care workstream reports YTD over spend of £0.4m however, FOT reduces to £0.1m adverse.
  - YTD Planned care position reflects over spends in CHC* (£0.4m), Acute outpatients & critical care overspends (mainly UCLH & Moorfield's) plus mitigating impact of £0.6m under spend against HUHFT planned care. The HUHFT underspend is the expected QIPP target for the escalation ward & PUCC expected via a contract variation.
  - CHC over spend owes to increase in patient numbers within fast track and physical disability activity. Challenges are being made to the £0.8m adverse FOT through the workstream CHC Improvement Group.
- The large in-month movement on forecast outturn between Planned and Unplanned Care is attributable to correct allocation of over performance between the workstreams.
- Children's and Young people adverse position relates to over spends in UCLH maternity and CHC spot purchase complex care packages.

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

Risks and Mitigations Month 6 - City and Hackney CCG

Summary and Progress Report on Financial Risks and Opportunities to 30 September 2017

Ref:		Description	Risks/ (Opps) £'000	Prob. %	Adj. Recurrent £'000	Adj. Non Recurrent £'000	Narrative
1	Risk	Homerton Acute performance	1,500	30%	450	0	Gross position based on historic trend. Net risk based on the trend relating to claims and challenges.
2		Homerton Identification Rule (IR) changes	1,865	0%	0	0	Impact of Identification Rule changes relating to high cost drugs within the Homerton acute portfolio. Awaiting £165k reimbursement
3		Bart's Acute performance	1,500	15%	225	0	Gross position reflects over-performance risk and possible NHSE disputed misattribution.Net risk likley on a year to go basis.
4		Outer sector - Acute performance	2,500	45%	1,125	0	Increased NCL provider over-performance risk contained by reserves.
5		Non-Contracted Activity (NCA) performance	600	0%	0	0	Gross risk reflects uncertainty of costs, including mental health choice, resulting in a recognised cost pressure.
6		Continuing Healthcare, LD & EOL	2,500	27%	663	0	Risk relating to activity increase above plan, high cost patients packages and service provision. Gross risk high given worsening 2016/17 trends and increased FNC tariff pressure.
7		Non Acute performance	900	11%	103	0	Non acute cost pressure across the portfolio.
8		Programme Costs	1,000	0%	0	0	Possible in-year non-recurrent costs in support the integrated commissioning programme and other non-recurrent schemes
9		Property Costs	700	0%	0	0	Property services potential cost pressure
10		Non Recurrent Investment Cost Pressure	3,600	25%	0	900	Underwriting NR investment programme, dispute resolution and other pressures
11		Primary Care - Rent Revaluation	750	0%	0	0	Consequence of retrospective rent increases in 2017/18.
12		Primary Care - Rates	250	0%	0	0	Consequence of increased rateable value on properties in 2017/18
13		QIPP Under Delivery	600	0%	0	0	Potential under-delivery for schemes within the Operating Plan phased on a year to go basis.
Total Risks			**18,265**	**19%**	**2,566**	**900**	
1		Acute contract Claims and Challenges	(2,100)	56%	(1,176)	0	Based on historic trend.
2		Outer sector - Acute performance	(600)	25%	(150)	0	Current projected forecast underspend
3		Acute Reserves	(475)	100%	(475)	0	Release of reserve to contain activity pressures.
4		Contingency (0.5%)	(1,867)	3%	(55)	0	Release of contingency.
5		Prescribing	(400)	27%	(108)	0	Historic trend indicating possible underspend in 2017/18
6		Running Costs	(1,400)	43%	(600)	0	Additional headroom declared to contain non acute pressures and QIPP delivery on a year to go basis
7		Prior year Items	(4,000)	23%	0	(900)	Opportunities arising from settlement of disputed items, accruals etc. invoices provided for in prior year resulting in an upside available 2017/18.
8		Non Recurrent Investment slippage	(500)	0%	0	0	Reviewed and risk assessed with position contained at month 3
9		QIPP Over Delivery	(500)	0%	0	0	Expectation is minimum on-plan delivery of £5.0m QIPP declared in the Operating Plan.
10		QIPP - new schemes / CEP Programme	(1,436)	100%	(1,436)	0	QIPP in addition to the £5.0m recognised within the Operating Plan, ring-fenced and to be deployed on a year to go basis as directed by NHSE.
Total Opportunities			**(13,278)**	**37%**	**(4,000)**	**(900)**	
					(1,434)	**0**	
				Net Underlying Forecast Outturn		**(1,434)**	
				Net Cumulative Brought Forward surplus		**(30,198)**	
				Headline Forecast Outturn Cumulative		**(31,632)**	

City of London Corporation – Position Summary at Month 6

				YTD Performance			Forecast		
	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Comm'ned & *DD	Unplanned Care	65	26	18	8	65	-	-
		Planned Care	208	24	14	10	202	6	6
		Prevention	10	3	-	3	10	-	-
Pooled Budgets Grand total			283	53	32	21	277	6	6

	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Aligned Budgets	Comm'ned & *DD	Unplanned Care	208	-	-	-	208	-	-
		Planned Care	3,850	1,910	1,880	30	3,927	(77)	(85)
		Prevention	2,170	694	990	(296)	2,334	(164)	(137)
		Non - exercisable social care services (income)	(271)	(113)	(77)	(36)	(197)	(74)	(96)
Aligned Budgets Grand total			5,957	2,491	2,794	(303)	6,271	(314)	(318)
Grand total			**6,240**	**2,544**	**2,825**	**(282)**	**6,548**	**(308)**	**(312)**

* DD denotes services which are Directly delivered .
* Alinged Pooled budgets include iBCF funding - £179k
* Comm'ned = Commissioned

- At Month 06 the City of London Corporation reports an over spend of £282k.
- **Pooled budgets** are under spent by £6k attributable to BCF services within Planned care work stream - Care Navigator Service.
- **Aligned budgets** are over spent by £314k. This is being driven by the Prevention workstream which is £164k adverse as a result of pressures on the adult social care budget (largely driven by the cost of home care), along with increased contract costs for the public health service.
- In addition, there has been a broadening of the substance misuse and healthy weight / exercise services that are being offered and taken up by City residents including services provided by Square Mile Health (smoking, alcohol and substance misuse).
- The adverse forecast position includes a 27% shortfall against the chargeable income projections.
- A request for additional funding to cover the forecast over spends will be made. The position does not reflect the anticipated application of any such reserve funding.

