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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 13 December 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	1-4 5-8	
3.	Questions from the Public	Chair	Verbal	-	
4.	Minutes of the Previous Meeting	Chair *For approval* *For noting* *For approval*	4.1 Minutes of Joint ICBs meeting in common, 15 November 2017 4.2 ICB Action Log 4.3 Ratification of Hackney ICB Decisions	9-19 20 21-33	
5.	Children & Young People and Maternity Services Care Workstream – Assurance Review Point 1	Angela Scattergood / Amy Wilkinson *Discuss and*	5. CYPM Assurance Review Point 1 Submission	34-58	10.15

	• Workstream Priorities • Workstream Asks • Strategic Priorities	*approve*			
6.	Discharge to Assess Business Case	Tracey Fletcher *Discuss and approve*	6. D2A Business Case	59-94	10.35
7.	Development Plan for Neighbourhoods Business Case	Tracy Fletcher / Nina Griffith *Discuss and approve*	7. Development Plan for Neighbourhoods Business Case	95-148	10.50
8.	Better Care Fund Monitoring Report	Neal Hounsell / Anne Canning *For noting*	8.1 - City BCF Monitoring Report 8.2 - Hackney BCF Monitoring Report	149-158 159-171	11.10
9.	Outcomes Framework	David Maher / Anna Garner *Approve process and timelines*	9 - Outcomes Framework	172-178	11.20
10.	Update from Transformation Board	David Maher *For noting*	Verbal	-	11.30
11.	Reflections on Meeting	Chair *For discussion*	Verbal	-	11.35
12.	AOB	Chair	Verbal	-	11.45
	Attached for Information - Integrated Commissioning Boards Forward Plan (Paper 13, page 179)				
PART 2 - PRIVATE SESSION					
13.	Integrated Commissioning Evaluation	Anna Garner/ Devora Wolfson *Discuss and approve*	To be shared in confidence	-	11.20

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
David	Maher	13/09/2017	C&H CCG Deputy Chief Officer	World Health Organisation	Member, Expert Group to the Health System Footprint on Sustainable Development	Non-financial professional 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
David	Maher	13/09/2017	C&H CCG Deputy Chief Officer	World Health Organisation	Member, Expert Group to the Health System Footprint on Sustainable Development	Non-financial professional 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

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

Hackney Integrated Commissioning Board

and the

City & Hackney Clinical Commissioning Group and City of London Corporation

City Integrated Commissioning Board

Meeting of 15 November 2017

<u>ATTENDANCE FOR HACKNEY ICB</u>

MEMBERS

Hackney Integrated Commissioning Committee
There were no Members from Hackney present

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
Philippa Lowe – 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

David Maher - Deputy Chief Officer, City & Hackney CCG

Devora Wolfson –Programme Director, Integrated Commissioning

Amy Wilkinson – Workstream Director – Children, Young People and Maternity

Kate Heneghan – Public Heath Strategist (for item 9)

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

APOLOGIES

Members

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

Cllr Rebecca Rennison - London Borough of Hackney

ATTENDANCE FOR CITY ICB

MEMBERS

City Integrated Commissioning Committee

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

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

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

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

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

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

STANDING INVITEES

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

Jake Ferguson – Chief Executive, Hackney Council for Voluntary Services

Jon Williams – Director, Hackney Healthwatch

OFFICERS PRESENT

David Maher - Deputy Chief Officer, City & Hackney CCG

Neal Hounsell - Assistant Director of Commissioning and Partnerships, City of London Corporation

Mark Jarvis – Director of Finance, City of London Corporation

Devora Wolfson –Programme Director, Integrated Commissioning

Amy Wilkinson – Workstream Director – Children, Young People and Maternity

Kate Heneghan – Public Heath Strategist, London Borough of Hackney

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

1. Introductions

1.1.1. Claire Highton welcomed members and attendees to the meeting, noting that it was a joint meeting of the two Integrated Commissioning Boards and it had been agreed between the Chair of the Hackney ICB and the Chair of the city ICB that the Chair of the Hackney ICB would facilitate the joint meeting. Decisions made by the two boards would be done so separately and independently, and this would be reflected both in the minutes and in the recommendations set out in future agenda papers.

1.1.2. There were no elected members from the London Borough of Hackney present, and so the meeting was not quorate. The Hackney ICB agreed to proceed with discussions, but noted that no decisions could be made at this time. Officers would discuss the matter with legal counsel and identify a way forward in respect of items of business to be taken forward.

2. Declarations of Interest

2.1. There were no declarations of interest made in respect of items on the agenda.

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

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

3. Questions from the Public

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

4. Minutes of the previous Meeting

4.1. The CCG Members of the Hackney Integrated Commissioning Board:

- **APPROVED** the minutes of the Hackney ICB meeting on 18 October 2017;
- **NOTED** the minutes of the City ICB meeting on 18 October 2017; and
- **NOTED** progress on actions recorded on the action log

4.2. The City Integrated Commissioning Board:

- **APPROVED** the minutes of the City ICB meeting on 18 October 2017;
- **NOTED** the minutes of the City ICB meeting on 18 October 2017; and
- **NOTED** progress on actions recorded on the action log

5. Options Appraisal for Local Response to North East London Integrated Urgent Care Service (NEL IUC)

5.1. David Maher reported on the development of a new City and Hackney 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.

5.2. The paper set out the requirements of the new model and the options identified, noting their relative advantages and disadvantages in terms of quality and cost. The long term solution should be one that is integrated with existing services providing a similar function (i.e. urgent primary care), enabling providers to work together and minimizing system costs. However, it was recommended that the current GP out of hours contract with CHUHSE 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 cheapest option, the Unplanned Care Board and the Transformation Board had recommended that it was the safest and highest quality solution given the current time-frames and I risks related to a scarce GP work-force. HUHFT would be asked to provide some additional infrastructure support to the existing service to ensure it remained robust.

5.3. It was noted that this option would be subject to the scrutiny of the CCG Contracts Committee, meeting in December 2017. The Contracts Committee would also debate this in the context of the legal advice about the preferred option. The outcomes of this discussion will be fed back to the ICBs in January 2018.

5.4. Dhruv Patel noted that the longer-term plan appeared to be based around a hub in the north of Hackney and that the location of a southern hub was not yet agreed. He stated that it was critical that the location that was identified ise

accessibile to City residents. It was noted that City residents are being consulted on the options for the location of the southern hub.

5.5. It was noted that it was difficult to communicate changes to patients without clarity on the wider NEL IUC. Nevertheless, Claire Highton observed that central to any communications plan would be promoting easier ways of contacting in-hours GP services.

5.6. Honor Rhodes, speaking as the Chair of the CHUHSE Oversight Group, said she was struck by how consistent and professional CHUHSE have been, given the difficulty of the task presented to them.

5.7. The City ICB:

- **ENDORSED** the proposal to commission a standalone face to face service (option 4) as an interim solution once the telephone advice and triage transfers to NEL IUC up until March 2019.
- **ENDORSED** 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.
- **ENDORSED** additional funding required as set out in the report.
- **ENDORSED** the unplanned care workstream's commitment to developing an integrated solution.

5.8. The CCG Members of the Hackney ICB:

- **ENDORSED** 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.
- **ENDORSED** 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.
- **ENDORSED** additional funding required as set out in the report.
- **ENDORSED** the unplanned care programme's commitment to develop an integrated solution.

6. The City of London Plan, Section 256 Supporting Hospital Discharge and the Better Care Fund

6.1. Ellie Ward introduced the report, which set out proposed plans for the use of the remaining s256 funding allocated in 2016/17 for supporting hospital discharge and admission avoidance, and delivering the locality plan. With the creation of the new integrated commissioning governance structures, it was deemed that the plans for the remaining £138,000 of this allocation that is still unspent, should be agreed by the City Integrated Commissioning Board. Similarly, plans for the disposition of the remaining £30,000 from the 2016/17 City of London Better Care Fund will need to be agreed by the City ICB. Plans for both streams of funding are tied into the City Locality Plan and the Joint Health & Wellbeing Strategy, and form part of a much bigger picture of action being taken.

6.2. Honor Rhodes asked what measures are being used with regards loneliness and social isolation. Ellie Ward responded that there is a nationally defined scale that local areas can use, and she agreed to send the details to Honor outside of the meeting.

6.3. Hackney members discussed provision of access to IT for the elderly within Hackney. It was noted that a variety of provisions are in place and that some focused work on IT access is being carried out between December and January. It was suggested that Ellie Ward could contact Lola Akindo, the Programme Director, to discuss this further.

6.4. **ACTION ICB1711-1**: To discuss the work being done on improving IT access for elderly people in Hackney with Lola Akindo, and to share information on loneliness measurements with Honor Rhodes. (Ellie Ward)

6.5. The City Integrated Commissioning Board **APPROVED** the plans for use of the City of London Corporation S256 funding agreements and the remaining money from BCF 2016/17.

7. Co-Production Charter

7.1. Jon Williams presented the updated Co-Production Charter for Health and Social Care in Hackney and the City. This was endorsed by the Transformation Board on 13 October and Hackney ICB on 17 October. City ICB had given a number of

points of feedback, set out in the cover report, which have beenaddressed in the updated version.

7.2. Jake Ferguson asked how the progress and success of co-production will be monitored. Honor Rhodes advised that this would be part of the Integrated Commissioning Evaluation.

7.3. The City Integrated commissioning Board **APPROVED** the Co-Production Charter for Health and Social Care in Hackney and the City.

8. System Performance Management

8.1. Anna Garner presented a draft proposal on how to identify and manage performance and financial risks across the City and Hackney system in a way that is joined up, to ensure grip within the governance of integrated commissioning without processes becoming too onerous.

8.2. The partners will need to agree on a system process, and to test what that might look like, what the pressure points are, and to consider whether there is enough responsiveness and trust to align existing systems and for partners to feel comfortable with this..

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8.5. **ACTION ICB1711-2:** – To bring a paper back to the ICBs in January 2018 with proposals for piloting of new performance management processes. (Anna Garner)

8.6. The City Integrated Commissioning Board **NOTED** the report and the next steps agreed in the meeting.

8.7. The CCG Members of the Hackney Integrated Commissioning Board **NOTED** the report and the next steps agreed in the meeting.

9. Monthly Consolidated Finance Report - Month 6

9.1. Mark Jarvis, Philippa Lowe and Anne Canning presented the report on financial performance for the period from April to September 2017 across CoLC, LBH and the CCG integrated commissioning funds. The forecast variance reported was £5.2m adverse; 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. A full report on Learning Disabilities will be brought to the ICBs in February 2018ry.

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

9.3. The CCG Members of the Hackney Integrated Commissioning Board **NOTED** the report.

10. School-based and Vulnerable Children's Health Services

10.1. Amy Wilkinson reported on the redesign and procurement for the school-based health services and services for vulnerable young people; school nursing and Family Nurse Partnership Services.

10.2. The London Borough of Hackney has statutory responsibility for several elements delivered through School Based Health Services, and have recently been granted permission by Hackney Cabinet Procurement Committee to go out to procurement for the services, which will be available to all pupils at state-maintained schools in Hackney and the City of London. The tender papers will go to advert in November 2017, with the services operating as a partnership and delivering in full from September 2018– one of the first priorities of the Children, Young People and Maternity Integrated Commissioning Workstream.

10.3. Neal Hounsell noted that a good liaison was needed with Islington and Tower Hamlets, since those are the boroughs where most children from the City of London attend school.

10.4. **ACTION ICB1711-3:** To include consideration of how to liaise with neighbouring boroughs where children from the City and Hackney attend school, as part of the process of developing children's health services. (Amy Wilkinson)

10.5. Gary Marlowe noted that the lack of communications between school nurses and GPs is a safeguarding issue, particularly in terms of mental health, as teachers are often the best placed to identify early-stage psychoses in young people. The Boards encouraged the workstream to link with the emerging neighbourhood model to facilitate comms between schools and primary care. Amy Wilkinson replied that raising the profile of this channel of communication is included in the service specification, but it would be useful to facilitate further conversations between primary care and schools. More generally, the contract now has a much stronger focus on school nurses, and it now includes 25 key performance indicators for nurses, compared to just 4 in 2013.

10.6. The City ICB **NOTED** the report.

10.7. The CCG Members of the Hackney ICB **NOTED** the report.

11. Update from Transformation Board

11.1. There were no issues to report from the Transformation Board that had not been covered elsewhere in the agenda.

12. Reflections on Meeting

13. Any Other Business

13.1. Claire Highton noted that this was Paul Haigh's final meeting as Chief Officer of the CCG. The Boards acknowledged the huge amount of work Paul had put into the Integrated Commissioning programme and thanked him for his outstanding vision and leadership.

13.2. It was noted that Jane Milligan will be a voting member of the CCG Integrated Commissioning Committee and therefore of the Hackney ICB and the CIty ICB, and that one of the Governing Body GPs (Haren Patel and Gary Marlowe) would

be considered a voting member of the CCG Committee if a member was unable to attend a meeting.

13.3. Philippa Lowe drew attention to the existing s256 agreements with London Borough of Hackney which will need revamping to continue with the joint transformation programme work over the next year. The ICBs noted the importance of having the funding in place to continue the work underway and noted that the CFOs will enact these by the end of November.

Ratification of Decisions from Inquorate Meetings

13.4. The City of London standing orders state that for a sub-committee to be quorate, three Members have to be in attendance at the meeting to make decisions.

13.5. It was noted that the City of London Integrated Commissioning Board was inquorate on 23 May 2017 and 28 June 2017 so any decisions or endorsements needed to be ratified by the Board with a quorum of members present.

13.6. The City of London Integrated Commissioning Board **RATIFIED** the recommendations and endorsements made at the May and June meetings.

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

Ref No	Action	Assigned to	Assigned from	Assigned date	Due date	Status	Update	Update provided by
CICB 1810 -1	To consider how statutory services are considered within the prioritisation process and how process could be trialed on a couple of workstream projects	Anna Garner	City Integrated Commissioning Board	18/10/2017	30/11/2017	Open	Anna Garner to give a verbal update at December ICB.	Anna Garner
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		
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 1810-3	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	Anna Garner to give a verbal update at December ICB.	Anna Garner
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	TBC	Open	To be scheduled for TB and ICB following further guidance on the timeline for further roll out	
ICB 1711-1	To discuss the work being done on improving IT access for elderly people in Hackney with Lola Akindo, and to share information on loneliness measurements with Honor Rhodes.	Ellie Ward	Joint Integrated Commissioning Boards	15/11/2017	30/11/2017	Closed	Complete. Both actions have been carried out by Adam Johnstone, CoLC Social Isolation lead.	Ellie Ward
ICB 1711-2	To bring a paper back to the ICBs in January 2018 with proposals for piloting of new performance management processes.	Anna Garner	Joint Integrated Commissioning Boards	15/11/2017	31/01/2018	Open	Update on progress against pilots added to the Forward Plan for January 2018.	Anna Garner
ICB 1711-3	To include consideration of how to liaise with neighbouring boroughs where children from the City and Hackney attend school, as part of the process of developing children’s health services.	Amy Wilkinson	Joint Integrated Commissioning Boards	15/11/2017		Open		

Title:	**Ratification of decisions from inquorate November meeting of the Hackney ICB**
Date:	13 December 2017
Lead Officer:	Devora Wolfson, Integrated Commissioning Programme Director
Author:	Matt Hopkinson, Integrated Commissioning Governance Manager
Committee(s):	Hackney Integrated Commissioning Board - 13 December 2017
Public / Non-public	Public

Executive Summary:

The 15 November 2017 meeting of the Hackney Integrated Commissioning Board was inquorate so decisions or endorsements need to be brought back to the Hackney ICB for ratification.

The full minutes are also included in this agenda paper.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **RATIFY** the recommendations and endorsements made at the August meeting.
- To **ENDORSE** the minutes of the Hackney ICB meeting of 15 November 2017

The meeting was held in common with the City Integrated Commissioning Board. In the absence of the Hackney Integrated Commissioning Committee members, the City ICB and the CCG Committee and the officers and observers present discussed the item and there was a consensus that the direction was the right one, though no formal recommendation could be agreed.

The following recommendations were set out in the agenda papers:

Minutes

- To **APPROVE** the minutes of the Hackney ICB meeting on 18 October 2017

Options Appraisal for Local Response to North East London Integrated Urgent Care Service (NEL IUC)

- To **ENDORSE** 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.

- To **ENDORSE** 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.

- To **ENDORSE** additional funding required as set out in the report.
- To **ENDORSE** the unplanned care programme's commitment to develop an integrated solution.

The Hackney ICB is asked to **NOTE** the draft minutes (see below) and to **ENDORSE** the recommendations.

Sign-off:

City & Hackney CCG _____David Maher, Deputy Chief Officer

London Borough of Hackney_____Anne Canning, Group Director, Children, Adults and Community Health

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

Hackney Integrated Commissioning Board

and the

City & Hackney Clinical Commissioning Group and City of London Corporation

City Integrated Commissioning Board

Meeting of 15 November 2017

For Ratification

ATTENDANCE FOR HACKNEY ICB

MEMBERS

Hackney Integrated Commissioning Committee
There were no Members from Hackney present

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
Philippa Lowe – 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

David Maher - Deputy Chief Officer, City & Hackney CCG

Devora Wolfson –Programme Director, Integrated Commissioning

Amy Wilkinson – Workstream Director – Children, Young People and Maternity

Kate Heneghan – Public Heath Strategist (for item 9)

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

APOLOGIES

Members

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

Cllr Rebecca Rennison - London Borough of Hackney

ATTENDANCE FOR CITY ICB

MEMBERS

City Integrated Commissioning Committee

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

For Ratification

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

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

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

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

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

STANDING INVITEES

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

Jake Ferguson – Chief Executive, Hackney Council for Voluntary Services

Jon Williams – Director, Hackney Healthwatch

OFFICERS PRESENT

David Maher - Deputy Chief Officer, City & Hackney CCG

Neal Hounsell - Assistant Director of Commissioning and Partnerships, City of London Corporation

Mark Jarvis – Director of Finance, City of London Corporation

Devora Wolfson –Programme Director, Integrated Commissioning

Amy Wilkinson – Workstream Director – Children, Young People and Maternity

Kate Heneghan – Public Heath Strategist, London Borough of Hackney

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

For Ratification

1. Introductions

1.1.1. Claire Highton welcomed members and attendees to the meeting, noting that it was a joint meeting of the two Integrated Commissioning Boards and it had been agreed between the Chair of the Hackney ICB and the Chair of the city ICB that the Chair of the Hackney ICB would facilitate the joint meeting. Decisions made by the two boards would be done so separately and independently, and this would be reflected both in the minutes and in the recommendations set out in future agenda papers.

1.1.2. There were no elected members from the London Borough of Hackney present, and so the meeting was not quorate. The Hackney ICB agreed to proceed with discussions, but noted that no decisions could be made at this time. Officers would discuss the matter with legal counsel and identify a way forward in respect of items of business to be taken forward.

2. Declarations of Interest

2.1. There were no declarations of interest made in respect of items on the agenda.

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

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

3. Questions from the Public

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

4. Minutes of the previous Meeting

4.1. The CCG Members of the Hackney Integrated Commissioning Board:

- **APPROVED** the minutes of the Hackney ICB meeting on 18 October 2017;
- **NOTED** the minutes of the City ICB meeting on 18 October 2017; and
- **NOTED** progress on actions recorded on the action log

For Ratification

4.2. The City Integrated Commissioning Board:

- **APPROVED** the minutes of the City ICB meeting on 18 October 2017;
- **NOTED** the minutes of the City ICB meeting on 18 October 2017; and
- **NOTED** progress on actions recorded on the action log

5. Options Appraisal for Local Response to North East London Integrated Urgent Care Service (NEL IUC)

5.1. David Maher reported on the development of a new City and Hackney 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.

5.2. The paper set out the requirements of the new model and the options identified, noting their relative advantages and disadvantages in terms of quality and cost. The long term solution should be one that is integrated with existing services providing a similar function (i.e. urgent primary care), enabling providers to work together and minimizing system costs. However, it was recommended that the current GP out of hours contract with CHUHSE 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 cheapest option, the Unplanned Care Board and the Transformation Board had recommended that it was the safest and highest quality solution given the current time-frames and l risks related to a scarce GP work-force. HUHFT would be asked to provide some additional infrastructure support to the existing service to ensure it remained robust.

5.3. It was noted that this option would be subject to the scrutiny of the CCG Contracts Committee, meeting in December 2017. The Contracts Committee would also debate this in the context of the legal advice about the preferred option. The outcomes of this discussion will be fed back to the ICBs in January 2018.

5.4. Dhruv Patel noted that the longer-term plan appeared to be based around a hub in the north of Hackney and that the location of a southern hub was not yet agreed. He stated that it was critical that the location that was identified ise

For Ratification

accessibile to City residents. It was noted that City residents are being consulted on the options for the location of the southern hub.

5.5. It was noted that it was difficult to communicate changes to patients without clarity on the wider NEL IUC. Nevertheless, Claire Highton observed that central to any communications plan would be promoting easier ways of contacting in-hours GP services.

5.6. Honor Rhodes, speaking as the Chair of the CHUHSE Oversight Group, said she was struck by how consistent and professional CHUHSE have been, given the difficulty of the task presented to them.

5.7. The City ICB:

- **ENDORSED** the proposal to commission a standalone face to face service (option 4) as an interim solution once the telephone advice and triage transfers to NEL IUC up until March 2019.
- **ENDORSED** 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.
- **ENDORSED** additional funding required as set out in the report.
- **ENDORSED** the unplanned care workstream's commitment to developing an integrated solution.

5.8. The CCG Members of the Hackney ICB:

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For Ratification

6. The City of London Plan, Section 256 Supporting Hospital Discharge and the Better Care Fund

6.1. Ellie Ward introduced the report, which set out proposed plans for the use of the remaining s256 funding allocated in 2016/17 for supporting hospital discharge and admission avoidance, and delivering the locality plan. With the creation of the new integrated commissioning governance structures, it was deemed that the plans for the remaining £138,000 of this allocation that is still unspent, should be agreed by the City Integrated Commissioning Board. Similarly, plans for the disposition of the remaining £30,000 from the 2016/17 City of London Better Care Fund will need to be agreed by the City ICB. Plans for both streams of funding are tied into the City Locality Plan and the Joint Health & Wellbeing Strategy, and form part of a much bigger picture of action being taken.

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points of feedback, set out in the cover report, which have beenaddressed in the updated version.

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12. Reflections on Meeting

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<u>Ratification of Decisions from Inquorate Meetings</u>

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13.5. It was noted that the City of London Integrated Commissioning Board was inquorate on 23 May 2017 and 28 June 2017 so any decisions or endorsements needed to be ratified by the Board with a quorum of members present.

13.6. The City of London Integrated Commissioning Board **RATIFIED** the recommendations and endorsements made at the May and June meetings.

For Ratification

Title:	Care Work stream Assurance Review Point 1: Children, Young People and Maternity Workstream
Date:	8 December 2017
Lead Officer:	Angela Scattergood
Author:	Amy Wilkinson
Committee(s):	Children, Young People and Maternity Work stream – for information: November 2017 Integrated Commissioning Steering Group – for discussion and challenge 29 November 2017 Transformation Board – for endorsement and recommendation to ICBs: 8 December 2017 Integrated Commissioning Boards – for decision: 13 December 2017
Public / Non-public	Public

Executive Summary:

The care work stream assurance review process was approved by the Transformation Board on 12 May 2017 and subsequently by the ICBs on 23 and 24 May 2017.

It was agreed by the partners that there should be a lighter touch review for Review Point 1, focusing on the following areas:

1. Establishment of robust governance arrangements to support collective delivery
2. Confirmation of work stream priorities
3. How the work streams will be supported by the enabler groups
4. Proposals about moving budgets between work streams
5. OD issues

The purpose of this report is to provide an update on the progress that has been made by the Children, Young People and Maternity Work stream and to ask the TB and ICBs to endorse the direction of travel and the areas set out above.

It is important to note that the care work streams are at different levels of maturity. The CYPM workstream began its work in October 2017 has had a Workstream Director in place since 02 October 2017 and held its first workstream meeting on 13th November 2017.

This paper outlines the development and position of the Children, Young People and Maternity workstream. The submission seeks assurance as part of Care Workstream Assurance Review Point 1.

This care worksteam is the final workstream to seek assurance, and the submission describes the proposed governance, membership, delivery framework, key principles and identification of transformation priorities. This paper also states the proposed way forward in terms of establishing a clear financial position and workstream budget, along with and options for financial arrangements going forward.

City and Hackney
Clinical Commissioning Group

Questions for the Transformation Board

The Transformation Board is asked to review the submission, with particular emphasis on agreeing the governance, transformation priorities and proposed method of progress for consolidating budgets for this work stream.

Issues from Transformation Board for the Integrated Commissioning Boards

To be reported verbally at the meeting.

Recommendations:

The Transformation Board is asked to:

1. **Note** the response from the Children, Young People and Maternity Work stream (CYPM) Assurance Review Point 1; including the governance arrangements for the work stream and progress to date.
2. **Recommend to the ICBs** the proposal for moving budgets and services across work streams (Appendix 2); and establishing a clear financial position for the work stream
3. **Endorse** the priorities being taken forward by the workstream and recommend these to the ICBs

The ICBs are asked to:

1. **Approve** the submission from the Children, Young People and Maternity Workstream (CYPM in relation to Assurance Review Point 1; including the governance arrangements for the work stream, and progress to date.
2. **Approve** the proposal for moving budgets and services across workstreams (Appendix 2); and note that further report setting out the proposal for pooling and aligning CYPM budgets will be brought to ICB in early 2018
3. **Approve** the priorities being taken forward by the workstream, noting that they are broadly aligned to our strategic priorities

Links to Key Priorities:

The report outlines how the CYPM work stream might support delivery of the 'NHS 5 Year Forward View', the 'Hackney: A place for all' strategy, the 'Health and Wellbeing Strategy' and relevant City of London framework, in terms of children and their families.

Specific implications for City and Hackney

The implications for both City and Hackney would be delivery of a transformational integrated health care system for children, young people and their families that takes into account the wider determinants of health. A key part of the work will be to develop a delivery model that is appropriate and effective for the City of London children, young people and their families.

Patient and Public Involvement and Impact:

The public representative on the CYPM work stream has been involved in the development of these proposals. They will be considered by the full range of public representatives, including Young Parents and Children and Young People after approval by the Transformation Board.

Clinical/practitioner input and engagement:

The clinical leads on the CYPM work stream has been involved in the development of these proposals: Rhiannon England, Laura Smith and Balvinder Duggal.

Impact on / Overlap with Existing Services:

The proposed impact on existing services will be the requirement to deliver an integrated and transformational agenda for children, young people and their families.

Main Report

1.0 Governance arrangements

The CYPM Integrated Commissioning Work stream will work as follows:

Integrated Commissioning Boards

Transformation Board

Core Planning Group

CYPM Integrated Commissioning Work stream

Delivery Task and Finish Groups according to priorities. Broadly:

- Improving **emotional health** and wellbeing
- Strengthened health support for **vulnerable groups**
- Improving care in **maternity and early years**

The **Core Planning Group** meets fortnightly, and steer the development of the work stream. The **CYPM Integrated Commissioning Work stream** will meet monthly in the first instance. To date the Core Planning Group has met twice (12.10.17 & 23.10.17), and the Work stream has met once (13.11.17)

Membership of Core Planning Group

Angela Scattergood (Head of Early Years, Early Help and Prevention, LBH HLT): Senior Responsible Officer

Amy Wilkinson (CYPMS Work stream Director: **Chair**)

Theresa Shortland (City of London representative)

Dr. Rhiannon England (Clinical Lead, CCG)

Dr. Laura Smith (Clinical Lead, Head of Clinical Practise, LBH)

Sarah Wright (Director, CYPS LBH)

Pauline Adams (Young Hackney, LBH)

Pauline Frost (Children and Maternity Programme Boards Director, CCG)

Sarah Darcy (Children's Programme Board Manager, CCG)

Jairzina Weir (Maternity Programme Board Manager, CCG)

Olivia Katis (CYPMS IC Work stream Support Officer, CCG)

Mary Lee (Designated Nurse Safeguarding Children & Young People, CCG)

Membership of CYPM Work stream

Angela Scattergood (Head of Early Years, Early Help and Prevention, LBH HLT): Senior Responsible Officer and **Chair**

Amy Wilkinson (CYPMS Work stream Director)

Theresa Shortland (City of London representative)

Dr. Rhiannon England (Clinical Lead, CCG)

Dr. Laura Smith (Clinical Lead, Head of Clinical Practise, LBH)

Sarah Wright (Director, CYPS LBH) **Vice-chair**

Pauline Adams (Young Hackney, LBH)

Nadia Sica (Public Health Manager, CYP)

Pauline Frost (Children and Maternity Programme Boards Director, CCG)

Sarah Darcy (Children's Programme Board Manager, CCG)

Jairzina Weir (Maternity Programme Board Manager, CCG)

Olivia Katis (CYPMS IC Work stream Support Officer, CCG)

Mary Lee (Designated Nurse Safeguarding Children & Young People, CCG)

Greg Condon (CCG Mental Health Programme Manager)

Donna Thomas (Strategic Children's Centre Manager)

Anna Garner (Head of Performance, CCG)

Resident representative: Anne Marie Dawkins

Young Parent representative (being progressed)

VCS x 2 (to be advertised to HCVS and Interlink: being progressed)

Commissioning GP leads: Dr. Balvinder Duggal (Clinical Lead Maternity, CCG)

Provider Representation from:

GP Confederation (Dr. David Keene)

Providers (HUFT: Sarah Webb, Head of Midwifery, ELFT: Sharon Davies)
Head teachers x 2 (HLT to liaise: being progressed)

The work stream will approach Hackney Youth Parliament with a proposal to consult with, and be advised by them quarterly for input as appropriate.

It is also likely some members of the Workstream may move to delivery task and finish groups as the work progresses.

1.2 Workstream Priorities and Delivery

The Children, Young People and Maternity Workstream will work to deliver an integrated system for children, young people and their families across City and Hackney. The overarching aim is to co-ordinate, optimise and transform the delivery, and subsequently the health outcomes of our residents. Our transformation work will sit within the wider framework below. We will be:

- **Identifying and collating contracts across the partners**, and working to consolidate them. This will include proposals for aligning or pooling contracts, with the ultimate aim of reducing duplication and identifying and addressing gaps in provision. This will also include exploring potential areas in which to deliver efficiencies.
- **Re-freshing the governance of children's health** across the system, ensuring it is fit for purpose and increasing efficiency
- **Identifying key priority areas for transformational delivery.** Key priority areas will be areas where joint work across the partners will add value. These are likely to be areas of challenge, where performance needs improvement and where a joint approach would work more effectively
- Having **broad oversight of performance**, including key performance indicators across City and Hackney and working to improve performance as appropriate

Our work will be evidence based (see example at appendix 2) and is informed by analysis of the relevant needs assessments (0-5 Health Needs Assessment (2015), the 5-19 Health Needs Assessment (2016), the Joint Strategic Needs Assessment) and ongoing analysis of live performance data.

The CYPM Work stream has **3 overarching priorities**:

- Improving emotional health and wellbeing
- Strengthening the offer of support for vulnerable groups
- Improving the offer of care in maternity and early years

See high level delivery plan in Appendix 1.

The work stream has agreed ways of working in line with the Mental Health Operating Model as appropriate for children and young people.

Key principles, aims and objectives

The work stream is in the process of agreeing that all aspects of the work delivered through the CYPSM work stream will be underpinned by the following **principles**:

We will:

- Work toward the implementation of clear life-long pathways through the health and social care system for City and Hackney children and young people and their parents / carers
- Work to ensure the profile of children and young people across the system is high, and children and young people's issues continue to be prioritised
- Work with a view to reducing inequalities by, where possible, focussing resource at the earliest stage of life, in line with Marmot principles and recommendations
- Work to implement local solutions to local need, in an evidence based way, and in line with the NHS 5 year forward view, the Hackney 'A place for All' framework, and relevant frameworks for the City of London.
- Infuse all of our work with a 'Think Family' approach

We **aim** to improve and transform the health system, and subsequently the health outcomes for our City and Hackney children, young people and their families through:

- Increasing engagement of children and young people in the strategic planning, design and delivery of their health services, in line with the NHS 5 year forward view
- Working through our explicit and identified key priorities to contribute to reducing school and system exclusions
- Encouraging all work around health to routinely consider the impact on mental health, those with SEND and children
- Ensuring there are clear tripartite processes in place around financial responsibilities, particularly with regard to our most vulnerable children and young people, and work to maximise the impact of our resource and deliver system wide efficiencies.

The delivery of our work will function as follows:

CYPMS Integrated Commissioning Work stream

- Consolidation and streamlining of **finance and budgets**
- Re-working of children's health **governance**
- Identification and delivery of transformation **priorities**
  - Improving **emotional health** and wellbeing
  - Strengthened health support for **vulnerable groups**
  - Improving care in **maternity and early years**
- Broad oversight of **performance and BAU**

Key:

Colour	Meaning
Orange	Transformation Priorities
Green	Processes

1.2.1 Enablers

Engagement Enabler Group

The workstream has met with the enabler group, who have secured one public representative (Anne Marie Dawkins) and are in the process of securing an additional Young Parent representative for the work stream. Workstream leads are currently working with the group on strengthening children and young people's voice and profile within the co-production charter. An early piece of work to re-design and procure / implement a strengthened offer for Looked after Children's Health has been identified as the first co-production pilot.

CPEN (workforce) Enabler Group

The work stream has had early discussions with the workforce CPEN Enabler Group, recently attending the CPEN Board session. Initial thoughts around areas for development include:

- Analytic support around children and families who are beneath the threshold for children's social care services, and explore ways of improving their access to health services
- Support for OD around culture change across community services in working to a neighbourhood model
- Analytic / evaluation support to look at maternity and under 5's re-admissions, including the implementation and impact of the new guidelines

IT Enabler Group

The Workstream Director attended the IT Enabler Group Board, and there is potential for a range of support for improving access to healthcare for children and young people. The workstream would like to work with Hackney Council for Voluntary Service to draft a submission around exploring how vulnerable groups use technology for communication, and potential analogies for health messaging. There have also been early discussions on if, and how this might work for the City of London. We would also like to look at ICT to enable us to follow the journey of the children through the system, which will enable us to focus on key areas of opportunity to strengthen communication and integration, and consider how we might improve the sharing of data across health and other children's services.

1.2.2 Links to other workstreams

Prevention

In addition to the proposed transfer of budget lines below, key areas of interface include:

- Childhood obesity and physical activity, both of which are technically in 'Prevention', although the CYPM work stream has proposed delivery of a maternal and pre-conception obesity pathway.
- Young People's substance misuse and smoking
- Adult and Children's mental health and wellbeing. Children's and maternal emotional wellbeing is a key priority for the CYPM work stream and links closely with wider adult mental health work through the Prevention work stream.
- Exploring how 'Making Every Contact Count' can be maximised for children and young people, particularly through Early Years

Unplanned Care

Discussions with Unplanned Care have highlighted potential areas for joint work around increasing diversion to PUCC for children and Young People, Children's A & E admissions and piloting of elements of community health service delivery through the neighbourhood model. I.e. School based health services.

Planned Care

Early thoughts include cross over on work around improving the Community Health Services (including children's and maternity services) offer to City resident/registered populations (referral routes/pathways appropriate and accessible for CoL population), and links to work on asthma for children and young people, as part of work on Long Term Conditions and reducing adverse childhood events.

1.3 Financial position and transfer of work stream services/budgets

Current Budget position

The separate budgets lines that form the total CYPM budget currently sit across 3 organisations, (4, including Hackney Learning Trust), making the development of a clear position on the final budget for the work stream relatively complex.

Proposals for aligning / pooling are being drafted currently. There is still some clarification, and confirmation needed around the proposals, particularly for the City of London and Hackney Learning Trust.

Generally, it is proposed that:

- All CCG budget lines are pooled – circa £45 million subject to approval of the business case
- Circa £10million of LBH CYP public health budgets are aligned / pooled. Some of these areas are services that also deliver for the City of London
- Some pilot areas of LBH CYPS (incorporating Children's Social Care and Hackney Learning Trust) are pooled in the short term, and this is reviewed with the potential to further pool in 2019/20. This looks like circa. £5 million initially
- By the end of 2019/20 a number of key contracts across Children and Young People's services will be ending, opening up the opportunity to design and commission an integrated 0-19yr. old or 0-25 yr. old service. Planning for this would need to start imminently. This also has the potential to deliver a significant level of 'efficiencies'.
- The workstream is clear and transparent around areas that are not available or appropriate, for alignment or pooling.