- **Note**: Local Authority YTD position does not include accruals and prepayments. Commentary is provided on the forecast outturn position (which takes into account any timing differences).

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

Risks and Mitigations Month 6 - City of London Corporation

City of London Corporation

Risks	Full Risk Value	Probability of risk being realised	Potential Risk Value	Proportion of Total
TOTAL RISKS	0	0	0	0
Mitigations	**Full Mitigation Value**	**Probability of success of mitigating action**	**Expected Mitigation Value**	**Proportion of Total**
Uncommitted Funds Sub-Total	0	0	0	0
Actions to Implement				
Actions to Implement Sub-Total	0	0	0	0
TOTAL MITIGATION	0	0	0	0

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

London Borough of Hackney – Position Summary at Month 6

	ORG Split	WORKSTREAM	Total Annual Budget	Pooled Annual Budget £000's	Aligned Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend £000's	Forecast Variance £000's	Forecast Prior Mth Variance £000's
Pooled and Aligned Budgets	Commissioned & Directly Delivered	LBH Capital BCF (Disabled Facilities Grant)	1,299	1,299	-	650	707	(58)	1,299	-	-
		LBH Capital subtotal	1,299	1,299	-	650	707	(58)	1,299	-	-
		Unplanned Care (including income)	5,452	1,593	3,859	2,726	4,250	(1,524)	4,480	972	876
		Planned Care (including income)	60,509	22,640	37,869	30,255	37,495	(7,240)	66,332	(5,823)	(4,960)
		Prevention	34,867	-	34,867	17,434	16,301	1,133	34,867	-	-
		LBH Revenue subtotal	100,828	24,233	76,595	50,414	58,045	(7,631)	105,680	(4,852)	(4,084)
Grand total			**102,127**	**25,532**	**76,595**	**51,064**	**58,752**	**(7,689)**	106,979	(4,852)	(4,084)

* DD denotes services which are Directly delivered .

102,127

- **Aligned Budgets:** The Unplanned Care workstream has had a favourable movement of £96k from the forecast reported in August. The movement is driven by a refund within the Single Homeless & Rough Sleeper service of £85k.
  - The overall Unplanned care forecast under spend relates to Interim Care (£0.6m) and is offset by linked over spends on care packages expenditure which sits in the Planned Care workstream.
  - The favourable forecast also reflects underspends in Substance Misuse (£0.3m) due to declining activity levels.
  - The delay in implementation of Telecare charging coupled with the undelivered savings to date in Housing Related Support are being partially offset by one off additional income.
- **Prevention Budgets:** Public Health (constitutes 100% of LBH Prevention budgets) forecasts a breakeven position.

- At Month 06 LBH reports a forecast over spend of £4.9m
- **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (including the Integrated Independence Team IIT) and Learning Disabilities.
- **Aligned Budgets:** The Planned Care workstream is driving the LBH over spend. Learning Disabilities Commissioned care packages within this work stream is the main area of over spend, with a £5.3m pressure, which reflects a £750k adverse movement on the August position. The movement is primarily driven by two significant factors:
  - growth in client numbers as a result of 3 transitions (adolescent to adult care) and 3 new client referrals with an associated cost of £490k (M06-M12); and
  - additional care provision for existing clients due to increased care needs with a total cost impact of £260k.
- The overall budget pressure within LD represents undelivered savings from previous years (£3m) and increases in complexity of clients resulting in higher cost packages.
- Management actions through the Care Funding Calculator (CFC) will seek to mitigate some of this pressure this financial year. The LD Budget Review meetings will continue to look at the service in further detail to attempt to manage these pressures.

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

Risks and Mitigations - London Borough of Hackney

London Borough of Hackney

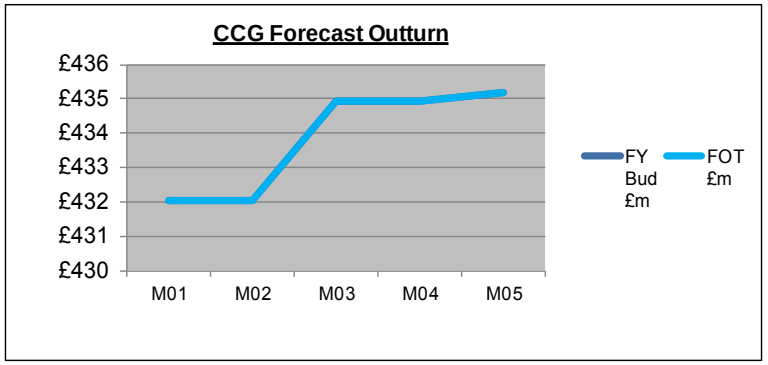
Risks	Full Risk Value £'000	Probability of risk being realised %	Potential Risk Value £'000	Proportion of Total %
Pressures remain within Planned Care (mainly Learning Disabilities Commissioned care packages) as mitigating actions are unlikely to have significant impact in this financial year	4,852	100%	4,852	100%
TOTAL RISKS	**4,852**	**100%**	**4,852**	**100%**

Mitigations	Full Mitigation Value £'000	Probability of success of mitigating action %	Expected Mitigation Value £'000	Proportion of Total %
Management actions through the implementation of initiatives such as the Care Funding Calculator (CFC) will seek to mitigate some of this pressure this financial year.	TBC	TBC	TBC	TBC
Review one off funding	4,852	100%	4,852	100%
Uncommitted Funds Sub-Total	**4,852**	**100%**	**4,852**	**100%**
Actions to Implement				
Actions to Implement Sub-Total	**0**	**0**	**0**	**0**
TOTAL MITIGATION	**0**	**0**	**0**	**0**

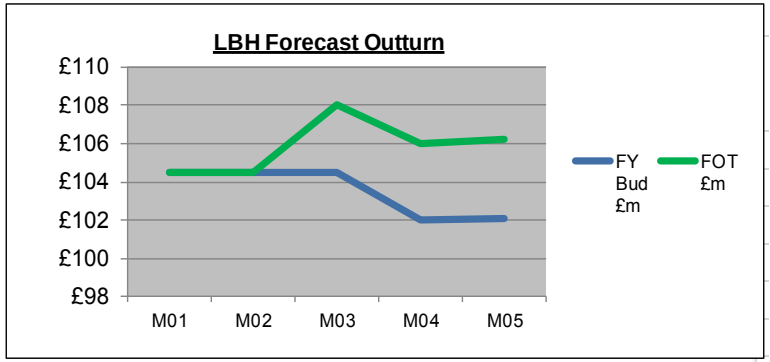
Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Forecast Run Rate at Month 06