The proposal for the pooled and aligned CYPM budgets will be submitted to the Transformation Board and the ICBs in early 2018.

Proposals for transferring budgets

It is proposed that the following budgets transfer to the CYPM Workstream from the Prevention Workstream:

Budget Line	Contract status	Amount per year
The Healthy Child Programme 0-5 year olds	HV part way through 5 year contract. Commissioned 2015/16. FNP out for tender.	6,500,000
Public Health Programmes for 5-19 year olds	School nursing services out for tender. YP community health services commissioned 2016/17 and bedding in.	1,825,892
Oral Health	Service commissioned 2016/17. Bedding in.	250,000
Healthy Schools (City of London)	TBC	TBC

1.4 Virtual teams

There is currently good ‘buy-in’ across the partners for integration and transformation. The virtual team in the widest sense comprises:

- CCG Children and Maternity managers and commissioners
- London Borough of Hackney (LBH) and City of London (CoL) public health services, specifically those working on children and young people’s agendas
- Hackney Learning Trust staff, including Teachers and Early years
- LBH and CoL Children and Young People’s Services (Children’s Social Care and Young Hackney),
- System provider and practitioner staff

The work stream links with the Mental Health Co-ordinating Committee through the CCG Mental Health Programme Manager (Greg Condon), and the Clinical Lead for both Mental Health and The CYPSM work stream (Rhiannon England).

1.5 OD

There are no identified OD issues currently, although areas for strengthening will be identified once the teams begin full implementation and delivery. This will include disseminating and embedding our vision of an integrated system across current service delivery and supporting new ways of working to implement this.

2.0 Alignment of the work stream priorities to our strategic priorities

The stated work stream priorities are broadly aligned to our strategic priorities. Priorities take into account a range of performance data indicators, FYFV commitments, business as usual and partner statutory obligations, as well as opportunities for joint transformation.

3.0 Next Steps

As immediate priorities, the work stream will:

- Clarify any outstanding issues in relation to finances and budgets
- Develop the CYPM management and delivery teams
- Begin delivery of key transformation priority areas.

The workstream is looking to go through Assurance Review points 2 and 3 together, possibly in February / March 2018.

Supporting Papers and Evidence:

Appendix 1: CYPM Work stream Priorities
Appendix 2: CYPM Work stream Asks
Appendix 3: Strategic Framework

APPENDIX 1

CYPM Work stream Priorities
High Level Delivery Plan

The Delivery and Action Plan will be underpinned by a 'Think Family' approach, considering the impact on the system pathway for the whole family throughout, and working from a systemic view point. Indicators and outcomes measures will be agreed subsequently as part of the wider Delivery and Action plan.

We will work to the following assumptions:

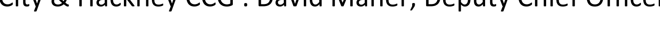
- The need to deliver efficiencies
- The need to deliver on NHS 5 year forward view commitments and system statutory requirements
- The need to work toward delivering an integrated system
- The underlying impetus linking return on investment in early years and early help to reduced inequalities, improved health outcomes and maximised value for money

Transformation Priority	Theme	Deliverables	Timescales	Leads (to be confirmed)
Improve CYP Emotional health and wellbeing across the system	Ensure the development of a clear prevention offer, with an emphasis on wellbeing, and young people getting support where needed	Oversight and support implementation of the CAMHS transformation plans, including schools work	2017/18, 2018/19	Amy Wilkinson, Rhiannon England, Greg Condon, Laura Smith, Sharon Davies, Sophie McElroy, Nicole Klynman
	Review and consolidate service delivery	Re-design of service system	2018/19, 2019/20	Amy Wilkinson, Rhiannon England, Greg Condon, Laura Smith, Theresa Shortland
	Investigate the increase in self- harm presentations	Identify key trends / issues and making recommendations to address	2018/19	Rhiannon England, Laura Smith, Sharon Davies, Nicole Klynman
Strengthen health support for vulnerable groups to reduce health inequalities	Improve the health offer for Looked After Children	Re-design and procure integrated HLAC provision Further integrate LAC pathways with health pathways, particularly for those CYP with complex health needs, mental health	2017/18	Amy Wilkinson, Sarah Darcy, Mary Lee, Nick Corker, Theresa Shortland, Sarah Wright, Nadia Sica

		needs and challenging behaviour needs		
	Oversight of the health elements of the SEND offer and targeted joint work as appropriate	Focussed work on: ▪ ensuring clear and effective pathways particularly around the offer at early years ▪ the offer of support at key transition points Continue to work with partners including the OJ community to support access to provision	2018/19, 2019/20	Angela Scattergood, Toni Dawodu, Andrew Lee, Sarah Darcy, Donna Thomas
	Support work to reduce childhood obesity amongst vulnerable groups	Development of a maternal obesity pathway (linked to priority below)	2017/18, 2018/19	Damani Goldstein, Kate Heneghan, Jairzina Weir, Jayne Taylor
	Support work with children to manage Long Term conditions	Support STP Integrated Asthma provision work Support delivery of Primary Care Vulnerable Children's contract	2018/19	Sarah Darcy, Sarah Webb, Rhiannon England, Lucy Vanes, David Keene Sarah Darcy, Rhiannon England, Donna Thomas, David Keene
	Scope potential for joint work across the CSE, harmful sexual behaviours and CSA agenda	Deliver on STP proposals for development of CSA hub	2018/19	Sarah Wright, Nadia Sica, Mary Lee, Pauline Adams, Laura Smith
	Support integration and development of Young Black Men's programme work	Explore use of technology as a medium for communicating health messages and increasing access to services Explore links to reducing exclusions	2017/18, 2018/19	Pauline Adams, HCVS, Nadia Sica, Angela Scattergood
Improve the offer of **care across Maternity and Early Years**	Explore and propose work to reduce rates of infant mortality: Reduction in rate of stillbirths, neonatal and maternal deaths	Deliver a review of variables to identify if, and where, there may be an issue and opportunity to improve Explore and evaluate data around re-admissions and identify action plan	2017/18, 2018/19	Amy Wilkinson, Jairzina Weir, Head of Midwifery, Pauline Frost, Balvinder Duggal

	Reduce rates of smoking in pregnancy	Embed HUFT maternal smoking pathway and explore UCL pathway Smoking in pregnancy prevention programme	2017/18, 2018/19	Miranda Eeles, Jessica Veltman, Jairzina Weir, Pauline Frost, Balvinder Duggal, Theresa Shortland
	Support work to improve rates of immunisations	Support work to improve rates of antenatal flu and pertussis vaccine Support work to improve rates of immunisations at 1 and 2 years Explore options for a devolved commissioning role	2017/18, 2018/19	Rhiannon England, Pauline Frost, Nicole Klynman, Kate Heneghan
	Support work on choice of maternity care and perinatal mental health	Explore options for development of a 'supporting parents' pathway, linked to substance misuse Look at evaluation linked to the 5YFV work.	2018/19	Pauline Frost, Jairzina Weir, Kate Heneghan, Helen Brock, Sharon Davies

Sign-off:



Workstream SRO : Angela Scattergood London Borough of Hackney : Anne Canning, Group Director, Children, Adults and Community Health.
City of London Corporation : Neal Hounsell, Assistant Director Commissioning & Partnerships
City & Hackney CCG : David Maher, Deputy Chief Officer

Ask of the Children, Young People and Maternity work stream

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

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

This will involve:

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

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

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

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

- Ensure delivery of the Child and Adolescent Mental Health Services Transformation Plans, as agreed by NHS England including delivery of transformation of the full range of service, working toward an more integrated system and delivering improvement models for:
    - strengthening prevention in schools
    - the offer at transition (from young people to adult services)
    - support for parenting
    - ensuring young people get access to support quickly and where it is needed
- Building on the 'strengthening prevention' work as part of the CAMHS Transformation Plans (above), ensure development of a clear prevention offer for children and young people where they are at, including community settings and alternative provision.
- Conduct analysis of increasing presentations of self-harm and suicide in children and young people, leading to the development of an improvement and delivery plan (for delivery in 2018/19)

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

    - Improving the offer and subsequently the health outcomes of City and Hackney Looked After children. We will:

        - Re-design and re-commission the Health of LAC service, continuing with an integrated partnership model
        - Further integrate LAC pathways with health pathways, particularly for those CYP with complex health needs, mental health needs and challenging behavior needs

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

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

    - Ensuring clear and effective pathways for SEND children, and improving these specifically for under 5's
    - Developing and implementing a clear offer of support at key transition points between services
    - Developing a robust mechanism for ensuring our universal Children and Young People's health services are key partners in the development of EHCPs, in line with recent Ofsted / CQC recommendations
    - Responding to the recommendations of the Children's Disability Needs Assessment, improving how we record and share information about local needs, health service activity and compliance with statutory timeframes for Education Health and Care Plans (EHCPs)
    - Quality assessing EHCPs and support plans for children with SEND to determine whether health needs are appropriately identified in plans

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

- Develop work to improve the identification and management of children with long term conditions, including:
  - Localised delivery of the STP integrated asthma provision
  - Delivery of the Primary Care Vulnerable Children's contract (as above), and continued delivery of support in primary care to children and young people with asthma, diabetes, epilepsy and sickle cell
  - Strengthen transition between children and adult's services, and continue to improve the quality of personalized care planning to encourage self-management with less need for emergency care
- Scope the potential for development of a joint pathway across the system to increase preventative support, for those at risk of Child Sexual Exploitation, and provide efficient and effective physical and emotional support and treatment where appropriate for those at risk of and experiencing Harmful Sexual Behaviours and Child Sexual Abuse, in line with the STP. This includes:
  - Working with the NEL STP to deliver an appropriate NEL CSA Hub , incorporating principles behind the 'Child House' model
- Continue to work with the Young Black Men's work programme in order to reduce disparities in health outcomes for this group. This will involve:
  - Exploring the use of technology as a medium for communicating health messages and increasing access to services
  - Working with HCVS to support further work on early years and early intervention
  - Explore the impacts of poor mental health and emotional health and wellbeing and the links to exclusions
- Work across the system in order to improve the offer of care at maternity in City and Hackney, specifically:
  - In line with commitments in our Sustainability and Transformation Partnership (STP), reduce the rate of infant deaths and stillbirths in line with national expectations (20% by 2020). In order to achieve this we will:
    - Manage the HUFT maternity contract to improve performance, and provide assurance that care is safe, effective and responsive

- Continue to work to increase the number of pregnant women making their initial booking 'early'
- Develop a shared local plan in line with 'Better Births' (the 5YF national maternity review) to support personalized, continuous and choice of care, improved postnatal care and perinatal mental health support, and easier access to services
- Review data and recent audit around maternal re-admissions (including guideline introduction on post-natal care), and support implementation of recommendations and a follow up audit / evaluation
- Work closely with the Prevention workstream on reducing rates of smoking in pregnancy, through embedding the HUFT maternal smoking pathway, and looking at developing a UCL maternal smoking pathway for CoL and Hackney residents. We want to further reduce the rate of women who are known smokers at time of delivery.
- Maximise the impact of delivery of the GP Contract elements on pre-conception care, linked to better outcomes in maternity, and to the development of a clear maternal pre-conception and pregnancy healthy weight pathway.
- Improve rates of antenatal flu and pertussis vaccine

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

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

- The current NHS and Social Care metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories for 2017/18. Expectations for delivery by the system will be confirmed shortly

- Deliver national CQUIN measures and targets as appropriate

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

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

- Manage the CYPM care budget and agree remedial action to be implemented on 1 April 2018 to bring the budget back into balance should PbR spend increase during 17/18

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

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

- Agree system action plans to take forward local transformation initiatives:
    - CAMHS Transformation plans, particularly links with schools
    - Re-design and procurement of health services for Looked After Children
    - Improved quality of provision for those with SEND
    - Improvements in the quality of maternity care, in line with STP and FYFV expectations
    - Continued integration of Early Years provision, maximizing positive outcomes for children

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

Objectives for 2018/19:

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

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

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

- Evidence impact of new delivery models implemented in 2017/18 on agreed metrics. This will include:
    - Improved health outcomes for Looked After Children, as a result of bedding in new arrangements
    - Changes in flows of Children and Young people through CAMHs
    - Increases in satisfaction by users of SEND services, and improvements in timeliness and quality of care planning for this group
    - Continuing to improve health outcomes for children with long term conditions (Indicators TBA)
    - Improvements in maternity care (as reported in satisfaction surveys and local and national indicators), reductions in smoking at delivery and reductions in maternal re-admissions
    - Improvements in health outcomes for children in early years, including more integrated health checks delivered, less A&E admissions for under 5's and increased levels of immunisation

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

STRATEGIC FRAMEWORK FOR WORKSTREAMS

The NHS Five Year Forward View said:

"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."

As local partners we endorse this statement with the addition that social care is an integral part of the services needing to integrate around each patient and that we need ever closer working between the NHS and local government to achieve our aims for our communities.

Aims and Objectives

As a system we want to achieve the following and each workstream will need to contribute towards this collective ambition and delivery:

- 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;
- Deliver a shift in focus and resource to prevention and proactive community based care;
- Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value;
- Ensure we deliver parity of esteem between physical and mental health;
- Ensure we have tailored offers to meet the different needs of our diverse communities;
- Promote the integration of health and social care through our local delivery system as a key component of public sector reform;
- Build partnerships between health and social care for the benefit of the population;
- Contribute to growth, in particular through early years services;
- Achieve the ambitions of the NEL STP.

The Framework

Over the course of 2017/18 each workstream will contribute to the establishment of an accountable care system across Hackney and the City by April 2018 which demonstrably achieves and will continue to achieve our system aims and objectives. To do this the partners involved in each workstream (supported by the 'enabler groups') will take collective responsibility for:

- Overseeing contractual performance and proposing changes to contractual arrangements
- Organising service delivery to achieve integration
- Developing and embedding innovative front line practice and delivery
- Implementing transformation initiatives
- Achieving local ambitions and those of NEL STP
- Delivering improvement in population health outcomes
- Delivering NHS Constitution and other standards and metrics
- Maintaining financial balance and delivering savings plans

- Workstreams to work together in a truly integrated way to address shared issues/common outcomes

This will be achieved through work with clinicians, public and other stakeholders to develop and implement robust integrated delivery plans across local providers.

Principles

We will deliver our plans adhering to the following principles:

- **Addressing the wider determinants of health** to address underlying health inequalities, focusing both on direct service commissioning and influencing and advocacy in the wider system
- **Enhanced primary care** – practices working together within each of the 4 quadrants and delivering population and preventative healthcare
- **A fully integrated community health and social care team in each of the four quadrants** building on the success of One Hackney and the City, alongside **quadrant-based voluntary sector organisations** delivering a range of social, wellbeing and public health services via social prescribing and integration with statutory services
- **A physically integrated single point of coordination (SPOC)** for crisis care
- **Empowered patients** equipped with skills and information to help them self-manage, access the right services when needed, make informed decisions on the evidence and options for their care and who are active in the co-design of our service delivery arrangements and pathways
- **Strong safe local hospital care** delivering:
  - High quality 7 day services, integrated with mental health resources and networked with other local hospitals where necessary.
  - Fewer face to face outpatients - replaced by digital solutions.
  - Support and expert advice to primary and community care.
  - Demand management of tertiary service.
  - Reductions in variations between teams.
  - Minimal length of stay, thanks to good primary and community services which command universal clinical confidence.
  - Aligned clinical behaviours across primary community and secondary care, which see the community / home as the default and support the delivery of patient care plans.
  - Preventative interventions.

We will measure the impact of this new way of working on delivering our aims and objectives, both in terms of integration of planning and decision making and the impact on the population. How we do this will form the basis of the external evaluation we are commissioning.

In the meantime we will want to assess how the plans of each workstream are making progress in implementing this service model, their plans to improve health and care for the population and how they are operating within the framework outlined above. This will be built into the gateway process by which we will support the workstreams to take on increasing responsibilities.

November 2017

Title:	**Discharge to Assess Pilot**
Date:	Thursday 30 November
Lead Officer:	Tracey Fletcher, SRO, Unplanned Care Workstream
Author:	Mark Watson, Senior Commissioner & Better Care Fund co-ordinator - London Borough of Hackney
Committee(s):	Unplanned Care Board, 24th November *For decision* Transformation Board, 10th November *For information* Hackney Integrated Commissioning Board, 13th December ***For decision***
Public / Non-public	Public

Executive Summary:

This report seeks approval from the Hackney Integrated Commissioning Board, for the proposed Discharge To Assess Pilot project, run as an extension to the Integrated Independence Team, using BCF funding, for an initial period of 12 months, at a cost of £341,341.

The pilot project has been presented at the Unplanned Care Board and agreed in principle. It has also been presented to the Transformation board for information.

The Discharge To Assess model is one of eight elements of the High Impact Change Model, which all local areas are expected to implement. The model identifies eight system changes that will have the greatest impact on reducing delayed discharges.

Discharge delays are not only distressing for the patients and their families, they can be risky. For older people, staying in a hospital bed for too long can lead to loss of muscle tone and a number of adverse effects.

For the hospital, high numbers of DTOCs have a significant impact on their ability to run smoothly and there is a strong link between DTOCs and patients waiting for extended periods in the A&E department.

A discharge to assess model is where as soon as a patient is medically optimised, they are provided immediate support to be able to go home, and then are assessed in their own homes, providing better more accurate assessments in the environment someone will live.

NHS England and NHS Improvement have stated that delayed transfers of care (DToC) remain a significant barrier to improving patient care on emergency care pathways and performance against the four-hour standard. Over the course of 2017, they have specified that the local systems must have clear plans in place to reduce delayed transfers of care and this includes having a Discharge to Assess service.

The pilot will involve 11 part time staff and 2 co-ordinators which will initially will be managed by the Integrated Independence team (IIT) and provide care support in peoples own home, while they are being assessed for longer term support needs. The pilot will also include 1 post that will help facilitate discharges for patients that may be eligible for Continuing Healthcare and will need an assessment once they are home or in another community placement.

The Better Care Fund targets for non-elective admissions were increased above our 2016/17 actuals. Whilst our current performance is under plan, there is the risk that more people will be admitted to hospital, increasing flow through the hospital and numbers requiring discharge.

In Hackney, our DToC performance in 2017 has been below target against both BCF targets and in relationship to comparators. A plan has been developed by the partnership to deliver and sustain improved performance, both through management actions and transformational change.

This year's DToC performance figures have been more of a challenge in terms of performance, which has led us to be placed in the bottom quartile for rate of DToC (total delayed days per day per 100,000 18+ population).

Due to this performance we have received a joint letter from the Department of Health and the Department of Communities and Local Government, which said that we will be monitored more closely, and that some of the Improved Better Care Fund money provided to the Local Authority might be at risk.

The letter noted that we will be contacted in November to describe what will happen next. It is therefore imperative that Hackney can demonstrate rapid improvement by the end of November in its DToC Performance.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **AGREE** the proposal to implement a discharge to assess (D2A) model of care across Hackney, to run for 12 months
- To **APPROVE** the Business Case for Discharge to Assess
- To **APPROVE** expenditure of £341,314 of the Hackney BCF to implement the model.

Links to Key Priorities:

This work links to Objective 4 of the Joint Health & Wellbeing Strategy:

"Caring for people with dementia, ensuring our services are meeting the needs of the older population."

This also directly contributed to the Unplanned Care workstream 'big ticket item', Integrated Hospital Discharge.

Specific implications for City

There are no direct implications for the City. The City of London Corporation has its own Discharge to Assess Scheme called Reablement Plus, which is provided by an external provider. This scheme covers all City of London residents regardless of hospital. Very few City of London residents are admitted to Homerton University Hospital Foundation Trust (HUHFT) but for those that are, and require Discharge to Assess, then they will need to be redirected back into City of London Corporation pathways.

Specific implications for Hackney

Recent communication jointly from DCLG and DoH stated that they reserve the right to reduce the published iBCF allocation for those areas where DToC performance fails to improve. The grant conditions are linked to the three key areas outlined above, so it is unlikely that they would withdraw all iBCF funds but will tie funding to implement the high impact change model plans.

Patient and Public Involvement and Impact:

The Patient and User Experience Group (PUEG) discussed the discharge to assess business case in September 2017. Dialogue included an overview of local issues with delayed transfers of care and targets set by NHSE. The group expressed their concern at the targets set and expressed the view they were unrealistic. They also expressed concern at the capacity of current services to deliver this change safely. Specifically whether there was sufficient staff capacity to manage the shift in service. Representatives also stated that intermediate care beds needs to be part of the options available to patients as not all people could be cared for at home. There was support for the model; however, the group wanted to ensure consultation continued and service users were part of ongoing work related to discharge.

A patient rep has now joined the monthly hospital discharge group and other elements of the work, will be co-produced with patients and families.

Clinical/practitioner input and engagement:

For the hospital and clinical staff, high numbers of DToCs have a significant impact on their ability to run smoothly and there is a strong link between DToCs and patients waiting for extended periods in the A&E department.

Clinicians are involved and taking the lead in the development of the Discharge to Assess model which will have one of the biggest impacts on the improvement of these figures.

Impact on / Overlap with Existing Services:

The service will impact positively on HUHFT, by reducing delays in discharging patients with ongoing health and social care needs. The performance action plan will not mean service will overlap with existing services but should have a positive impact in the overall health economy. We will be evaluating the roll out of the Discharge to Assess model to see what impact this will have on the wider NHS and Local Authority, acute, GP and community services. The GP Confederation and a number of other partners are being invited to take part in the evaluation process.

Sign-off:

Workstream SRO: Tracey Fletcher, Chief Executive, Homerton University Hospital, NHS Foundation Trust

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

City & Hackney CCG: David Maher, Deputy Chief Officer,

Members of the Finance Economy Group:

- Ian Williams
- Dilani Russell

Main Report

Introduction

This paper asks the ICB to endorse the proposal to implement a discharge to assess (D2A) model of care across Hackney. This pilot has been endorsed by the Unplanned Care Board and the Transformation Board. There is a compelling evidence base for success that this model has had in reducing delayed transfers of care (DToC) and reducing length of stay in hospitals.

Funding for the pilot has been identified from within Better Care Fund (BCF) monies. The service will be delivered through the Integrated Independence Team.

Definitions

Delayed Transfers of Care (DToC)	A delayed transfer of care from acute or non-acute care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when: a) A clinical decision has been made that the patient is ready for transfer AND b) A multi-disciplinary team decision has been made that the patient is ready for transfer AND c) The patient is safe to discharge/transfer
Medically Optimised (Medically Fit for Discharge)	A medically optimised patient is one who has completed acute care and who is now fit for discharge from a medical perspective. All relevant investigations have been completed and none further are anticipated. The patient may, require further therapy or social care input. This should be provided in an alternative setting, e.g. intermediate care bed.
Discharge to Assess (D2A)	"Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'and step down'". (The NHSE Quick Guide)

Background and Current Position

It is essential that everyone across the system recognises that poor patient flow leads to a reduction in high-quality care and that effective and timely discharge is key to this. Poor patient flow (resulting in crowded Emergency Departments) and high bed occupancy, adversely impacts on patient outcomes:

- For patients who are seen and discharged from ED, the longer they have waited to be seen the higher the chance they will die during the following 7 days

- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles for people aged over 80
- Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience
- Lowering levels of bed occupancy is associated with a reduction in hospital mortality and improved performance on the 4-hour target.

It is for these reasons; NHS England and NHS Improvement have stated that delayed transfers of care (DToC) remain a significant barrier to improving patient care on emergency care pathways and performance against the four-hour standard. Over the course of 2017, they have specified that local systems must have clear plans in place to reduce delayed transfers of care. This has been reinforced through a key focus on discharge within the following plans:

- The national CQUIN for proactive discharge
- Winter readiness checklist
- Urgent and Emergency Care National Milestone Tracker
- Better Care Fund (BCF) plans
- The high impact change model (HICM)
- The quality premium for reducing the amount of continuing healthcare (CHC) assessments done in an acute setting to less than 15%
- Placement without prejudice process

The Department of Health and Department for Communities and Local Government have set DToC expectations that will support the NHS to meet its target to limit delays to around 4,000 beds per day. These targets, set as part of the Better Care Fund (BCF) planning process, are in terms of delayed beds per day for each CCG, and Health and Wellbeing Board (HWB). CCGs and HWBs are expected to achieve these targets by November 2017, and maintain this level of performance through winter to March 2018.

In June of 2017, NHSE conducted a Home to Hospital Visit to review the hospital and Local Authority processes of managing DToC. A summary report was provided which acknowledged that the local system has made significant gains in the management of DToC over the past year but highlighted there are too many variations in performance. A key recommendation from this review was the need to implement a local Discharge to Assess (D2A) model. Specifically, the report stated:

- There is a good infrastructure in place, including the (Integrated Discharge Service) IDS and Integrated Independence Team (IIT) to enable rapid progress to be made in implementing Discharge to Assess; however, it did not appear that the system has a shared 'home first culture' which should

underpin all improvement

- It appeared that a number of operational processes affecting discharge may be too linear and sequential, adding to unnecessary delays
- Partners should rapidly implement Discharge-to-Assess process, building up incrementally from small patient cohorts, without waiting for the outcome of investment business cases

More recently, there has been more scrutiny in this area from the Secretary of State for Health and NHSE has written a letter saying the expectation is that D2A must happen, if it is not already running in the local area. The letter written to the Leader of Hackney Council stated:

“Where councils, including yours, have significant performance challenges, there will be additional monitoring and escalation. This means that with effect from now:-

- We will be closely monitoring your DToC progress between now and November.
- We will include your council in the November review of 2018/19 iBCF allocations announced at Spring Budget.

We will be looking for evidence of significant performance improvements in the September data (published in November) before making a final decision on which local authorities will be formally reviewed.”

The CCG will equally be effected as the letter states “CCG’s have been set clear targets for Continuing Healthcare (CHC) assessments, including for 85% to take place out of hospital. CCGs are now being required to report progress against these in their public board meetings. DToC performance is also a key element of the CCG improvement and assessment framework. For CCGs with particularly poor performance, NHS England will consider whether to take action through this framework including placing a CCG in special measures or under statutory directions.”

This highlights the need for significant progress in reducing all DToC, including those due to awaiting a CHC assessment.

In addition to a challenging target for DToC for the CCG and H&WB areas, NHSE have identified provider expectations, and by November 2017, the Homerton University Hospital Foundation Trust (HUHFT) is expected to have reduced their delays per occupied bed to 3.5%. The threshold for medically optimised patients is also set at 3%.

Current DToC Performance

Table 1 shows that current Social Care bed day delays are 468, with a target of 230 – therefore showing 238 over target in October. Official November figures are not published yet but local data suggests November will have similar activity levels to October.

Figures peaked in May 2017. Since August we have seen a month on month reduction, with increased activity within this area and a DToC performance improvement plan starting to have a positive effect.

Table 1: Hackney performance against NHS England's expectations.

Published monthly figures for Hackney	Apr	May	Jun	Jul	Aug	Sep	Oct
Actual total bed delays	**821**	**1,019**	**843**	**837**	**868**	**768**	**619**
Total bed days target				814	654	564	526
Actual NHS bed day delays	**299**	**325**	**318**	219	218	225	124
NHS target				324	314	304	294
Actual Social care bed day delays	**522**	**694**	**514**	594	619	513	468
Social care target				488	338	258	230
Actual Both bed day delays	**0**	**0**	**11**	24	31	30	27
Both target				2	2	2	2
Average DToC All Delays per 100K Pop	12.7	15.3	13.0	12.5	13.0	11.9	9.3
Average DToC SC Delays per 100K Pop	8.1	10.4	8.1	9.3	9.7	8.4	7.4
Target DToC All Delays per 100K Pop	NA	NA	NA	12.2	9.8	8.7	7.9
Target DToC SC Delays per 100K Pop	NA	NA	NA	7.3	5.1	4.0	3.5

Table 1

Learning from implementations elsewhere

The Department of Health (DoH), NHS England (NHSE), and the Association of Directors of Adult Social Services (Adass), support the D2A model, implemented in a number of hospitals including Medway, South Warwickshire, Sheffield, and the Royal London Hospital and Bexley, all of which report strong outcomes. Key learnings are documented and paramount of these is to:

a) Start the process rather than spend too much time on planning and
b) Start small and build up incrementally all the while using feedback mechanisms, for example using PDSA cycles. (Plan, Do, Study Act)

While there is not one recommended model, there are a number of principles, which help with the success of this type of scheme. Providing the local model understands and incorporates these principles, there is no reason to believe that the model should not work for Hackney.

Discharge to assess should look like:

- Assessment within an environment familiar to the patient. The patient's immediate and longer-term needs can be more appropriately evaluated in their own home.
- Assessment of the issues which may have precipitated the acute admission and anticipatory plans put in place while the patient was still able to be at home
- Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient.

Issue & Local Context

As stated, there is not only a requirement, but a moral duty for the local system to, without further delay implement the well evidenced D2A model in order to realise the anticipated benefits of reduction in length of stay (LOS) and DToC, improved patient experience and reductions in use of long term care support. In simple terms, the aim and requirement is to implement an integrated discharge to assess model for Hackney residents so that they are discharged from hospital as soon as they are medically optimised, rather than waiting on the ward for functional and social care assessments to be undertaken.

Homerton University Hospital

As stated above, the HUHFT is expected to reduce their delays per occupied bed to 3.5%. An un-validated weekly report from the North East London CSU the week ending 24 September 2017, shows an average of 10 beds were occupied by patients with DToC. To put this performance in context, the HUHFT is currently reporting on the Capacity Management System (CMS) that there are 248 beds within the Trust to which general and acute patients can be admitted (excluding escalation beds). This suggests that approximately 4% of total general and acute (G&A) beds were occupied by patients with DToC.

Past performance

Annual	Annual Avr	G&A acute beds	Estimated DTOC percentage
2015/16	13	248	5.1%
2016/17	11	248	4.4%

Methodology: The percentage shown is based on the DToC bed totals for the month divided by the number of General and Acute beds reported by the HUHFT. The HUHFT has reported in the annual bed audit, and capacity management system that it has 248 G&A beds. This may differ from some of the analysis on DTOC carried

out by NHSE.

Discharge to assess is only one of eight elements of the High Impact Change model, which all areas are expected to implement. The model identifies eight system changes, which will have the greatest impact on reducing delayed discharge:

- early discharge planning
- systems to monitor patient flow
- multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- ***home first/discharge to assess***
- seven-day services
- trusted assessors
- focus on choice
- enhancing health in care homes

Options

Options	Reasons for not selecting
1. Do nothing	We are not meeting our current DToC numbers and have a large number of people in hospital waiting for assessments that are medically optimised and could be discharged home. Not doing anything will miss an opportunity to reduce the number of DToC's and occupied bed days (which will include a number of excess bed days) The Government will take stock of DToC progress in November and consider reviewing 2018/19 allocations of the social care funding provided in the Spring Budget 2017 for any areas that remain performing poorly (this could result in loss of funding).
2. Develop a standalone project and tender the pilot out to other providers.	Apart from this taking too much time the current ITT project has the skills, contacts and procedures to allow this pilot to be up and running quickly, and supported by all delivery partners.
3. Manage the pilot with no new resources.	The current performance against Metric 4 DToC measures indicate the service are constrained by the current budget and not able to increase capacity from within their current spend.

Options	Reasons for not selecting
4. Focus resources on developing an intermediate care bed base	The Home to Hospital June visit has recommended: • develop a system wide demand and capacity plan which does not depend on significant increases in the bed stock in the borough • agree and implement a home first approach to discharge to assess The role of intermediate care beds is important in supporting earlier discharge and ongoing assessment of need out of hospital. Step up beds also play a key role in preventing admission. This is phase two of a discharge to assess approach and the LBH is considering how IC beds are incorporated into plans to increase the number of care home beds locally. Current discussions are underway regarding potential location and a £2.5m capital investment would be required.

Equalities and other Implications:
A full equality Impact Assessment was carried out in September 2017 against the full Better Care Fund 2017/18 and 2019/20 plan of which this pilot was part of the plans. The assessment did not evidence any negative impact against any of the Equality Act 2010 Characteristics. This will be re-assessed as part of the nine month review of the pilot.

Proposals

Development of a Hackney D2A Model - The Proposal

This paper proposes running a pilot discharge to assess service, by utilising the Quality Improvement (QI) methodology to test a local D2A model in small scale initially, and through PDSA cycles of learning and improvement then scale the model up. Practically this will see the pilot commence on two wards, the Acute Care Unit (ACU) and Elderly Care Unit (ECU).

Evidenced models (e.g. Tower Hamlets, Medway, Bexley and Sheffield) have been successful because they have integrated the D2A model with existing intermediate care, discharge planning and hospital social work services rather than setting up a stand-alone team. Consequently, this proposal seeks to employ two co-ordinators and up to 11 support workers, who will be managed and employed through the

Integrated Independence Team (IIT). The benefit of managing the scheme via IIT is that the governance of the care provided to patients will be the same as for patients currently supported by the service and consequently existing arrangements in terms of interface with community teams (e.g. district nursing, community therapy, voluntary sector, GP's) will happen in the same way. Incorporating the pilot within IIT will further benefit from the peer support of the services' existing co-ordinators and management team who are experienced in both the management of the in-house care support staff and completion of community based assessments.

A key element of the pilot will be to collect data on the average amount of care support deemed appropriate at the point of hospital discharge versus at the end of the D2A process. It is anticipated that systems savings will be quantified via this process, which will provide some of the requisite evidence to support the D2A sustainability question.

We also plan to explore via the project how the Take Home and Settle service provided by Age UK will need to interface differently with D2A than it does with the wards.

Scope of the pilot
The pilot will collect data from Mosaic which will inform how the local system will need to evolve so as to embed the D2A model in Hackney. The current longer-term vision for this approach is that the Integrated Independence Team and the Integrated Discharge Team will require re-modelling to include the D2A approach. Consideration will also be required for how the wider system (e.g. adult therapies, community nursing, voluntary sector) will need to interface with the D2A model. An initial evaluation will be undertaken at month 6 and then at the 9-month stage to plan for the future of the service, which we anticipate will be to mainstream the model by incorporating existing separate services into a singular mainstream service. We anticipate the eventual destination of this function as a joint community-based service incorporating IIT, the Integrated Discharge team, and potentially supporting continuing healthcare (CHC) assessments.

Continuing Healthcare

The CCG commissions the NEL CSU for the day-to-day management of our CHC service, and the Homerton University Hospital Foundation Trust to provide a community nursing team who completes assessments, develops care plans, brokers care and completes subsequent eligibility reviews. The CCG has recently commissioned an independent review of the CHC service. Whilst there is evidence of good practice within the individual teams involved in the CHC pathway, this has been undermined by a lack of 'joined up' working across team interfaces. Leadership support, integrated governance arrangements and communication mechanisms need to be strengthened. The CHC team are behind in the schedule of reviews for CHC patients and additional resources have been put in place to address this. We have a monthly operational improvement group meeting with partners to address the issues raised in the report. Longer-term decisions on better integration of the CHC pathway with Adult Social Care are being considered through the Planned Care

Workstream.

As referenced already, there is a national expectation that CCGs are doing all they can to reduce delays caused by NHS organisations. CCGs have been set clear targets around CHC assessments, including 85% of assessments to take place out of hospital. This is a very challenging target for our local system; our 2017/18 Q1 performance was 51% completed in an acute environment and this has risen to 85% in Q2. There needs to be a clear process to stop assessments from taking place in acute settings and it is logical to tie this into the D2A model rather than LBH and the CCG creating a separate and disjointed arrangement.

The Planned Care Workstream has requested an additional post as part of the D2A service, as extra resource is required to accelerate our performance against the CHC quality premium target as quickly as possible. The extra staff resource will support discharges for more complex patients that where it is indicated that they need to be assessed for continuing healthcare eligibility. The post will link the D2A model, ITT staff and Social Workers to the community CHC team and help to establish the future state of an integrated community team. The CHC Improvement group will review the capacity needed in the community CHC team. Achievement of the Quality Premium will enable additional funding to be put into the system.