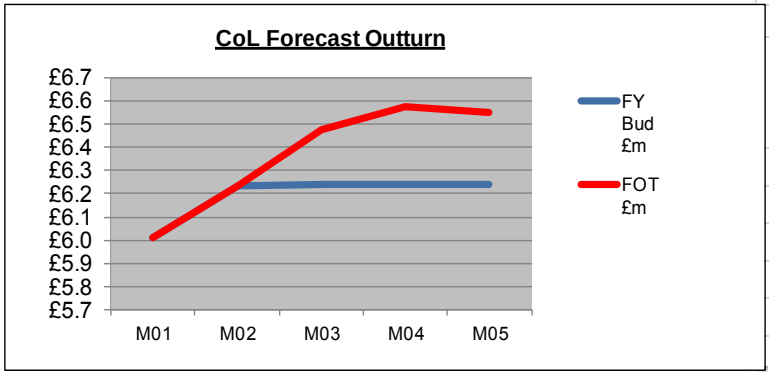
City and Hackney CCG Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	432.0	432.0	-
M02	432.0	432.0	-
M03	434.9	434.9	-
M04	434.9	434.9	-
M05	435.2	435.2	-
M06	432.8	432.8	-



London Borough of Hackney Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	104.5	104.5	0.0
M02	104.5	104.5	0.0
M03	104.5	108.1	(3.5)
M04	102.0	106.0	(4.0)
M05	102.1	106.2	(4.1)
M06	102.1	107.0	(4.9)



City of London Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	6.0	6.0	0.0
M02	6.2	6.2	0.0
M03	6.2	6.5	(0.2)
M04	6.2	6.6	(0.3)
M05	6.2	6.6	(0.3)
M06	6.2	6.5	(0.3)



- At Month 06 the CCG is forecasting a breakeven position at year end. This position include application of reserve funding to mitigate over spends across the workstreams.
- At Month 06 LBH is forecasting a £4.9m adverse position at year end. This is being driven by Learning Disabilities commissioned care packages. Mitigating actions are being undertaken by management to reduce the overspend, which is largely underpinned by unmet savings targets in previous years. The budgets are reported net of savings.
- At Month 06 the CoLC is forecasting an adverse position of £0.3m for year end due to increasing cost of homecare. This will be mitigated by the application of reserve funding which is not currently reflected in the position.

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

Integrated Commissioning Fund – Savings Performance Month 6

City and Hackney CCG

The CCG has a recurrent QIPP savings of £5m which has been removed from the respective budgets ,therefore the budgets reported are net of QIPP.

- The CCG has identified an additional QIPP of £1.4m which is over and above the £5m target is not reflected in the position as advised by NHSE.
- QIPP reported at Month 6 is reported to plan with a small over performance of £37k against a target of £2.5m
- The full year forecast has been reported achieve the target of £5m. Weekly QIPP delivery meetings are the platform to address any slippage and identify mitigations.
- There is some risk around the achievement of the additional £5m stretch target (see mitigations table).

London Borough of Hackney

LBH has agreed savings of £3.5m for 2017/18 (this includes delayed telecare charging implementation from 2016/17 of £0.3m), of this we anticipate that we will deliver £3.0m for 2017/18.

The shortfall in savings relates to:

- Housing Related Support (£1,062k savings agreed) - the savings achieved to date is £838k, leaving a shortfall of £224k which is offset by one off additional income.
- Telecare (£362k savings) charging agreed as part of the 2016/17 savings, has been delayed due to issues with the previous provider. The service is now working with a new provider and it is anticipated that the charging will not be implemented until the 2018/19 financial year.

City of London Corporation

- The CoLC have not identified a saving target to date for the 2017/18 financial year

Document 10.1

Title:	School Based Health Services and Vulnerable Children's Services
Date:	15th November 2017
Lead Officer:	Amy Wilkinson
Author:	Kate Heneghan
Committee(s):	Transformation Board – for information- 10 November 2017 Integrated Commissioning Board – for information – 15 November 2017
Public / Non-public	Public

Executive Summary:

This report provides an update on the redesign and procurement for the school based health services and services for vulnerable young people – school nursing and Family Nurse Partnership Services.

The London Borough of Hackney have statutory responsibility for several elements delivered through our School Based Health Services, and have recently been granted permission by Hackney Cabinet Procurement Committee to go out to procurement for the School Based Health services and services for vulnerable young people (our Family Nurse Partnership). The tender papers will go out to advert in November, with the services delivering in full from September 2018.

The Health of Looked After Children's service, ideally and historically part of this procurement has been removed. This service is scheduled to be redesigned as a partnership – one of the first priorities of the Children, Young People and Maternity Integrated Commissioning Workstream.

Questions for the Transformation Board

The Transformation Board is asked to note this paper for information. The Public Health procurement processes outlined in this paper are in progress and were approved by Hackney Cabinet Procurement Committee in October, 2017.

Issues from Transformation Board for the Integrated Commissioning Boards

Feedback from the Transformation Board to be provided verbally at the meeting

Recommendations:

The Integrated Commissioning Board is asked to **NOTE** the report.

Links to Key Priorities:

This procurement supports the Council to meet its duties and obligations as set out by the Health and Social Care Act 2012 and the Children and Families Act 2014, to protect and improve the health and well-being of families and local children.

Since 2013, part of the local authority Public Health mandate has been to deliver on key functions defined within the national 5-19 Healthy Child Programme, and from 2015, the 0-5 programme equivalent. The holistic programme defines a comprehensive package of evidence-based, public health interventions aimed at creating and sustaining good health, wellbeing and resilience in children from pre-birth and up to 19 years of age by addressing a number of key health themes including sexual health and emotional wellbeing. The services proposed enable the Council, to meet their statutory duties to deliver on the programme, building on the successes already realised through delivery of the existing services to-date.

In addition, the health and wellbeing of children and young people in Hackney and the City of London is a key local strategic priority given the level of need around key public health issues such as obesity as identified through the National Child Measurement Programme (NCMP) and the local Joint Strategic Needs Assessment, which remains a key area of concern for our children.

Furthermore, the services contribute the council's wider safeguarding duties in relation to supporting the most vulnerable children and young people around their health needs by taking both a preventative approach, as well as delivering on early help requirements in partnership with children's social care.