There is also an expectation for all systems to develop a placement without prejudice model. This is an agreement between NHS and local authorities (LA) to fund care pending further assessments, which will determine responsibility for ongoing placements or packages of care (POC). This is an agreement about funding only,, and will support the role out of the D2A model. The LA's would put a package of care in place and then a multidisciplinary team (generally, social worker and CHC nurse, although can include therapy staff) would undertake an assessment in the community for any patient that has received a positive checklist for CHC. If a patient is deemed eligible for CHC the CCG will reimburse the LA for the POC from the date of discharge. There will be some patients that cannot be discharged with support from the D2A care support workers only, so additional packages of care may need to be put in place to safely discharge a patient home. More complex patients may not be able to go home at all and discussions are planned with local nursing homes to reach agreement on the process for accepting patients for what may be an interim placement. The HUHFT has already agreed that complex patients that potentially require CHC, can be placed at Mary Seacole pending assessment.

Using the D2A approach, we see that as the pilot roles out, staff will move from assessing people in the hospital environment to assessing in individual homes and other community settings.

The full review will be tasked to consider the level of resource required and how existing resources will need to move from the acute hospital into the community in order to facilitate the D2A approach.

A number of key stakeholders will be involved with the development of the pilot, for example:

- BCF Project leads NHS/LA
- Head of Commissioning
- Principal Head of Adult Social Care
- Strategic Commissioner OP/LTC
- Head of Integrated Discharge
- Head of Integrated Independence team
- LBH Performance & Improvement Manager
- Service user involvement
- HUH medical consultant
- Community nursing
- GP
- GP Federation and Neighbourhood Project Lead
- Relevant voluntary sector organisations, e.g. Age UK
- Head of adult therapies, HUH

Clearly this proposed pilot service will need to understand how it will interface with not only existing statutory and voluntary services but also with emerging models of care such as the neighbourhood model. Given both this pilot and the neighbourhood model are within the scope of the Unplanned Care Work stream, and matrix staff are involved in both steering groups, there will be ongoing opportunities to sense check alignment and synergies of both models are being appropriately considered.

National evidence shows that most D2A models operate on a three-pathway model:

Pathway 1	Patient needs can be met safely at home with support from re-ablement and intermediate care
Pathway 2	Patient needs cannot be met safely at home and require Intermediate Care Bed (ICB) or Interim Residential Care
Pathway 3	Requires Nursing Home

This Pilot will work with the cohort who fall into Pathway 1.

Work is progressing in pathways 2 and 3 through separate Task and Finish groups, which report to the Discharge steering group. The implementation of a permanent local intermediate care bed base for instance will only come to fruition in years not months and consequently does not fit with the timescales of the proposed D2A model.

Discharge to Assess Referral and Discharge Process

Referral sent to IIT Single Point of Access (SPA)

↓

SPA Screener goes to the ward

↓

Discuss immediate needs with MDT and

→

Patient Medically Optimized

→

Care support requirements arranged via coordinators

↓

Discharge Home

↓

D2A review within agreed timeframe but no more than 72 hours. Care support workers trained to escalate any concerns to IIT co-coordinators

Fig 1

Outcomes, benefits and Performance

The proposed model anticipates realising similar benefits that comparable other models nationally have reported:

Outcomes

Outcome	Measured by
1. Improvement on the current DToC performance	Nationally published DToC figures
2. Reduction in hospital length of stay – limited baseline data is available to reflect the current or historical number of days medically optimised patients remain in hospital whilst awaiting care support to commence.	% reduction in the number of bed day delays due to waiting an assessment (baseline 78 per month)
3. Increase the number of weekend discharges – currently, patients who require new or increased packages of care remain in hospital over the weekend. D2A will enable weekend discharges and will report on the number of instances where patients are discharged at the weekend. Bed day reductions will be possible to calculate from this.	Local figures, reported monthly to establish a baseline
4. Patient and Family experience.	Quarterly questionnaire as party of the pilot. Satisfaction will be 85% positive or above.
5. Reduction in long term care support needs – On average, reablement interventions reduce personal care support packages by 3.6 hours per week. This reduction was based upon the audit of 121 reablement interventions.	Local figures reported monthly, to establish a baseline

6. Opportunity to support the CHC CQUIN through scoping out the potential for the D2A model, in partnership with community Social Work and CHC team to undertake DST assessments in the community. Q1 performance was 51% (18 people) assessed within an acute environment. In Q2, performance was 85**%** **(17 people)** assessed in the acute setting as there were only three assessments done in the community.	Local figures now reported monthly due to failing to meet targets.
7. Final evaluation report, A wider evaluation should also take place, which would include: • Service User and Family/Carer feedback • Staff feedback • Feedback from the Hospital • Review of the impact on resources on the hospital assessment team as assessments in hospital reduce • Evaluation against the guiding principles	Final report produced.

Performance Targets

Measure	Performance target
Time from referral to initial screening and acceptance by D2A team	2 hours
Number of days support service involved	42 days: 6 weeks or less
Patient has a personalised care plan	100%
Average number of community care assessments conducted on the ward by the Hospital Social Work Team each month (baseline 35)	90% reduction
Number of people with care and support needs	Monitor weekly, to report monthly
Number of people with reablement needs	There were 484 reablement interventions during 2016/17 of which 396 came via a hospital discharge
Reduction in care and support needs from start to end of service	Based on 121 reablement interventions completed between June and October 2017 the average reduction in personal care was 3.6 hours per week.
Reduction of excess bed days/costs –	Current system measures excess bed days; however, this information is not easily compared to delayed bed days as the two are very different. This information will need to be investigated further to determine how to link the data.
Reduction in the number of people admitted to care homes	During 2016/17 a total of 33 service users were placed in care homes on discharge from hospital.
The number of patients that the service was not able to take on due to lack of capacity and the associated bed day delays	Between the 1st April 2017 and 30th September 2017, a total of 45 clients could not be taken on due to capacity issues. Between the 1st September 2016 and 31st August 2017 a total of 649 bed day delays were recorded under the reason "Further non acute NHS"

Project duration

As stated earlier in the paper, this is a proposal for a 12-month pilot, which should allow time for the staff to develop and the project to reach its maximum benefits. An initial evaluation should be completed alongside two quarters of the performance

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data, which will be presented to the Discharge group, with a full report at 9 months, with proposals for the future of the model presented to the Unplanned Care Group.

Principles

The following principles set out in the Quick Guide should underpin our local D2A model.

Principle	What does this mean?
Essential criteria	• Supporting people to go home should be the default pathway • Free at the point of delivery • To be safe if the person is going home, the assessment should be done promptly to assess what care support is needed. • Support services should be time limited – but with a maximum of up to 6 weeks. Non – selective, including end of life care
User focus	• Put people and their families at the centre of the decision • Understand both the family and the patients point of view • Ensure the person and their family have clear information and their care and what will happen on discharge • Ensure continuity of communication so all members of the team are working to agree care plans • Where the patient may not have the capacity for a decision about discharge placement/assessment, apply the Mental Capacity Act 2005 (MCA) informed by the MCA Code of Practice and relevant case law.
Easy access to services	• Provide simple access to information, advice and services; including support and access to information and self-management. • This will be ideally a one-stop shop always available when needed.

Effective assessment	• Ensure the assessment is rapid, effective and able to mobilise the required services • Assess long term care needs • Take steps to make sure assessments are not duplicated • At the end of the assessment and at transition to long-term support (if required) develop proactive/advance care plans with people and their carers • Ensure people do not have to make decisions about long term residential or nursing home when in crisis.
Easy flow information	• Enable information to move with the person – create a system where once something is known about a person, everyone that needs to know within the system is informed (within Information Governance limits) • Ensure consent is sought from people at the earliest opportunity to facilitate the sharing of information across partners.
Network of care	• Build networks of service that place more emphasis on the person's needs. • Where it exists ensure input from all agencies, carers and families.
Blurred boundaries	• Empower staff with the right skills to offer what is needed and find new ways to manage actual and perceived risk • Develop a competency based/trusted assessor approach, enabling interdisciplinary and cross disciplinary work
Continuous evaluation and feedback	• Use PDSA cycles (Plan, Do, Study, Act) to test new ideas • Build in evaluation and feedback loops to review the whole system.

Volume and Costs

In order to deliver the pilot, we are proposing that we need a pump prime element of funding start to deliver this scheme.

In order to estimate the initial pump prime staff resource needed we have done the following calculations:

Outcome of re-ablement for IIT patients	Average hours of care support reduction from start to end of treatment
All patients discharged by IIT	4
Patients who do not complete treatment (e.g. hospitalisation, self-discharge, deceased)	3
Patients who completed treatment	5
Average weekly number of care support hours required at commencement of IIT treatment	13
DToC Data Hackney and Homerton 2017/18 M1-M6	
6 month total delays in bed days (taken from table A+E)	575
Number of delayed patients over 6 months assuming each delay equates to 7 bed days	82
Calculated number of patients with delays per month (for category A+E)	14
Number of care support hours required per week (including travel, sickness and leave)	192
Total number of care support workers (18 hour contract) required to meet demand	11

Bed Day Delays - Homerton Only	Totals
A- COMPLETION_ASSESSMENT	459
C- FURTHER_NON_ACUTE_NHS	162
DI - RESIDENTIAL_HOME	384
DII - NURSING_HOME	180
E - CARE_PACKAGE_IN_HOME	116
F - COMMUNITY_EQUIP_ADAPT	50
G- PATIENT_FAMILY_CHOICE	259
Grand Total	**1610**

Role	Cost	WTE	Total
Support worker (Part Time 0.5 FTE)	£14,713	11*	£161,843
Co-ordinator	£42,387	2	£84,774
Other (Agency Premium, Recruitment, Travel, etc)			£40,224
Band 7 CHC Post	£54,500	1	£54,500
Total			**£341,341**

The IIT plan to recruit within 12-16 weeks and during the recruitment period would develop operational policy and procedure against the essential principles to ensure good communication with GPs and other relevant health care and voluntary social care services. Agency staff may be utilised to enable a quicker start of the service, and this has been modelled above for the first three months of the pilot.

The funding for this pilot has been identified through the Better Care Fund budgets.

However, as we have stated in this proposal, part of the evaluation of the pilot will be to look at how we may re-model the existing services to identify funding to make the service model sustainable going forward.

Project constraints and risks
The project will be constrained by the following:

Risk	Mitigation
The ability to recruit staff and any unexpected sickness	IIT has not had a material problem with recruitment to date. The service would look to advertise to appeal to HCA's, new graduates, and those allied professions looking to gain experience in the healthcare sector.
The change in culture needed both from a clinical and patient/family perspective	Change of culture would need close management and a more robust plan will be developed. Ward staff and discharge planners would need to have a common message that they convey to patients and families upon admission.

A risk register will be developed for the PID and maintained throughout the pilot.

Major project milestones

Milestones/ Deliverables	Target Date
Project Business Case approved	*September 2017 (Delayed to October 17)*
Project Task & Finish group set up	*October 2017*
Project start-up and initiation	*December 2017*
Phase I completed – Recruitment and setting up	*January 2018*
Phase II completed – Rolling out and developing	*From March 2018*
Phase III completed – Initial evaluation and Future proposals	*June 2018*
Phase IV completed –Final evaluation and future proposals	*September 2018*
Pilot closure	*January 2019*

Cost benefit analysis

NICE Costing Statement (NG27) NICE 2015 states “Improving the coordination of a person’s discharge from hospital is likely to lead to savings and benefits in several areas, although estimating these savings at a local and national level is challenging.”

The NICE (NG27) goes on to say “If hospital care is avoided, either by early discharge or reduced readmissions, there will be system savings. Commissioner savings will come from reduced admission tariff payments and bed days avoided (beyond the length of stay for which the standard tariff applies). The Trust will benefit from reductions in stay within the trim point.”

Savings should be made to the system through decreased LTC costs, reduction in bed days, which will help with hospital capacity and possible closing or repurposing of beds.

Conclusion

Delivering a Discharge to Assess model within Hackney is part of the High Impact Change Model criteria and a “must do” for each local area.

It is seen as critical to helping us reduce the number of bed days and help towards meeting our challenging DToC targets for our population.

This paper proposes a Pilot, using pump prime money from slippage, with a view to presenting a dull report after nine months of the pilot to be clear about where ongoing funding already in the system will be used to fund this on a permanent basis.

Supporting Papers and Evidence:

N/A

Appendix 1

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	
Service	Discharge to Assess
Commissioner Lead	Sharon Ellis
Provider Lead	Mervyn Freeze
Period	12 months
Date of Review	6 and 9 months from start.

1. Population Needs

1.1 National/local context and evidence base

NHS England and NHS Improvement have stated that delayed transfers of care (DToC) remain a significant barrier to improving patient care on emergency care pathways and performance against the four-hour standard. Over the course of 2017, they have specified that local systems must have clear plans in place to reduce delayed transfers of care. This has been reinforced through a key focus on discharge within the following plans:

- The national CQUIN for proactive discharge
- Winter readiness checklist
- Urgent and Emergency Care National Milestone Tracker
- Better Care Fund (BCF) plans
- The high impact change model (HICM)
- The quality premium for reducing the amount of continuing healthcare (CHC) assessments done in an acute setting to less than 15%
- Placement without prejudice process

The Department of Health and Department for Communities and Local Government have set DToC expectations that will support the NHS to meet its target to limit delays to around 4,000 beds per day. These targets, set as part of the Better Care Fund (BCF) planning process, are in terms of delayed beds per day for each CCG, and Health and Wellbeing Board (HWB). CCGs and HWBs are expected to achieve these targets by November 2017, and maintain this level of performance through winter to March 2018.

Local

As stated, there is a requirement for the local system to, without further delay implement the well evidenced D2A model in order to realise the anticipated benefits of reduction in length of stay (LOS) and DToC, improved patient experience and reductions in use of long term care support. In simple terms, the aim and requirement is to implement an integrated discharge to assess model for City & Hackney residents so that they are discharged from hospital as soon as they are medically optimised, rather than waiting on the ward for functional and social care assessments to be undertaken.

Homerton University Hospital

As stated above, the HUHFT is expected to reduce their delays per occupied bed to 3.5%. An un-validated weekly report from the North East London CSU the week ending 24 September 2017, shows an average of 10 beds were occupied by patients with DToC. To put this performance in context, the Homerton is currently reporting on the Capacity Management System (CMS) that there are 248 beds within the Trust to which general and acute patients can be admitted (excluding escalation beds). This suggests that approximately 4% of total general and acute (G&A) beds were occupied by patients with DToC.

Past performance

Annual	Annual Avr	G&A acute beds	Estimated DTOC percentage
2015/16	13	248	5.1%
2016/17	11	248	4.4%

Methodology: The percentage shown is based on the DToC bed totals for the month divided by the

number of General and Acute beds reported by the HUHFT. The HUHFT has reported in the annual bed audit, and capacity management system that it has 248 G&A beds. This may differ from some of the analysis on DTOC carried out by NHSE.
2. Outcomes

2.1 NHS and Adult Social Care Outcomes Framework Domains & Indicators and

NHS Outcomes Domains:

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

Social Care Outcomes Domains:

Domain 1	Enhancing quality of life for people with care and support needs	✓
Domain 2	Delaying and reducing the need for care and support	✓
Domain 3	Ensuring that people have a positive experience of care and support	✓
Domain 4	Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm	

2.2 Local defined outcomes

Outcome	Measured by
8. Improvement on the current DToC performance	Nationally published DToC figures
9. Reduction in hospital length of stay – limited baseline data is available to reflect the current or historical number of days medically optimised patients remain in hospital whilst awaiting care support to commence.	% reduction in the number of bed day delays due to waiting an assessment (baseline 78 per month)
10. Increase the number of weekend discharges – currently, patients who require new or increased packages of care remain in hospital over the weekend. D2A will enable weekend discharges and will report on the number of instances where patients are discharged at the weekend. Bed day reductions will be possible to calculate from this.	Local figures, reported monthly to establish a baseline
11. Patient and Family experience.	Quarterly questionnaire as party of the pilot. Satisfaction will be 85% positive or above.
12. Reduction in long term care support needs – On average, reablement interventions reduce personal care	Local figures reported monthly, to establish a baseline

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support packages by 3.6 hours per week. This reduction was based upon the audit of 121 reablement interventions.	
13. Opportunity to support the CHC CQUIN through scoping out the potential for the D2A model, in partnership with community Social Work and CHC team to undertake DST assessments in the community. Q1 performance was 51% (18 people) assessed within an acute environment. In Q2, performance was 85**% (17 people)** assessed in the acute setting as there were only three assessments done in the community.	Local figures now reported monthly due to failing to meet targets.
14. Final evaluation report, A wider evaluation should also take place, which would include: • Service User and Family/Carer feedback • Staff feedback • Feedback from the Hospital • Review of the impact on resources on the hospital assessment team as assessments in hospital reduce • Evaluation against the guiding principles	Final report produced.

3. Scope

3.1 Aims and objectives of service

To deliver a more timely discharge of patients from hospital when they are clinically optimised but awaiting assessment for future care provision. This will result in better patient experience and increased patient flow within the system.

3.2 Service description/care pathway

Pathway 1	Patient needs can be met safely at home with support from re-ablement and intermediate care
Pathway 2	Patient needs cannot be met safely at home and require Intermediate Care Bed (ICB) or Interim Residential Care
Pathway 3	Requires Nursing Home

This pilot will take patients from Pathway 1.

Development of a Hackney D2A Model - The Proposal

This pilot will utilise the Quality Improvement (QI) methodology to test a local D2A model in small scale initially, and through PDSA cycles of learning and improvement then scale the model up. Practically this will see the pilot commence on two wards, the Acute Care Unit (ACU) and Elderly Care Unit (ECU).

Evidenced models (e.g. Tower Hamlets, Medway, and Sheffield) have been successful because they have integrated the D2A model with existing intermediate care, discharge planning and hospital social work services rather than setting up a stand-alone team.

For the pilot the service will employ two co-ordinators and up to 11 support workers, who will be managed and employed through the Integrated Independence Team (IIT). The benefit of managing the scheme via IIT is that the governance of the care provided to patients will be the same as for patients currently supported by the service and consequently existing arrangements in terms of interface with community teams (e.g. district nursing, community therapy, voluntary sector, GP's) will happen in the same way.

A key element of the pilot will be to collect data on the average amount of care support deemed appropriate at the point of hospital discharge versus at the end of the D2A process. It is anticipated that systems savings will be quantified via this process which will provide some of the requisite evidence to support the D2A sustainability question.

The pilot will collect data which will inform how the local system will need to evolve so as to embed the D2A model in Hackney. The current longer-term vision for this approach is that the Integrated Independence Team and the Integrated Discharge Team will require re-modelling to include the D2A approach. Consideration will also be required for how the wider system (e.g. adult therapies, community nursing, voluntary sector) will need to interface with the D2A model. An initial evaluation will be undertaken at month 6 and then at the 9-month stage to plan for the future of the service, which we anticipate will be to mainstream the model by incorporating existing separate services into a singular mainstream service. We anticipate the eventual destination of this function as a joint community-based service incorporating IIT, the

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Integrated Discharge team, and potentially supporting continuing healthcare (CHC) assessments.

3.3 Population covered

The service will be available to all Hackney patients who are registered with a Hackney CCG GP practice who require support but who are clinically optimised for discharge from an acute setting, pending an assessment for ongoing support.

3.4 Any acceptance and exclusion criteria and thresholds

D2A (1) pathway is available to all patients who require an assessment but who can go straight home with a period of ongoing support and rehabilitation in their own home which will best suit their clinical needs.

3.5 Interdependence with other services/providers

The service will impact on the current IIT, hospital social work and discharge teams and this will form part of the overall review. We anticipate the D2A service will have a low impact on GP services, although this will be closely monitored. We are unclear what impact this may have on the new neighbourhood model, and again this will be evaluated over the lifetime of the pilot.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NHSE Quick Guide: Discharge to Assess (http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf)

Principle	What does this mean?
Essential criteria	• Supporting people to go home should be the default pathway • Free at the point of delivery • To be safe if the person is going home, the assessment should be done promptly to assess what care support is needed. • Support services should be time limited – but with a maximum of up to 6 weeks. Non – selective, including end of life care
User focus	• Put people and their families at the centre of the decision • Understand both the family and the patients point of view • Ensure the person and their family have clear information and their care and what will happen on discharge • Ensure continuity of communication so all members of the team are working to agree care plans • Where the patient may not have the capacity for a decision about discharge placement/assessment, apply the Mental Capacity Act 2005 (MCA) informed by the MCA Code of Practice and relevant case law.
Easy access to services	• Provide simple access to information, advice and services; including support and access to information and self-management. • This will be ideally a one-stop shop always available when needed.
Effective assessment	• Ensure the assessment is rapid, effective and able to mobilise the required services • Assess long term care needs • Take steps to make sure assessments are not duplicated • At the end of the assessment and at transition to long-term support (if required) develop proactive/advance care plans with people and their carers • Ensure people do not have to make decisions about long term residential or nursing home when in crisis.
Easy flow information	• Enable information to move with the person – create a system where once something is known about a person, everyone that needs to know within the system is informed (within Information Governance limits) • Ensure consent is sought from people at the earliest opportunity to facilitate the sharing of

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	information across partners.
Network of care	• Build networks of service that place more emphasis on the person's needs. • Where it exists ensure input from all agencies, carers and families.
Blurred boundaries	• Empower staff with the right skills to offer what is needed and find new ways to manage actual and perceived risk • Develop a competency based/trusted assessor approach, enabling interdisciplinary and cross disciplinary work
Continuous evaluation and feedback	• Use PDSA cycles (Plan, Do, Study, Act) to test new ideas • Build in evaluation and feedback loops to review the whole system.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Discharging older patients from hospital, National Audit Office, May 2016
- NHS England's Quick Guide: Discharge to Assess and benefits for older, vulnerable people.
- The Care Act, Care and Support Statutory Guidance which can be found at https://www.gov.uk/government/publications/careact-2014-statutory-guidance-for-implementation.

4.3 Applicable local standards

- London Living Wage
- London Multi-Agency Adult Safeguarding Policy and Procedures
- London Safeguarding Children Board Policy and Procedures

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

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The Provider's Premises are located at: Homerton University Hospital
7. Individual Service User Placement

Appendix 1

Performance Targets

Measure	Performance target
Time from referral to initial screening and acceptance by D2A team	2 hours
Number of days support service involved	14 days: 2 weeks or less on average
Patient has a personalised care plan	100%
Average number of community care assessments conducted on the ward by the Hospital Social Work Team each month (baseline 35)	90% reduction
Number of people with care and support needs	Monitor weekly, to report monthly
Number of people with reablement needs	There were 484 reablement interventions during 2016/17 of which 396 came via a hospital discharge
Reduction in care and support needs from start to end of service	Based on 121 reablement interventions completed between June and October 2017 the average reduction in personal care was 3.6 hours per week.
Reduction of excess bed days/costs –	Current system measures excess bed days; however, this information is not easily compared to delayed bed days as the two are very different. This information will need to be investigated further to determine how to link the data.

Measure	Performance target
Reduction in the number of people admitted to care homes	During 2016/17 a total of 33 service users were placed in care homes on discharge from hospital.
The number of patients that the service was not able to take on due to lack of capacity and the associated bed day delays	Between the 1st April 2017 and 30th September 2017, a total of 45 clients could not be taken on due to capacity issues. Between the 1st September 2016 and 31st August 2017 a total of 649 bed day delays were recorded under the reason " Further non acute NHS"

Title:	**Neighbourhood Development Business Case**
Date:	13 December 2017
Lead Officer:	Tracey Fletcher (SRO – Unplanned Care Work stream)
Author:	Jennifer Walker (Neighbourhood Development Lead) and Neighbourhood Development Steering Group
Committee(s):	Unplanned Care Programme Board – for decision (24/11/17) Neighbourhood Steering Group – for decision (29/11/17) Transformation Board – for endorsement of the business case and recommendation to the ICBs (8/12/2017) Integrated Commissioning Board – for approval of the business case and release of the funds (13/12/2017)
Public / Non-public	Public

Executive Summary:

A Transformation Board Workshop was held on 10 November to discuss the development of a Neighbourhood Model. The workshop endorsed the Neighbourhood Model as the method for delivering locally integrated care for the whole Hackney & City population. The NHS Five Year Forward View sets out a clear direction for the NHS to develop new models of care that will provide more integrated services. To make this happen, barriers between hospital, community and primary care will need to be removed so the focus is on patients and systems of care rather than individual organisations. The neighbourhood model is the vehicle for achieving this within Hackney and City.

The development of a neighbourhood model is a whole system transformation programme and has significant implications for the way out of hospital care is provided/organised. The neighbourhood model will also be a delivery mechanism for services and transformational change across all work streams not just in unplanned care. The expected improvements to outcomes and benefits from this new way of working will apply to the whole system not just the urgent and emergency care patient flow.

The presentation to the workshop in November outlined the need for a business case to be bought back to the December Transformation Board to support the detailed planning and design phase for the City and Hackney Neighbourhood programme. This is now attached.

The attached business case has been agreed by the Neighbourhood Steering Group and Unplanned Care Programme Board and sets out initial planning and design and delivery costs. It is expected that a further business case will be submitted to the ICBs in 2018 once a more detailed specification for specific aspects of the neighbourhood model once the detailed planning and design phase has been completed.

The business case summarises:

- The Neighbourhood Model
- The evidence base for the model
- The national and local strategic context
- Expected benefits from the implementation of a neighbourhood model
- The evidence base for investing in resources for the design and planning phase
- The detail and rationale for all requested funds
- An assessment of the risks of not approving the requested funds

The paper clearly sets out how (when implemented) the neighbourhood model will impact on the Better Care Fund metrics. The case is clear though that in order to implement the model successfully a detailed planning and design phase working with all providers and patients must be completed first.

It is important to note that the both the Neighbourhood Steering Group and the Unplanned Care Board have attempted to minimise costs to the system and expenditure being mindful of the current financial climate by adhering to the following principles:

The case has been developed focusing on the following core principles:

- Focusing on how we can work differently and more effectively with the resources we have within Neighbourhoods rather than investing heavily in additional teams/posts
- Investing appropriately in planning and design to create a model of care through neighbourhood working that has longevity and sustainability
    - Investing in clinical and practitioner expertise to help design and plan the new ways of working
    - Investing in limited project management infrastructure to drive the programme forward
- To use existing resources and skills wherever possible in the design, planning and delivery of this work to reflect the known talents and experience within Hackney & City and limit use of expensive short term posts
- A recognition of the importance of placing strong, integrated data at the heart of what we do in neighbourhoods and investing appropriately in the data development process
- A recognition of the value of true coproduction and resourcing and supporting this appropriately
- The programme will be flexible and adaptive and will reflect on learning throughout the design and planning phase and adjust the model accordingly
- The programme will rigorously adopt a QI approach to the delivery of change

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across the neighbourhoods

DECISION - MAKING PROCESS - DEVELOPMENT OF NEIGHBOURHOODS

The decision-making process for the neighbourhoods proposal is complex and the following decision-making framework should be used.

Transformation Board

The TB will be asked to consider the following questions in relation to the proposal before deciding whether to recommend the model to ICB:

- Is there a clear system benefit from the proposed neighbourhood model?
- Is it clear what outcomes neighbourhoods will deliver?
- Has the plan been developed using the principles in The Coproduction Charter and will these be adhered to as the proposal is developed?
- Is the benefit for the City of London sufficiently articulated and does the proposal address how the segments in the CH population will be served?
- Does the proposal offer VFM?
- Does the proposal have clinical and patient consensus across the system
- Is the delivery and implementation plan robust and is the TB comfortable with the proposed milestones?
- Does the plan outline how the providers will come together to deliver an integrated offer?

The TB will be invited to recommend the endorsement of the proposal to the ICBs

ICB decision

The ICB will note the recommendation of the TB and its assurance of the plan against the above (and any other criteria)

The funding is from the Hackney BCF and the City BCF which is delegated under the s75 agreement to the Hackney ICB and City ICB respectively to agree.

The ICBs are asked to endorse the proposed service model and implementation plan.

The questions for the ICBs are:

- Are the ICBs content to spend unallocated BCF money on the proposal as outlined and is it content that the proposal will support the delivery of the BCF metrics?
- Does the proposal represent VFM?
- Is the City ICB comfortable that the interests of the City will be met through the proposal?

The ICB may therefore want to agree to the proposal in principle, subject to any

caveats and further assurance following the TB input, and ask for a specification to be brought to the next ICB which:

- Outlines who the unplanned care board will commission to deliver the various elements of the service and how they will hold the providers to account
- Assures the ICB that the way the different elements are commissioned will deliver the objectives and ensure the integration of service delivery by the providers
- Shows the trajectory for the proposed outcome improvements
- Can separately articulate the milestones and measures relating to the City

For any elements where the unplanned care board is proposing to contract with the GP Confederation, the ICB may seek independent assurance from the CCG Contracts Committee

The **Hackney ICB** is asked to agree expenditure of £818,314 unallocated component of the Hackney BCF to implement the model.

The **City ICB** is asked to agree expenditure of £40,081 unallocated component of the City BCF to implement the model.

The ICBs are both asked to endorse the proposed service model and implementation plan and additionally the City ICB is asked to confirm it is comfortable that the model will meet the interests of the City.

The ICBs are asked to consider whether the proposal offers value for money (p.11-13) and will support the delivery of BCF metrics (p.10-11)

Issues from the Transformation Board for the Integrated Commissioning Board to consider:

Verbal update to be provided

Recommendations:

The Hackney ICB is asked to:

- **ENDORSE** the proposed Neighbourhoods service model and implementation plan;
- **APPROVE** the Business Case for initial planning and design and delivery costs; and
- **APPROVE** expenditure of £818,314 unallocated component of the Hackney BCF to implement the model.

The City ICB is asked to:

- **ENDORSE** the proposed Neighbourhoods service model and implementation plan, and to confirm it is comfortable that the model will meet the interests of the City.
- **APPROVE** the Business Case for initial planning and design and delivery costs; and
- **APPROVE** expenditure of £40,081 unallocated component of the City BCF to implement the model.

Links to Key Priorities:

This proposal links to the following local strategies:

- Hackney and City Health and Wellbeing Strategy
    - The Hackney Health and Wellbeing Strategy states a clear commitment to a shared vision for integrated care and support in Hackney. The neighbourhood model provides a clear structure for delivering a local integrated care model involving all providers and recognising the crucial role that the voluntary sector have to play in this model.
- Hackney and City Devolution Plans
    - The Hackney and City Devolution plans commit to the following: "We want our acute services to fully integrated with community, social care, primary care and tertiary services" and talks about "coordinating community based services around GP practices". At the heart of the neighbourhood model are clusters of GP practices who in the first phase of the programme will work together on understanding how these clusters of practices will work more closely together to deliver better outcomes for their local population. Each neighbourhood will have integrated community, social care, primary care and tertiary teams. This integration will be informed by a robust co-production process.

- North East London Sustainability and Transformation Plan
    - The NEL STP talks about the need "to develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care". Following extensive research of national and more local models and particularly drawing on the learning from the One Hackney and City programme, teams have developed the Neighbourhood model to deliver better outcomes for the whole population. Neighbourhoods offer a robust model to strengthen the existing prevention agenda at a local level working closely with the Prevention work stream.

The development of a neighbourhood model for City and Hackney is also expected to positively contribute to the achievement of the Better Care Fund Metrics. This is set out below:

Metric 1: Reduction of non-elective admissions

The Neighbourhood model will deliver an evidenced based, standardised and sustainable model to support high cost patients/high risk patients where admissions are deemed to be avoidable through improved coordination of care and support.

The Neighbourhood model will review tools for case finding and risk stratification of patients at risk of admission and ensure that there is an MDT approach to planning care for these patients.

Prevention and self-care will be a priority for neighbourhoods and the neighbourhood model will support the aims and work of the Prevention work stream.

Metric 2: Admissions to residential and care homes

The delivery of improved case finding, care planning and coordination/support for high risk/complex individuals will help connect services and identify needs which will enable individuals to remain safely in their own homes for as long as appropriate

Earlier identification of at risk individuals will allow appropriate and timely interventions to help patients/carers and families to remain independent in their own homes

Strong partnership working with the voluntary sector will help with the holistic needs of patients/carers and families. The intention being to reduce isolation, minimise the risk of carer breakdown and connect individuals to appropriate third sector support to help maintain independence and well-being

City and Hackney
Clinical Commissioning Group

Metric 3: Effectiveness of reablement

The creation of a neighbourhood model will improve communication between the teams delivering reablement and primary care. At risk patients will be clearly identified and discussed in either a neighbourhood or practice MDT. This will ensure that there is a strong MDT support for patients undergoing reablement.

Strengthened links to voluntary sector services will help reduce isolation, support carers and improve wellbeing. The model will also help provide quantifiable evidence of gaps in provision which if addressed could help maintain independence at home

Metric 4: Delayed Transfers of Care

It is anticipated that the neighbourhood model will actively contribute to a reduction in delayed transfers of care in two main ways:

Firstly through improved case finding and identification of complex/at risk patients and proactive MDT support and care planning. Thus reducing the risk of them being admitted and if admitted it is more likely that they already have appropriate home based support for discharge.

Secondly through the development of a high risk/complex receiving team/model for complex discharges which will help improve the interface between the acute team and primary care/community services for highly complex and risky discharges.

Specific implications for City

Early discussions have already been held with representatives from the City to discuss the implications for residents of the new Neighbourhood way of working.

The planning and design phase will develop a detailed working model/specification for how the City will interact with its Neighbourhood and develop bespoke pathways/integration models where appropriate.

Specific implications for Hackney

The London Borough of Hackney are committed to the model and recognise that it is likely to mean a change to existing model of care for social work. The London Borough of Hackney also recognises that this model offers an opportunity to strengthen safeguarding reporting and also to respond to recommendations across safeguarding reports which calls for better integration and communication across different providers.

LBH recognise that given the implications for their social care teams/model that there needs to be sufficient planning and design resources. This is reflected in the business case submitted.

Particular attention needs to be paid to the relationship between neighbourhoods and the strong Children's Service model. Close working will also be required with the Public Health team. Early work has begun in both these areas although more work is required.

Patient and Public Involvement and Impact:

There are three patient representatives for the Neighbourhood development programme. They will form an initial patient panel who will work alongside the Core Project Team and reporting into the Steering Group focusing on design and planning co-production phase and the ongoing co-production model once neighbourhoods have gone live. A meeting has been held with each representative to talk about the model and how they might be involved with the work. The patient representatives will agree amongst themselves who will sit on the steering group and a partner will be nominated to attend steering group meetings with them.

It is expected that the patient panel will meet monthly during the design and planning phase. A check will be kept on how the work of the panel interfaces with the broader co-production work stream to ensure there is no overlap/duplication.

The business case has been shared with Health Watch Hackney, the patient engagement officer and the patient representative on the Unplanned Care Board. Feedback from the above has been incorporated into the report submitted.

The report is unlikely to impact on public and patient perceptions of service providers at this stage. The report sets out an early proposal to invest in resources across providers to help plan and design services at a neighbourhood level to better meet the needs of the local population.

Clinical/practitioner input and engagement:

City and Hackney
Clinical Commissioning Group

There has been extensive discussion with clinicians and practitioners to date to develop the high level neighbourhood model. There are clinicians/practitioners from the main providers represented at both the Neighbourhood Steering Group and Unplanned Care Board. In the early design and engagement phase of this work clinicians and practitioners have had input and been engaged through the existing quadrant development MDT meetings, GP Confederation Meetings, local provider discussions and a focused neighbourhood workshop in July.

Given the significant implications for social care – it is important to note that there has been strong early engagement and preliminary discussions about the changes required to support a neighbourhood model from both Hackney and the City social work teams/practitioners.

The report proposes to further strengthen this clinical input and engagement by appointing a lead clinician/practitioner for the overall neighbourhood model.

Impact on / Overlap with Existing Services:

The report requests a draw-down of resources to develop a detailed operational model for the integration of services at a local (neighbourhood) level within City and Hackney. As the service specification is developed, it is expected to have a considerable positive impact on the way that all providers work together and improve communication across teams, reducing duplication and delays.

Main Report

See Business Case, below.

Supporting Papers and Evidence:

The following papers have been submitted as appendices:

- Appendix 1 – Detailed Cost Breakdown of requested funds

Sign-off:

Work stream SRO – Tracey Fletcher (CEO – Homerton University Hospital NHS Foundation Trust)

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

City & Hackney CCG - David Maher, Deputy Chief Officer

City of London Corporation - Neal Hounsell, Assistant Director Commissioning & Partnerships

Unplanned Care Programme Board

Proposal for Programme Design and Planning Costs

Hackney and City Neighbourhood Model

1. Introduction

A Transformation Board Workshop was held on 10 November to discuss the development of a Neighbourhood Model. The workshop endorsed the Neighbourhood Model as the method for delivering locally integrated care for the whole Hackney & City population.