Specific implications for City and Hackney

The new integrated school based health service will be available to all pupils at state maintained schools in Hackney and the City of London. The elements of the service that provide a full health offer to children with safeguarding responsibilities are available to all children resident in City and Hackney. The services for vulnerable young people will be available to first time young, vulnerable mothers who are residents in Hackney or the City of London.

Patient and Public Involvement and Impact:

As part of this procurement, Public Health have conducted a year long process of service user and relevant public involvement, with excellent participation levels. The patient and public involvement sought to establish how the school based health services and services for vulnerable young people services can better tailor provision to those who are most in need and to ensure that resident/user feedback forms a key component of the design process. The insight provided has been used to inform the final service specifications.

The public involvement included:

- Participation workshop with Hackney Youth Parliament
- Participation workshop with Hackney Gets Heard
- Parent workshop with Hackney Independent Parents (HIP)
- Interviews with students in Hackney schools
- Focus group with Family Nurse Partnership clients

Clinical/practitioner input and engagement:

There was significant stakeholder engagement in the design of the three new school based health services throughout 2013. This design work was originally informed through schools and young people's surveys on their health needs, satisfaction with and aspirations for Children's Health Services.

As part of this current commissioning cycle, an intensive programme of targeted engagement with key stakeholders from across City and Hackney was completed, drawing on local strategic and oversight groups, and complemented with a schedule of semi-structured, one-to-one interviews, focus groups and attendance at strategic groups facilitated by partners across sectors. Stakeholder engagement included:

- Interviews with staff from schools across Hackney and the City, including special schools
- Interviews with the providers of the current schools based health and Family nurse Partnership services
- Workshops with key partners at the Hackney and City Family Nurse Partnership annual review
- Attendance at GP consortium meetings
- Focus group with members of the Clinical Commissioning Group (CCG) Children's Programme Board
- Interview with Children's Social Care Staff
- Interview with the Independent Chairs team meeting (Safeguarding and reviewing)

Many of the stakeholders who were involved in the current commissioning cycle include those who were already on the service design journey of the school based health services since 2013. This enabled a re-visitation of the issues and challenges first addressed in the original re-design process with the opportunity to even further refine and redefine functions according to tried and tested approaches. The accumulated insight gained through the multiple engagement platforms has underpinned the re-design of the future services.

Impact on / Overlap with Existing Services:

Hackney Cabinet Procurement Committee granted permission to extend the existing contract for the Family Nurse Partnership (due to expire on 31 March 2018) until September 2018 so that the contract can be let co-terminus with the School Based Health Service (improve attractiveness to bidders). The current school based health service contracts are due to expire in September, 2018. The newly procured services will therefore replace the existing service.

Main Report

Background and Current Position

Background

The transfer of Public Health responsibilities into the Council in 2013, for children aged 5-19 years of age and subsequently those aged 0 to 5 in 2015 provided the Council with the opportunity to integrate provision, ensuring that the Council makes the best use of our wider resources to improve health outcomes for children and young people.

During the redesign of the school based health services in 2013, the key functions were split into separate services to enable a focus and development on the key deliverables of the functions and increase performance. The current school based health services are:

- Safeguarding School Health Service (School nursing service for children with defined vulnerabilities and known to Children's Social Care, currently delivered by Whittington Health)
- School Health Service for Disabled Children with those with additional and complex needs (School nursing service delivered by Homerton University Hospital Foundation Trust providing a full time nurse for each of Hackney's special schools and school nurses to develop Individual Healthcare Plans for children with additional needs in mainstream schools)
- School Health Service delivering the National Child Measurement Programme and Reception Health Check (delivered by Homerton University Hospital Foundation Trust)

The Family Nurse Partnership Service (FNP) was procured by Hackney Public Health in 2013. FNP is a licensed programme and provides intensive support for first time teenage parents (delivered by Whittington Health).

Current Position

Following the previous re-design and tender of the School Based Health services, Public Health are now in a position where service delivery through close contract monitoring and partnership working for school based health provision has improved significantly, and where the service is delivering a safer and more robust health offer for Hackney and City children and young people.

The procurement allows for the reconfiguration of three of the current services into one,

integrated service, maximising the potential for improving health and safeguarding outcomes. The extensive engagement that has been completed as part of this engagement has provided valuable and practical input into shaping the design of the service. The reconfiguration also enables further alignment and value for money by creating an economy of scale and helps us to cater for our increased child population with no extra funds.

The Health of Looked After Children's service, ideally and historically part of this procurement has been removed. This service is scheduled to be redesigned across the partnership as a first priority of the Children, Young People and Maternity Integrated Commissioning Workstream.

The Family Nurse Partnership (FNP) is a licensed programme and so the service must adhere to the fidelity of the programme. Public Health continue to work closely with the FNP national unit to ensure the service is aligned and adapted to the latest evidence and guidance. As part of the FNP: Next Steps project, the new FNP service in Hackney and the City will accept referrals for vulnerable, first time mothers up to the age of 24 (rising from 20 years).

Both the school based health service and the FNP service will go out to advert in November, with the services delivering fully by September, 2018.

The cost of the School Based Health service is £1,370,892 per year (Lot 1) and the Family Nurse Partnership Service £455,000 per year (Lot 2). Both contracts will be awarded for 3 years, plus 1+1+1 (following a successful review at 3 years). The estimated cost over the maximum six year life of the contract will be £10.955m, and this cost will be recognised within the Public Health budget.

Options
This report is for information, as the procurement undertaken by Public Health has been approved by Hackney Cabinet Procurement Committee, so there are no further options to propose.

Equalities and other Implications:
There are no adverse impacts in terms of equalities.

Proposals
This report is for information, as the procurement undertaken by Public Health has been approved by Hackney Cabinet Procurement Committee, so there are no further options to propose.

Conclusion

After extensive work with providers to develop and improve services and stakeholder engagement, Public Health are in the process of procuring the school based health service and the vulnerable children's service, which both shall be delivering in full from September 2018.

Supporting Papers and Evidence:

N/A

Sign-off:

Work stream SRO: Angela Scattergood, Head of Early Years & Early Help London Borough of Hackney: Penny Bevan, Director of Public Health City of London Corporation: Theresa Shortland, Head of Early Years City & Hackney CCG: Pauline Frost, Interim Programme Director for Children & Maternity

Document 11.1

NHS City & Hackney Clinical Commissioning Group, London Borough of Hackney and City of London Corporation Integrated Commissioning Transformation Board

Meeting of 8 September 2017

ATTENDENCE

Members

Clare Highton	Governing Body Chair,	City & Hackney CCG (**In the Chair**)
Janine Aldridge		City of London Healthwatch
Penny Bevan	Director of Public Health, LBH and CoLC	LBH and CoLC
Deborah Colvin	Medical Director	City & Hackney GP Confederation
Tracey Fletcher	Chief Officer	Homerton University Hospital NHS Foundation Trust
Richard Fradgley	Director of Integration	East London NHS Foundation Trust
Simon Galczynski	Director of Adult Services	London Borough of Hackney
Paul Haigh	Chief Officer	City &Hackney CCG
Martin Kuper	Medical Director	Homerton University Hospital NHS Foundation Trust
Catherine Macadam	CCG Lay member for PPI	C&H CCG Governing Body Member
Vanessa Morris	Representative	Hackney Community and Voluntary Services
Raj Radia	Chair	Local Pharmaceutical Committee
Angela Scattergood	Head of Early Years and Early Help	London Borough of Hackney
Laura Sharpe	Chief Officer	City & Hackney GP Confederation
Paula Shaw	Representative	Healthwatch Hackney

In Attendance

Anna Garner	Head of Performance and Alignment	City & Hackney CCG
Siobhan Harper	Programme Director Planned Care	Integrated Commissioning

Matt Hopkinson	Integrated Commissioning Governance Manager	C&HCCG/CoLC/LBH
Sue Maughn	NEL Cancer Commissioning Director	NHSE London
Amaka Nandi,	Finance Consultant	City & Hackney CCG
Jarlath O'Connell	Integrated Commissioning Governance Manager	C&HCCG/CoLC/LBH
Sonia Rego	Representative	City of London Healthwatch
Fiona Sanders	Chair	Local Medical Committee
Gareth Wall	Programme Director Prevention	Integrated Commissioning
Ellie Ward	Integration Programme Manager	City of London Corporation

Apologies

Paul Calaminus	Chief Operating Officer	East London NHS Foundation Trust
Anne Canning	Group Director - Children, Adults and Community Health	London Borough of Hackney
Neal Hounsell	Assistant Director Commissioning & Partnerships	City of London Corporation
Philippa Lowe	Joint Chief Finance Officer	City & Hackney CCG
David Maher	Deputy Chief Officer	City &Hackney CCG
Chris Pelham	Assistant Director - People	City of London Corporation
Tim Shields	Chief Executive	London Borough of Hackney (Chair)
Ian Williams	Group Director - Finance and Resources	London Borough of Hackney
Devora Wolfson	Integrated Commissioning Programme Director	C&HCCG/CoLC/LBH
Kim Wright	Group Director - Neighbourhoods & Housing	London Borough of Hackney (Vice Chair)

1. Introduction

1.1. Clare Highton, in the Chair, welcomed members to the meeting and made note of apologies received.

2. Register of Interests

2.1. The Board **NOTED** the Register of Interests. No additional conflicts of interest were raised in respect of items on the agenda.

2.2. Deborah Colvin requested that her entry be amended to reflect that The Lawson Practice had now taken over the contracts for Springfield and Tollgate Lodge GP Practices.

3. Minutes of Transformation Board Meeting, 11 August 2017

3.1. The minutes were **APPROVED** as an accurate record of the meeting.

4. Action Log

4.1. The Board **NOTED** the updates to the action log.

5. Social Prescribing Contract Extension

5.1. The Board gave consideration to a report on the award of a new contract for the Social Prescribing Service in City and Hackney, introduced by Gareth Wall on behalf of the Prevention Workstream. It was noted that this was a limited extension so that the Prevention Workstream could look at how the service fits with similar services which have been commissioned by Public Health and the Workstream's aim was to ensure better alignment and links.

5.2. Vanesssa Morris welcomed the proposal but added that there needed to be a more robust mechanism for referrals. Paula Shaw added that the public needed to be reassured that this was not about stopping people accessing GPs. Ellie Ward asked whether commissioners were strengthening outcome measures here rather than just performance targets. It was noted that there was very intensive measurement of outcomes but that the KPIs would be looked at again. Deborah Colvin commented that the 80% positive response was already very high. There was a discussion on the contrast between the evidence base for this proposal vis a vis the RightCare Respiratory Disease one. Board Members concluded that this proposal needed to be given time to

work and Gareth Wall undertook to pick up these issues in the wider Prevention Workstream review.

5.3. The Transformation Board:

- **ENDORSED** the proposals set out in the report
- **RECOMMENDED** to the ICBs that the Social Prescribing contract is awarded to the current provider (Family Action) from 1 October 2017, for a further 2 year period (with the option of a one year extension).

6. RightCare delivery plan – Respiratory disease

6.1. The Board considered the proposals for activities to improve the care of people with respiratory disease in City and Hackney. Anna Garner introduced the report noting that it had already been discussed at the previous meeting but that the TB had requested that the report be resubmitted with an estimate of system savings attached to each activity. RightCare is a nationally mandated initiative for CCGs activities requiring investment: smoking cessation advisor within Homerton integrated COPD team (ACERS; published evidence on impact on admissions as well as other non-quantified impacts e.g. improved recovery post-surgery), new model for diagnosis of COPD and asthma (savings from reduced admissions following starting treatment; new model needed to align with new spirometry standards and regulations); and increased capacity for pulmonary rehab (robust evidence for improvements in quality of life and reduced admissions).

6.2. Deborah Colvin questioned the proposed savings on smoking cessation stating that '4 week quitters' was not a good measure and that patients with COPD have a lot of smoking cessation input but often are recalcitrant. She did not feel the saving proposals were realistic. AG replied that 4w quitters was only a activity measure and the estimated savings were based on similar services elsewhere. Penny Bevan added that many of this cohort were housebound and less able to access specialist services. DC asked why the service wouldn't be embedded within the smoking cessation service provided by the GP Confederation. Gareth Wall explained that there was strong evidence for embedding smoking cessation within the COPD treatment pathway and the services would work together in the partnership.

6.3. Paul Haigh noted that this delivery plan was mandated by NHSE with the aim of improving outcomes and delivering savings. It was noted that within the overall governance model it would fit within the Prevention Workstream.

6.4. DC commented that if ICB decided to fund this could we be certain that it would save money as we would need to cut other programmes to make up the savings if not. MK disagreed stating that this was the among the best validated preventative action that we could be taking and the evidence on pulmonary rehabilitation and stop smoking was very strong.