The workshop endorsed:

- The development of a neighbourhood model for Hackney and City
- A suggested neighbourhood configuration of eight areas serving populations of between 30,000 – 50,000
- A phased introduction of the neighbourhood model:
    - Phase 1 – Primary Care Development
    - Phase 2 – Neighbourhood Governance
    - Phase 3 – Service integration model and agreement of neighbourhood improvement projects/priorities
    - Phase 4 (New) – Neighbourhood Go Live – based on assessment of readiness
- Continuation of ongoing governance arrangements
    - Neighbourhood development work hosted by Unplanned Care Programme Board (UPCB)
    - Expansion of Steering Group membership

The workshop acknowledged that the neighbourhood model was both ambitious and had significant potential to deliver benefits for the whole population of Hackney and City. The workshop noted that it was a significant system transformation programme which would require additional resources to support the detailed planning and design phase. This must however be set against the backdrop of a challenging financial environment and as such additional resources must be proportionate and represent value for money.

This paper sets out an initial request for funding to support the detailed design, planning and early implementation phases of the neighbourhood development programme. All attempts have been made to utilise existing resources and ensure that programme costs are proportionate and realistic. This funding relates to the financial year 2017/2018 and requests that expenditure of £818,314 unallocated component of the Hackney BCF to implement the model and £40,081 unallocated component of the City BCF to implement the model.

While there is likely to be a further business case we do not expect this to be a request for a significant sum of recurrent funds as the intention is to use the requested funds to redesign existing services.

The case has been developed focusing on the following core principles:

- This is a provider developed and driven model

  - The aim and focus is on collaboration and partnership working between providers to develop the best possible model of care for local people
  - Working in partnership with local people to produce the model
- Focusing on how we can work differently and more effectively with the resources we have within Neighbourhoods rather than investing heavily in additional teams/posts
- Investing appropriately in planning and design to create a model of care through neighbourhood working that has longevity and sustainability
  - Investing in clinical and practitioner expertise to help design and plan the new ways of working
  - Investing in limited project management infrastructure to drive the programme forward
- To use existing resources and skills wherever possible in the design, planning and delivery of this work to reflect the known talents and experience within Hackney & City and limit use of expensive short term posts
- A recognition of the importance of placing strong, integrated data at the heart of what we do in neighbourhoods and investing appropriately in the data development process
- A recognition of the value of true coproduction and resourcing and supporting this appropriately

2. Background

2i. What do we mean by a neighbourhood model?

We anticipate that neighbourhoods will be a community where health and social care services are designed to best meet the needs of registered populations of between 30,000 and 50,000.

This equates to eight neighbourhood areas in Hackney and City. The configuration of these neighbourhood areas is included in Appendix 1.

The development of neighbourhoods will start with the clusters of GP surgeries in each neighbourhood working closely together. There will be a series of expected outcomes from this primary care development phase including:

- Detailed mapping of GP services across primary care clusters
- Development of a primary care leadership model for the primary care clusters
- Review of neighbourhood data and development of an understanding of priority areas for improvement
- Established meeting and governance structure
- Clarity of resource requirement

In parallel, the programme team will work up the governance model and structure of neighbourhoods. This will include:

- Development of a multi-disciplinary management team model
- Creation of a Memorandum of Understanding for neighbourhood working
- Agreement of managerial/administration resources required to support the neighbourhood model
- Development of QI support model
- Agreement on how the model will be evaluated and academic support
- Specification for additional Organisational Development support and Training need

The model will then focus on development of integrated health and social care teams focused on providing the appropriate intervention based on level of need. This will include work with the voluntary sector.

The development of a neighbourhood model will be underpinned by a strong co-production model.

2ii. What are the principles of neighbourhood working?

The following have been agreed as some of the core principles of the developing Hackney and City neighbourhood model. These will be expanded and further developed during the planning and design phase.

Neighbourhoods will:

- Deliver a total population health management model
- Develop and deliver appropriate interventions based on need
- Have robust governance
- Deliver effective collaboration within and between organisations
- Provide person centred care
- Commit to organisational development
- Demonstrate a consistent application of QI methodology
- Focus on the broader determinants of health – not just healthcare
- Have an ability to respond to local needs
- Use an integrated dataset to inform decisions
- Create a platform for excellent patient engagement
- Embed co-production at all stages of their development

3. Who was involved in producing the model?

The original concept for neighbourhoods was first endorsed in a senior leader's workshop at the end of 2016. There was broad agreement to the idea that integrating teams around clusters of GP practices should improve the way care is delivered and outcomes for patients. There was no specific agreement at this point to the size of the clusters. Through the subsequent engagement and early design work, further details about the size of neighbourhoods and core principles have been developed.

3i. Provider Engagement

There has been a significant engagement process with all providers across Health, Social Care and the Voluntary Sector. This has been an important exercise which has resulted in a provider led, driven and designed high level neighbourhood model.

There is still a further phase of detailed design work to create the operational model within neighbourhoods and confirm the details of the neighbourhood governance structure which is

outlined in this business case. This detailed phase will also focus on the way in which provider teams work within neighbourhoods and how we integrate the work of these teams with the patient at the centre.

The commitment and engagement of providers has been assured via the Neighbourhood Steering Group, Unplanned Care Board and Transformation Board.

3ii. Clinical/Practitioner Engagement

There has been considerable clinical/practitioner engagement into the design of the model to date. Using a number of different forums and meetings, the following clinical/practitioner groups have been involved:

- GPs
  - Via 3 rounds of quadrant MDT meetings and GP Confederation Meetings
  - Plus individual practice meetings
  - Contribution from Lead GPs
- Community Nursing
  - Through senior management team at the Homerton
  - Feedback through quadrant meetings from Community Matrons in particular
  - Meeting with Director of Nursing
- Secondary Care
  - Significant input, feedback and support into the design from Associate Medical Director/Consultant Geriatrician
  - Meeting with Medical Director
- Mental Health
  - Clinical Director for ELFT involved via UPCB
  - Meeting with CCG Clinical Lead
  - Meeting with Psychological Therapy Alliance Board
- Social Work
  - Senior social worker feedback via individual meetings
  - Further engagement and input through quadrant meetings
  - City specific meeting with social work team
- Allied Health Professionals
  - Engagement and input via quadrant MDT meetings
- Drug and Alcohol services
  - Feedback via quadrant meetings
- End of Life
  - Specific meeting with St Joseph Hospice regarding implications of neighbourhood model for their services
- Dementia Care
  - Engagement and input via quadrant MDT meetings
- Community Pharmacy
  - Some engagement and input via quadrant MDT meetings
  - Planned follow up meeting with team

This list is not exhaustive and other work has been undertaken with teams. The list is intended to give an overview of the scale of clinical and practitioner involvement to date.

3iii. Patient involvement

Meetings have been held with three patients who are interested in working on the Neighbourhood Model and these patients will form the Neighbourhood Patient Panel reporting into both the Neighbourhood Steering Group and the Strategic Enabler Group. Further recruitment will take place to try and identify a City resident to join this panel and also to see whether there are any further interested patients.

The patient panel will nominate a lead to attend the Steering Group. There will be a dedicated coproduction/patient feedback agenda item on the steering group. The neighbourhood development programme will also adhere to the Coproduction Charter recently published.

Additionally further involvement in the early design and thinking on the neighbourhood model has taken place with:

- The current patient representative on the UPCB
- Presentation to the Patient and User Experience Group
- Early presentation and discussion with Older Peoples Reference Group
- CCG workshops on devolution where early discussions on a local integrated care model were discussed

3iii. Learning from One Hackney and City Providers and Patients

During and at the end of One Hackney and City, review were undertaken of the model with patients and staff. In the patient review a number of detailed patient interviews were carried out with patients who had received support from the One Hackney and City model. The outcomes of these interviews and the learning from One Hackney & City have been built into the design of the Neighbourhood model.

The reflections from staff have also been included in the development of this model and a high level summary of the themes and learning are included in Section 9ii.

4. National and Local Evidence

An extensive evidence review has been completed looking at interventions which deliver a reduction in admissions and effective integrated working. This coupled with recent research on national models of care which have delivered quantifiable benefits by re-organising care within defined geographical areas suggested that working within smaller integrated provider communities could deliver improvements in care for Hackney and City. This section will summarise the relevant national and local evidence base.

The Transformation Board workshop also heard that the neighbourhood model was in line with the local strategic direction. Specifically:

- The Hackney and City Health and Wellbeing Strategy
    - This clearly states that all members of the Health and Wellbeing Board have signed up to a shared vision for integrated care and support in Hackney. The neighbourhood model is a well -researched and evidenced method of delivering a model for integrated care and support.
- Hackney and City Devolution Plans

  - The business case for devolution in Hackney and City expresses an aspiration that "We want our acute services to fully integrated with community, social care, primary care and tertiary services". It also talks about a model of care which "Coordinates community based services around GP practices". The neighbourhood model will deliver both these objectives.

- North East London Sustainability and Transformation Plan

  - The NEL STP confirms that it aims "To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care". The Hackney and City neighbourhood model is a total population model which will have a strong focus on prevention with the aim of improving outcomes through a locally based integrated care model.

4i. National Evidence

A snapshot of the national evidence base for integrated care models was presented at the workshop. This is summarised below:

- NHS Five Year Forward View

  - The next steps document for NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. This was based on the emerging evidence from the Vanguard sites where there had been a slowdown in the growth of emergency admissions and in some sites and cohorts a reduction in emergency admissions.

- McKinsey

  - A 2015 review of the evidence from integrated care models by McKinsey showed a statistically significant reduction in the probability of hospitalization for patients in integrated-care programs of 19 percent when compared with usual care

- Kings Fund

  - A collation of evidence on integrated care by the Kings Fund highlighted a number of sites which had delivered a quantifiable improvement in the use of resources. One of these was Torbay Care Trust Integrated health and social care teams. By using pooled budgets and serving localities of around 30,000 people working alongside GPs to provide a range of intermediate care services. There was a reduction in use of hospital beds, low rates of emergency admissions, and minimal DTOCs.

4ii. Local Evidence

A large number of local models were examined in developing the approach for neighbourhoods in Hackney and City. Local evidence suggests that this model will deliver benefits for the population. A summary of evidence from local sites is included below:

- Islington
  - Evidence and feedback from two pilot sites in 2015 was encouraging. This led to the roll-out of networks across Islington in 2016. There are now 12 networks in place. An evaluation in September 2017 showed that networks have led to a significant reduction in A&E attendances and admissions

- Camden
  - The borough-wide team has supported about 250 patients in its first year. Current results from 93 patients show an increase of 7 per cent in the number of days they were able to spend at home in the six months after receiving support. The impact of this has been: a 51.8 per cent reduction in emergency bed days; a 47.7 per cent reduction in accident and emergency attendances; and a 32.9 per cent reduction in first and follow up outpatients' appointments.
- Tower Hamlets
  - Tower Hamlets are in the top 3 vanguard sites showing improvement against the national dataset. Tower Hamlets had a long established network model which they further developed with vanguard funding.

5. Understanding the link to the National Association of Primary Care's Model – Primary Care Home

The most developed evidence on smaller provider communities comes from The National Association of Primary Care (NAPC) who developed the Primary Care Home (PCH) programme to inspire and support general practice to integrate with the wider health and social care workforce. The programme aims to redesign services to respond to changing population needs, including addressing the social determinants of health and ultimately to deliver on the quadruple aims of health care.

The Primary Care Home has the following characteristics:

- Provision of care to a defined, registered population of between 30,000 and 50,000
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care inclusive of patients and the voluntary sector
- A combined focus on personalisation of care with improvements in population health outcomes
- Aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards

The neighbourhood model has drawn extensively on this evidence base and will work initially on delivering the first three characteristics within a locally adapted model. It is expected that over time the neighbourhood model will move towards characteristic 3 as relationships strengthen and develop.

There is an increasing evidence base to suggest that there are both quantifiable and quantitative benefits to the Primary Care Home approach. A summary of the benefits from three test sites is included in Table 1 below:

Table 1: Evidence from 3 Pilot sites – Primary Care Home

Rapid Test Site Benefits		
A&E Attendances	▼	**£27k** of savings each year enabled by providing extended primary care access in Thanet
A&E Admissions	▼	**£295k** of savings from reductions in A&E admissions driven by Thanet Health
GP Referrals	▼	**330** GP referrals to hospital avoided, a slowdown in the growth rate, demonstrated by Beacon Medical Group
Prescribing	▼	**£220k** of prescribing savings demonstrated by Larwood and Bawtry
Staff Satisfaction	▲	**67%** of staff surveyed felt that PCH had improved their job satisfaction across the three sites
Utilisation	▲	**78%** of staff felt PCH had decreased or not added to their workload across the three sites
Staff Retention	▲	**86%** of staff regarded Beacon Medical Group as a good employer
Patient Experience	▲	**82%** of staff felt that PCH had improved patient experience across the three sites
GP Waiting Time	▼	**6** day reduction in the average time patients wait to see their GP at Beacon Medical Group

A more recent formative evaluation by the Nuffield Trust on the progress of the Primary Care Home (Nuffield Trust, 2017 - https://www.nuffieldtrust.org.uk/research/primary-care-home-evaluating-a-new-model-of-primary-care) highlighted the following points which are relevant to Hackney and City:

- The rapid test sites targeted their early work on meeting local health needs and addressing weaknesses in local services. Common objectives among the 13 sites studied included improving care for high-need, high-cost patients, increasing the sustainability of general practice, developing services to keep people healthy and developing new workforce skills.
    - The development of an appropriate and cost effective approach for high need/high cost patients will form part of the neighbourhood development programme
- The sites focused on 31 interventions tailored to the needs of different patient groups - with complex or frail older patients the most frequently targeted group. Within six months, the sites had stimulated partnership working and developed or improved services for at least one patient subgroup across most sites. A few were operating as pilot sites for local commissioners who were looking to expand the model.
    - We anticipate that neighbourhoods will (based on strong data) agree priority areas for improvement either among patient groups or clinical pathways
- The PCH model was observed as a strong catalyst for collaboration between organisations and care sectors.

  - We anticipate that this benefit will be realised through the neighbourhood model
- All case study sites were redefining relationships between GP staff and the wider primary community and voluntary sector workforce, often facilitated by colocation and creation of new multi-disciplinary teams.

6. Expected benefits of a Neighbourhood Model

6i. Improvement Domains

It is anticipated that the benefits for the system from the implementation of a neighbourhood model will fall into four main areas. As our data analysis develops, a baseline will be set and agreed improvement trajectories and outcomes agreed across the main outcome areas. The definitive outcome measures will be formally agreed for each domain during the planning and design phase.

DOMAIN 1 - Improving patient experience

- Reduction in duplication of assessment
- Effective MDT crisis and care planning
- Reduction in waiting and wasted time
- Patient reported measures

DOMAIN 2 - Improving staff satisfaction

- Improvement in recruitment and retention figures across key staff groups
- Improvement in staff survey results
- Bespoke analysis of staff satisfaction

DOMAIN 3 - More effective use of resources

- Identifying areas of saving from greater collaboration/reduction in duplication of effort/resources/time
- Reducing emergency admissions through appropriate evidenced based interventions focusing in particular on clinical pathways
- Adherence to agreed pathways, clear timelines and appropriate escalation reducing variation

DOMAIN 4 - Improving quality

- Improvements in MDT working delivering more rapid assessment, treatment/care and coordinated care planning
- Focus on safeguarding reducing risk of patients “falling between teams” or red flags not being picked up
- More effective communication across teams resulting in reduction in waiting
- Shared IT/data sharing resulting in better service and care planning

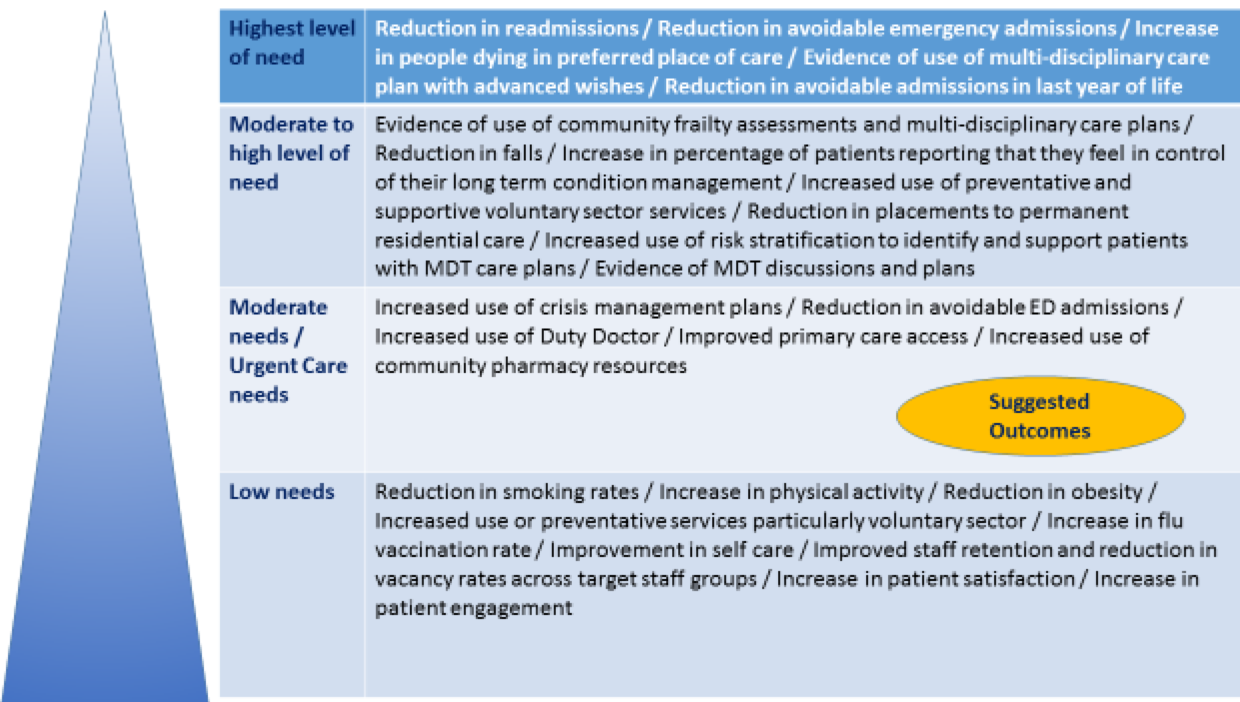
- Use of QI methodology to deliver improvement work on priority areas which will use resources more wisely and in a more targeted way

6ii. How this work will benefit the total population

An important principle of the City and Hackney Neighbourhood model is that it will benefit the total population. The neighbourhood model will deliver both an integrated community model for all patients but will also target specific interventions at specific groups of the population to help deliver improved health and wellbeing outcomes.