6.5. Simon Galczynski commented, regarding the comment on the cost of social care packages for those with COPD, that the highest cost of social care packages was actually in Learning Disabilities rather than in COPD. He added he would work further with AG on quantifying the cost of COPD on social care packages. Raj Radia added that he would like to be informed about how Community Pharmacies could be involved inthe improving diagnosis element.

6.6. The Transformation Board

- **RECOMMENDED** the resources attached to these activities outlined within the report
- **ENDORSED** the activities and logic model overall to be submitted to NHS England as part of the CCG's RightCare responsibilities.
- **NOTED** that the investment proposals would need to be considered against other investment proposals from workstreams

7. Hospice at Home Service Pilot Proposal

7.1. Anna Garner introduced the report describing this proposal for a pilot on behalf of the Unplanned Care workstream. The main element of the model was a multi-disciplinary crisis response service for patients at the end of life. She stated that discussions were ongoing with neighbouring boroughs on a 4-way split of the night service part of the £502k cost. Robust data from the Nuffield Trust suggests that provision of a Hospice at Home service can contribute £1140 per patient savings in cost of acute care in the last year of life, thus c. £350-450k of savings to the system with this service.

7.2. Members of the Board were supportive of this as long as there was sufficient support for those who do return home at end of life and that there was a sufficient safety net in place. Paula Shaw acknowledged the input of the Health in Hackney Scrutiny Commission 'End of Life Care' review into the development of this service. Catherine Macadam commented on the importance of reducing the impact on family carers and the need to include their health needs as an outcome and to involvethe Carers Centrein ensuring knowledge about the service. Laura Sharpe added that this needed to be aligned with the End of Life Care registers in GP Practices and Chair added that Coordinate My Care was important here. Martin Kuper asked if this could be doubled up with the 24hr Palliative Nursing Care in HUH and Barts.

7.3. Ellie Ward asked if the stakeholder input to the Pilot could ensure that the care pathways for City residents were included. The Chair added that it was crucial that this was part of the Single Point of Access for emergency care and that oncologists needed to be made aware of it.

7.4. **ACTION TB1709-1:** To ensure that the proposal includes reference to the care pathways for City residents. (Anna Garner)

7.5. The Transformation Board:

- **ENDORSED** the proposal for a new Hospice at Home Pilot including a strong focus on evaluation to ensure savings are realized
- **AGREED** that the ICBs be asked to consider whether the Pilot should go through the Prioritisation of Investment Process (see also item 9).

8. Integrated Assessment Framework (IAF) Cancer Improvement Plan

8.1. The Board gave consideration to a paper summarising the current action plan to improve the IAF assessment for cancer for City & Hackney CCG which was in 'greatest need of improvement'. The paper was introduced by Sue Maughn and Siobhan Harper on behalf of the planned care workstream

8.2. Sue Maughn noted that in early stage diagnosis the targets were hard to achieve and it was important to understand where we were on stage 1 and stage 2 cancers, currently we only had an annual report and there was a need to understand the realtime current position. There was also a need to look more broadly at colorectal cancer data across the STP area and both Cancer

Research UK and Macmillan were involved with the 7 CCGs on the Local Cancer Board. In terms of the National Survey it only gave a reliable picture in Hackney for breast cancer due to the small numbers in the sample size. Siobhan Harper added that in Integrated Commissioning there were a number of things they were already doing and cancer sat under the Planned Care Workstream but it was a bit early as yet to assess progress. Janine Aldridge asked if Healthwatch could work with the Cancer Board on improving the messaging on colorectal screening. Sue Maughn welcomed this and stated that at NEL level there was a group looking at what was working and that Cancer Research UK already provided information and support and could provide information to Healthwatches and GPs.

8.3. Penny Bevan commented that the latest data revealed that screening rates were getting worse and asked what NHSE was doing to address this. SM agreed that there was a need for the regional Cancer Boards to engage in better outreach. The Chair commented that when the ICBs are considering disinvestment it might be time to consider ending breast screening and bowel screening services as the response rates were so low. It was noted that the GP Confederation had been incentivised to increase screening but it was not proving effective. Deborah Colvin responded that GPs would often be more effective doing low level awareness raising work with patients instead. Martin Kuper disagreed stating that City and Hackney had very poor cancer outcomes due to late presentation and therefore there was a need to increase screening uptake rather than stopping it. England and Denmark had highly developed Primary Care systems and yet the poorest performance for cancer screening. Siobhan Haper pointed out that cancelling screening for breast cancer was not within the CCGs power. The Chair asked if there was deprivation weighted data on this and SM replied that NHSE had been asked to look at impact of deprivation on screening rates PB asked whether that there was a queue system developing for cancer treatment. SM replied that NEL was improving and was the only area in London to meet the waiting time standard for July. It was noted that 5 provider organisations in London were at risk of not meeting the waiting time standard required by November.

- The Transformation Board:
- **NOTED** the report and asked the planned care workstream to establish milestones for improvement for 1819 against the action plan

9. Process for Agreeing Investments for 2018/19

9.1. The Board gave consideration to a paper on the possible method for prioritisation of funding requests from the Integrated Commissioning system/workstreams. Anna Garner introduced the report and noted that the CCG already had a Prioritisation of Investment Committee chaired by CCG Governing Body member Catherine Macadam. It was noted that as part of this schemes were scored against value criteria and ranked. AG asked the Board to consider what future process might be needed for a fair and transparent system and one which would be applicable to very different schemes requesting funding.

9.2. It was noted that Care Workstreams were being asked to give plans for this year and next as part of Assurance Review Pts 2 and 3 and that there needed to be further discussion with LBH and CoLC on developing an integrated process. One option was a joint Prioritisation Committee. Also, consideration needed to be given to whether the process could be just confined to new requests.

9.3. Simon Galczynski stated that process had to be integrated and aligned to the local authority decision making timetable. He and Ellie Ward stated they were happy to work with AG on this. Penny Bevan cautioned that this would be a lengthy exercise and there would be a need to recognise that additional time would have to be built into the process. She added that commissioners' consider a vast range of value of contracts and she was not sure if excluding existing contracts was wise. There was a need to tweak the methodology for higher value and lower value contracts so as the concentrate on areas of greater savings and impact. Catherine Macadam stated that this would take a lot of time and that the Transformation Board was not the right one to do this. PB added that it was important to assess the scheme not the bid writer and there was a need to support bid writers to ensure an equitable quality of bid making. Laura Sharpe commented that the process must ensure that all of the original aims for City and Hackney ACS must be reflected in how the schemes are scored. PB added that the process so far had been based on investments and we are now moving toward disinvestment so we need to consider existing contracts also. Richard Fradgley stated that these proposals for investment and disinvestment must come up via the Workstreams and are part of QIPP and CIP challenge

9.4. **ACTION TB1709-2:** AG to return to the TB with a more detailed proposal including a proposal for a Terms of Reference for a group who would score the schemes and then make recommendations to the TB. It would ensure inclusion of the ACS aims in the value criteria, ensure that the timescales fit with LBH and CoCL budget setting timescales and the inclusion of disinvestments as well as investments.

9.5. There was a discussion on whether the 'RightCare Respiratory Disease' proposal and the 'Hospice at Home' Proposals should be put into this Prioritisation of Investment Process. Board members expressed concern that it would be unfortunate to delay the Hospice at Home Pilot by including it in this Process. The Chair added that she was reluctant to put Hospice at Home outside of the Process as the prioritisation process should include all requests.

9.6. Richard Fradgley also expressed concern about the level of Primary Care provider input to the Prevention Workstream. Laura Sharpe added that providers were not sufficiently represented on the Workstreams and there was no primary care presence on Prevention. Gareth Wall replied that their operating model was a Leadership Group and the detailed work was being facilitated by virtual teams involving all partners across the system. The Prevention Workstream had begun with a small group but the wider group included providers and the understanding was that his would be reviewed in six months' time. The issue in Prevention was that there was a very large number of providers including many VCS organisations. The Chair stated that there needed to be further discussion on this.

9.7. **ACTION TB1709-3:** The Workstreams to consider provider representation and how proposals get partner support before being presented to the TB. It was agreed that this could emerge as part of the next assurance point and be linked to the governance review (Workstream Directors)

9.8. The Transformation Board:

- **AGREED** that the proposals for a Prioritisation of Investment and Disinvesment Process be developed further and brought back the next meeting.

- **NOTED** Members concerns that the 'Hospice at Home' pilot should not be unduly delayed if the Integrated Commissioning Board decided that the Pilot be included in the Prioritisation of Investment Process.
- **NOTED** that consideration needed to be given to who would be involved in making recommendations as there needed to be a clear separation from the ICB members who would be considering the recommendations

10. Lea Surgery expansion/Kenworthy Health Centre void costs

10.1. The Board gave consideration to recommendations from the Estates Enabler Group regarding Lea Surgery's accommodation and the Kenworthy Health Centre void costs. Amaka Nandi introduced the paper and asked the Board to endorse the recommendations including the recommendations relating to Kenworthy Health Centre which would now be surplus to requirements.

10.2. Laura Sharpe asked whether the GP would get a lease from LBH now for the existing space he uses in Lea Surgery as LBH was the owner. AN replied that LBH was working with the CCG to regularise the tenancy and the plan was to sign a 5 years lease with break clauses. It was noted that Option 4 as set out in the paper was the option the Practice provided. This involves regularising the lease on the current premises and provides certainty on dealing with the void costs in Kenworthy Health Centre. It was noted that the GP's rent and rates were reimbursed by the CCG and service charges are not re-imbursed to the GP. A key issue was that if the GP moved to the Kenworthy Health Centre the service costs there are very high and should the CCG be asked to subsidise the service charges the process would be subject to an open book policy. It was noted that there were non-financial aspects too as there were design issues flagged by the Practice with using the Kenworthy space as a GP Practice including it note being as accessible for public transport as the current premises.

10.3. Tracey Fletcher noted that HUH had a small amount of services in the Kenworthy site and the impact on those would have to be considered should the site be released as surplus to requirement.

10.4. The Transformation Board :

- **ENDORSED** the recommendation of the Estate Enabler Group with regard to accommodation of Lea Surgery – the regularising of the lease of Lea Surgery and declaring the space at Kenworthy Health Centre surplus to requirements.

11. Finance Report Month 4

11.1 The Transformation Board **NOTED** the integrated finance report for Month 4 of the current financial year.

11.2 Paula Shaw asked about the cost pressures on Learning Disabilities service and whether care assessments might be affected. Simon Galczynski replied that they wouldn't as the Council had a statutory responsibility under to Care Act to deliver these. He added that there were a number of reasons for the increased cost pressures and he had a group looking at the issue and a new model for the service was being worked up by mid-October. The Chair asked if a report on it could come to this Board via the Planned Care Workstream.

11.3 **ACTION TB1709-4:** Planned Care Workstream to bring a report on the new model for Learning Disabilities and the work being done to tackle the cost pressures. (Simon Galczynski and Siobhan Harper).

12. Joint Grants Scheme – Innovation Fund & Healthier Hackney Fund

12.1. The Transformation Board **NOTED** the proposal for the Joint Community Grants Scheme which would combine two existing schemes the City and Hackney Innovation Fund and the Healthier Hackney Fund.

12.2. Ellie Ward asked if the implications for the City could be made clearer in the version going to the ICBs.

12.3. **ACTION: TB1709-5:** To provide further detail on the implications for the City of the Joint Grant Scheme. (Catherine Macadam/Eeva Huoviala)

13. AOB

13.1 Elle Ward queried the process for Strategies coming to the Transformation Board. The Chair stated that if there were things which the Board could

contribute to or clarify then it was appropriate that they should come. It was agreed that they be put on as information items. She added that cover sheets need to be clearer on what the Board was being asked to do and the flow of decision making needed to be made clearer.

13.2 Laura Sharpe asked if there could be a slot on a future agenda for a discussion on whether the Board is doing what is required of it. Paul Haigh agreed stating that the Board needed to look at how it was adding value. Penny Bevan commented that it would be worth looking at how to slim the process as, for example, the paper at item 12 had been to 6 committees. The Chair asked members if they could gather their thoughts on how this might work and to consider the operating model early in 2018 after the Board had had papers to consider from workstreams.

Integrated Commissioning Boards Forward Plan, 2017/18						
Title	**Summary of Decision**	**Originating Organisation**	**IC Decision Pathway**	**Care Workstream**	**Reporting Lead**	**Notes**
15-Nov-17						
School-based and Vulnerable Children's Health Services	Paper seeking LBH approval to procure services: Discabled Children's Services; Looked After Children's Health Services; Safeguarding School Health Services and Family nurse Partnership **ICBs For Information**	LBH	LBH CPC - 10 Oct 2017 - *For decision; TB 15 Nov for endorsing*	Children & Young People	Angela Scattergood / Amy Wilkinson	
Quarter 1 Quality & Performance Report	To review and discuss. Issues raised then taken to Dec TB.	CCG	GB - 27 October 2017; TB 8 Dec 2017	All	Sunil Thakker / David Maher	
Impact of QIPP programmes on City of London	Review and discuss specific impact of QIPP schemes on CoL residents	CCG	**City ICB Only**	All	Sunil Thakker / Dilani Russell	
Local Response to NEL Integrated Urgent Care		CCG	Unplanned Care Board - Oct	Unplanned Care	Anna Hanbury	
S256 Supporting hospital discharge and avoiding admissions		CoLC	**City ICB only**		Ellie Ward/Neal Hounsell	
S256 Supporting delivery of the locality plan		CoLC	**City ICB only**		Ellie Ward/Neal Hounsell	
System Performance Management		CCG			Anna Garner	
Hackney Community Strategy 2018-28	Overarching vision for Hackney over next decade.	LBH	LBH Cabinet 27 Nov; LBh council 24 Jan	All	Anne Canning	
13-Dec-17						
Children & Young People's Workstream Ask	Approval of Workstream Ask	CCG	Transformation Board - 10/11/2017	Children & Young People	Angela Scattergood / Amy Wilkinson	
London Streaming and Redireciton Model		CCG	Unplanned Care Board - Oct	Unplanned Care	Leah Herridge	
Workstream Assurance Review Point 3 - 18/19 Workplans, Financial Plans and Capability, management of risk, competence and capacity for delivery	Discuss and approve the workstream assurance documents for Planned Care, Unplanned Care and Prevention	All	TB 10 November 2017	Planned Care / Unplanned Care / Prevention	Devora Wolfson / Clara Rutter / Nina Griffiths / Siobhan Harper / Gareth Wall / Jayne Taylor	
Future vision for Outpatients Services	Discuss and endorse	CCG		Planned Care	Neal Hounsell/Gary Marlowe/Siobhan Harper	

Stop Smoking Service	STA to transfer existing contract to GP Confederation and extend the service by 9 months to facilitate procurement of new service - For discussion and recommendation	LBH	ICBs - 31/1/2018 - For endorsement Cabinet Procurement Committee 13/2/2018 - *For decision*	Prevention	Gareth Wall/Jayne Taylor	
Service Redesign and Clinical Leadserhip	To approve the proposal	CCG/ELFT		All	Clare Highton, Paul Calaminus	
VCS Strategy to support Transformation	To approve the strategy	VCS	CWDG - 26 Sept TB - 8 Dec	All	Sian Penner	
RightCare Business Case - Circulation	Endorse business case for submission to NHSE	CCG	TB Endorsement - 10 Dec	Planned Care	Anna Garner	
Outcomes Framework	Discuss and endorse proposed sytems outcomes framework	All	ICBs for decision TB for endorsement - 10	All	Anna Garner	
CYPM assurance review point 1	To endorse and recommend to the ICBs - CYPM workstream ask and assure governance etc.		ICBs for approval on 13 December 2017 TB for endorsement - 10		Angela Scattergood/ Amy Wilkinson	
Hackney DTOC action plan	To agree system actions to continue to improve DTOC performance in Hackney	LBH	TB for endorsement - 10 Dec	Unplanned care	Simon Galczynski	
Business Case for Pooling residential and continuing care (Planned Care) and prevention (Prevention)	To approve the business cases for further pooling of budgets		ICBs for approval on 13 December 2017 TB for endorsement - 10 Dec	Planned care, Prevention	Neil Hounsell, Anne Canning	
IC evaluation	Approve the outcome of the IC tender		ICBs for approval on 13 December 2017 TB for endorsement - 10 Dec	All	Anna Garner	
Business Case Commissioning Plan for Neigbhourhoods	Approve Business Case and agree expenditure			All	Tracey Fleetcher	
Discharge to Assess Pump Priming	Approve Business Case for release of funding			All	Tracey Fleetcher	
31-Jan-18						
Stop Smoking Service	STA to transfer existing contract to GP Confederation and extend the service by 9 months to facilitate procurement of new service	LBH	Transformation Board 8/12/2017 - *For discussion* Cabinet Procurement Committee 13/2/2018 - *For decision*	Prevention		
Quality & Performance Report 2017/18 - Quarter 2	Discuss and comment on reporting for Quarter 2	CCG	CCG Governing Body - 26 January	All	Philippa Lowe / Sunil Thakker	
Commissioning Intentions					David Maher/ Devora Wolfson	
Contract Award for Evaluation of Integrated Care	Discuss and endorse contract award for evaluation work	All	Integrated Commissioning	n/a	Anna Garner	
Integrated Commissioning Governance - 6 Month Review	Review and discuss outcomes of governance review and agree next steps	All	n/a	All	Devora Wolfson	

Procuring for Social Value	City ICB to discuss and endorse **City ICB only**	CoLC	Community and Children's Services Committee - TBC	Planned Care / Prevention	Ellie Ward / Neal Hounsell / Devora Wolfson	
Analysis of impact of Universal Credit	Discussion and to note	LBH		All	Ian Williams	
Carers Service	Provisin of Carers service across City and Hackney. For information.	LBH	Transformaiton Board - 10 Nov	Prevention	Simon Galczynski/ Gareth Wall and Jayne Taylor	
Learning Disabilities - New Model	Discuss and endorse	CCG	Transformation Board on 10 Nov	Planned Care	Simon Galczynski/ Siobhan Harper	
Transformation of Outpatients	Approve transformation proposals and business case			Planned Care	Neil Hounselll	
28-Feb-18						
Systems Commissionig Intentions						
Care Workstream Assurance Review Point 4	Approve assurance of transfomation capacity and capability	All	Transformation Board - 9/2/2018 - For disussion and endorsement Governing Body - 30/3/2018 - For assurance	Planned Care / Unplanned Care / Prevention	Devora Wolfson / Clara Rutter / Nina Griffiths / Siobhan Harper / Gareth Wall / Jayne Taylor	
21-Mar-18						
Outcome of Review of Commissioning Governance Arrangements	Agree next steps following review of governance arrangements			All	Devora Wolfson	
Unscheduled Items						