Diagram 1 below provides an early assessment of the types of changes we would expect to see across all levels of the risk stratification triangle.

Diagram 1: Risk Stratification Triangle and potential linked outcomes



Highest level of need	Reduction in readmissions / Reduction in avoidable emergency admissions / Increase in people dying in preferred place of care / Evidence of use of multi-disciplinary care plan with advanced wishes / Reduction in avoidable admissions in last year of life
Moderate to high level of need	Evidence of use of community frailty assessments and multi-disciplinary care plans / Reduction in falls / Increase in percentage of patients reporting that they feel in control of their long term condition management / Increased use of preventative and supportive voluntary sector services / Reduction in placements to permanent residential care / Increased use of risk stratification to identify and support patients with MDT care plans / Evidence of MDT discussions and plans
Moderate needs / Urgent Care needs	Increased use of crisis management plans / Reduction in avoidable ED admissions / Increased use of Duty Doctor / Improved primary care access / Increased use of community pharmacy resources
Low needs	Reduction in smoking rates / Increase in physical activity / Reduction in obesity / Increased use or preventative services particularly voluntary sector / Increase in flu vaccination rate / Improvement in self care / Improved staff retention and reduction in vacancy rates across target staff groups / Increase in patient satisfaction / Increase in patient engagement

This will be further developed during the planning and design phase.

6iii. Links to the Better Care Fund Metrics

It is critical that the neighbourhood model contributes significantly to the delivery of the Better Care Fund metrics.

A high level assessment of the expected impact against each areas is set out below

Metric 1: Reduction of non-elective admissions

- The Neighbourhood model will deliver an evidenced based, standardised and sustainable model to support high cost patients/high risk patients where admissions are deemed to be avoidable through improved coordination of care and support.

- The Neighbourhood model will review tools for case finding and risk stratification of patients at risk of admission and ensure that there is an MDT approach to planning care for these patients.
- Prevention and self-care will be a priority for neighbourhoods and the neighbourhood model will support the aims and work of the Prevention work stream.

Metric 2: Admissions to residential and care homes

- The delivery of improved case finding, care planning and coordination/support for high risk/complex individuals will help connect services and identify needs which will enable individuals to remain safely in their own homes for as long as appropriate
- Earlier identification of at risk individuals will allow appropriate and timely interventions to help patients/carers and families to remain independent in their own homes
- Strong partnership working with the voluntary sector will help with the holistic needs of patients/carers and families. The intention being to reduce isolation, minimise the risk of carer breakdown and connect individuals to appropriate third sector support to help maintain independence and well-being

Metric 3: Effectiveness of reablement

- The creation of a neighbourhood model will improve communication between the teams delivering reablement and primary care. At risk patients will be clearly identified and discussed in either a neighbourhood or practice MDT. This will ensure that there is a strong MDT support for patients undergoing reablement.
- Strengthened links to voluntary sector services will help reduce isolation, support carers and improve wellbeing. The model will also help provide quantifiable evidence of gaps in provision which if addressed could help maintain independence at home

Metric 4: Delayed Transfers of Care

- It is anticipated that the neighbourhood model will actively contribute to a reduction in delayed transfers of care in two main ways:
- Firstly through improved case finding and identification of complex/at risk patients and proactive MDT support and care planning. Thus reducing the risk of them being admitted and if admitted it is more likely that they already have appropriate home based support for discharge.

7. Assessment of financial impact of neighbourhoods

7i. Initial assessment of financial impact

It is expected that in the medium to longer term neighbourhoods will make a contribution to ensuring a stable and sustainable financial platform through the following areas:

Use of resources

- Controlling demand for non-elective admissions
- Reduction in the duplication of service provision
- Pooling and shared use of appropriate services

- Better care and crisis planning for high frequency and high risk patients

Estates

- A critical review of use of premises across neighbourhoods to look at any potential for improving use of existing estate in the future
- Overview of how changing service provision and ways of working across neighbourhoods might alter use of premises

Human Resources

- -Increased staff satisfaction and retention resulting in reduced use of bank and agency
- -Better workforce planning and appropriate skill distribution/utilisation

Quality/Improvement

- Better neighbourhood data and focus on key areas such as:
    - Prescribing
    - Immunisations
    - Flu vaccine
- Integrated assessment and working releasing capacity due to:
    - Coordinated access to specialist services
    - Reduction in assessments
    - Reduction in errors
    - Reduction in waiting
    - Reduction in cancelled appointments and DNA

As part of the planning and design phase using our internal financial teams and in partnership with an academic partner for evaluation, detailed financial modelling and impact assessment will be developed.

<u>7ii. Value for Money</u>

It is difficult at this stage to quantify the following with accuracy:

- System savings from either:
    - Reduction in activity
    - Changes to service provision through more targeted models and integrated working
    - Efficiency savings/Quality savings
        - E.g.
            - Prescribing changes
            - Reduction in errors/delays/duplicate assessments
- Return on investment

The intention is to work closely with an academic partner and internal financial teams to be able to model this with accuracy as the detailed model is developed.

Current national evidence suggests that the vanguards have slowed down and in some case reduced emergency admissions for the cohorts of patient they are working with using similar models to the proposed Neighbourhood model. The evidence from the National Association of Primary Care also suggests (albeit at a small scale) that there are potential financial benefits from the primary care home model across a number of areas (See Table 1). Although caution needs to be applied at this point while the detail of the model is worked up, it is reasonable to expect that this model will contribute in the longer term to a more efficient financial model.

The business case asks for an initial investment of just over £800,000. This is a significant sum of money but the Steering Group and UPCB considers that it does represent value for money for the following reasons:

- The money will be invested in the majority into clinical and practitioner time across all providers to enable them to work together and develop the detailed operational neighbourhood model

- The intention is to focus on using existing resources better by investing up front in senior clinical, practitioner and management time to look critically at how we deliver existing services rather than appoint to new posts

- The neighbourhood model is expected to be the long term way of working for Hackney and City and it is therefore critical to invest appropriately in getting the detailed model right and setting strong and sustainable foundations via an excellent and well governed neighbourhood structure to support changes over the longer term

- There is a clear high level programme plan which sets out what is expected from the initial investment and will closely monitor delivery. Based on an assurance process neighbourhoods are expected to go live from June 2018 and it is therefore reasonable to expect that there will be some early benefits seen during 2018. Clear performance trajectories and outcomes will be agreed for the programme as a whole and for each neighbourhood and service change as they go live.

- The neighbourhood model is designed to benefit the total population although specific interventions will be delivered for specific patient cohorts to target critical areas such as emergency admissions, supporting complex discharge and end of life care. This initial investment is expected to deliver a long term benefit for the whole population

8. The City of London – Consideration and Benefits

One of the main features of the Neighbourhood model is that it is designed to be able to respond to the local needs of the population. This is important when considering the different needs across Hackney and the City.

Although the City residents from the Neaman practice are within a larger neighbourhood in the South West, the needs of this particular population are being considered both on a neighbourhood level and at a practice level. Early neighbourhood and practice data identifies clearly the differences in the City population with significant differences from the Hackney average in terms of age profile, dementia prevalence and a comparatively high level of mental health diagnoses. Given that there are these differences even in early and high level data, it is clear that consideration needs to be given to how to best meet the needs of this population within the Neighbourhood model.

A number of steps have been taken to ensure we consider the particular needs of the City and their population, these are set out below:

- Funding and the need for a part time dedicated project management resource to help design and plan the specific and bespoke neighbourhood pathways and model required for the City where it differs from the requirements of the SW Hackney area
- Separation of practice data to enable a detailed understanding of the needs of the City patients
    - The development of an evidence based narrative which sets out the needs of the City population and helps the design team plan the appropriate interventions/pathways and changes

- Needs of an older population
- Higher dementia prevalence
- More patients on an end of life register
- High rates of some mental health diagnoses
- Reported social isolation

- Meetings already held with City social work team to start to look at how the model would work with the existing model in place
- City of London representation on the Steering Group
- Planned meetings with the Neaman practice to talk through their assessment of the needs of their patients, potential areas for improvement and how they see neighbourhoods working for their patients
- Work will begin to identify a specific City of London resident to be part of the Neighbourhood patient panel and help design any bespoke coproduction processes required for the City of London population

9. Evidence supporting requested investment

9i. Evidence to support importance of programme management resources

"Ambitious transformation programmes cost money – to set up a team to manage and drive the process, to take staff away from clinical duties, for external support, for 'quick wins' and sometimes for infrastructure, equipment or staff." (Health Foundation, 2015)

Both the local One Hackney and City evaluation and national evaluations of complex change programmes strongly advise that appropriate investment should be made into designing and implementing any complex change programme. A report from the National Audit Office on complex change (2015) stated that:

"Transformation programmes take a particularly heavy toll on senior leadership... Programme directors need to be highly experienced, understand how to manage the environment, and break down any resistance to change. The NAO's work shows how finely-balanced this arrangement can be, and the dependence on clear governance structures to make it work. While there is no easy formula for how much transformation an organisation can cope with, it is important to recognise that these are organisationally expensive in terms of leadership attention and capacity.

A Health Foundation report highlighted that successful transformation programmes need "Project managers and clinical leaders who can guide robust implementation planning, including resource requirements, timelines, milestones and so on"

The evidence also emphasises the need to ensure appropriate clinical engagement at an early stage. This time should be protected and ideally clinicians (and staff) should be released from existing commitments. Evidence on managing and delivering successful change also recognises that effective engagement and co-production is also critical to delivering a successful change programme. This is explained in the Health Foundation report below:

http://www.health.org.uk/sites/health/files/TransofrmationalChangeInNHSProviders_CCsupplement.pdf

The development of a neighbourhood model for Hackney and City and the associated improvement work constitute a complex system change programme. The Unplanned Care Team will lead on the

overall delivery of the programme. Currently the only dedicated resource specifically for the development of neighbourhoods is a part time programme lead (funded to March 2018). There are no dedicated clinical resources or project management time either for the overall programme or to support providers in working through the implications for their community services (teams) at the population interface. This is insufficient to develop and deliver a transformational change programme of this scale which has implications for the whole system and total population.

In order to progress the model and ensure that the design of the model is "bottom up" and clinically led, additional resources are required to support providers to release clinicians and management time to work up the model.

In order to ensure that there is a strong patient (and neighbourhood population) voice, resources need to be identified to support the development of a co-production model.

9ii. The learning from One Hackney and City and how this has been applied

The shared learning from the multiple reviews of the One Hackney and City programme concluded that any future programmes of change need to ensure:

- An agreed and shared vision
    - The creation of a simple and consistent narrative
    - A shared understanding at all levels of what will be different as a result of the change programme
- Robust governance
    - Ownership required at all levels of the change being implemented
    - Shared accountability and real consequences for success or failure
- Excellent data and evaluation systems
- A realistic time period to deliver and observe the change
- Realistic resources
    - Particularly for programme management
    - Clinical engagement
    - Design
- A Rigorous approach to design
    - Clinically and patient led

The request for resources for the planning and design of the Neighbourhood model reflect this learning and the need to dedicate sufficient resources to:

- Design and planning
- Data analysis, collection and production
- Programme Management functions

9iii. Implementing New Models of Care – Lessons Learnt

A November 2017 report from the Health Foundation focusing on the lessons learnt from implementing the new models of care across the country provides a timely and important reminder of the need to appropriately invest both time and resources in large scale change programmes. A link is included below:

http://www.health.org.uk/sites/health/files/SomeAssemblyRequired

The report identifies 10 lessons to support providers and commissioners seeking to adopt this new approach. These are listed below:

1. Start by focusing on a specific population.
2. Involve primary care from the start.
3. Go where the energy is.
4. Spend time developing shared understanding of challenges.
5. Work through and thoroughly test assumptions about how activities will achieve results.
6. Find ways to learn from others and assess suitability of interventions.
7. Set up an 'engine room' for change.
8. Distribute decision-making roles.
9. Invest in workforce development at all levels.
10. Test, evaluate and adapt for continuous improvement.

Of particular relevance to this business case are numbers 4 to 8. The detailed costs included in Appendix 1 identifies the initial resources we believe are required in City and Hackney to successfully plan, design and deliver the early phases of the neighbourhood model.

The report identifies that "Part of the hard work of making changes across boundaries is moving from the initial enthusiasm to creating clear objectives across organisations. Many sites began with an initial vision created by a small group of often senior leaders. They then brought together staff and patients to discuss and agree clear objectives". We have created a provider resource to allow the providers involved in the initial major change process to create senior time and capacity to design, plan and deliver the changes required within their organisations to work in a new way within neighbourhoods.

The report identifies that a critical factor in the success of major change programmes (already identified in other evidence earlier in this report is the central programme team. It states that "All the vanguard sites featured in this report had a dedicated central project team that brought staff and activities together, described in the MCP framework as an 'engine room to drive and manage the local transformation programme, with adequate dedicated resources and capabilities'. In the literature on implementation, these central teams are a key factor in achieving change when embarking on unfamiliar activities.[4]It was important that these teams included staff who had already worked in the local health and care system, to create confidence among stakeholders and increase how quickly teams

could start, thanks to their existing knowledge of the areas. The size of teams in the vanguard sites varied, but skills within them included project management, quality improvement, data analysis, communication and administrative expertise." We have identified a small central resource to create "an engine room" for Hackney and City and the neighbourhood model. It is useful to note the emphasis on data analysis and quality improvement both of which will be critical to the success of the Hackney and City neighbourhood model.

10. Summary of requested costs and how they will be spent and governed

10i. Summary of requested costs

A sum of 1.26 million for 17/18 and a further sum of 1.26 million for 18/19 were unallocated following the end of the One Hackney and City programme. This was expected to be used for the delivery of an integrated care model in Hackney and City building on the learning from the One Hackney and City programme. This is a total of 2.52 million for the financial years 2017/2018 and 2018/2019. The neighbourhood model has been developed to deliver an integrated care model including a specific focus on reducing emergency admissions for high risk (complex/vulnerable)/high cost individuals with a further aim of working with those individuals identified at most risk of future admissions without additional intervention.

The neighbourhood model was developed specifically by:

- Reflecting on the learning from One Hackney and City
- A comprehensive review of the international, nation and local evidence on integrated care models, locality models and admission avoidance work
- Extensive engagement and consultation with those who will be involved in making the change to neighbourhoods and delivering the proposed plans

This business case sets out the initial programme costs for the remainder of the 2017/2018 financial year and for 2018/2019. The total request at this stage is £818,314 from the total of £2.52 million. It is anticipated that a further business case will be submitted in early 2018 for the full delivery model for neighbourhoods. The Steering Group is however mindful of the non-recurrent nature of the funding and current financial climate and work is focusing on how we plan and design to use existing resources (wherever possible) to work differently within neighbourhoods to deliver better outcomes rather than investing in additional staff.

The costs identified in Appendix 1 fall into three main areas:

- Central Programme Management Costs
- Provider development, design and delivery costs
- Programme infrastructure and logistic costs

The Neighbourhood Steering Group has focused on identifying essential costs to plan, design and deliver the initial phases of the neighbourhood model for City and Hackney. It has sought to minimise costs wherever possible by using fixed term appointments,

secondment of existing staff and use of appropriate and available resources from existing teams.

Table 2 summarises these overall costs. The detailed costs and rationale are included in Appendix 1.

Table 2: Summary of Neighbourhood Costs (Jan 18 – Mar 19)

Area of Costs	Total Costs
Central Programme Management Costs	283,252
Provider Development, design and delivery costs	520,062
Programme Infrastructure and logistic costs	15,000
Total	818,314

10ii.What these costs will deliver

These costs will deliver the following phases of the neighbourhood model. It is anticipated that there will be a further business case in early 2018 which will focus on:

- Full co-production costs
- Any additional costs required to deliver a sustainable neighbourhood governance structure
  - Ongoing leadership team costs specifically
- Evaluation and QI costs
  - Based on developed specification
- Any additional costs to support changes to models of care such as the support model for high risk and complex patients
- Additional provider or work stream development costs

The high level programme plan is set out in Diagram 2 below with further detail provided in Table 3.

Diagram 2: High Level Programme Plan

Phase	Activities
Phase 1 **Primary Care Development**	- Intensive focus on work with all GP practices within a neighbourhood to create a shared vision, objectives and delivery plan - Regular primary care neighbourhood meetings - Mapping of primary care services across practices - Analysis of primary care data to identify improvement opportunities - Agreed primary care development/improvement priorities
Phase 2 **Neighbourhood Governance and Structure** **Overarching work programme**	Neighbourhood Governance - Creation of neighbourhood leadership teams and establishment of neighbourhood governance/meeting structure - Appointment of neighbourhood lead - Creation of a Memorandum of Understanding to cover the workings of all 8 neighbourhoods - Creation of a neighbourhood dataset - Agreement of local neighbourhood improvement priorities - Assurance process to be agreed to sign off neighbourhoods as ready to support improvement interventions and alignment of provider services Overarching work programme - Governance structure - Specification for evaluation support

	- Specification and model for QI methodology and support - Specification for OD support - Leading data analysis and neighbourhood dashboard work - Leading creation of system wide case finding/risk stratification and support model for high risk/complex and those at risk of admission - Coordinating provider design work and plans to align services - Developing detail of coproduction model
Phase 3 **Provider planning, design and initial delivery**	- Specific provider clinical/practitioner and management expertise to design a model to align teams to neighbourhood - Specific provider clinical/practitioner and management expertise to design contribution of services to neighbourhood leadership and governance model - Specific provider clinical/practitioner and management expertise to design a model to support identified/agreed cohort of high risk/complex/high cost and at risk of admission patients - If above completed, provider contribution to specific neighbourhood identified improvement priorities based on data
Phase 4 **Neighbourhood Go Live based on assessed readiness and capacity**	- Following agreed assurance process via the Steering Group neighbourhoods will formally go live from June 18 onwards - Once live neighbourhoods will (using agreed QI methodology and support) test changes to the way that provider services such as community nursing, social care, ELFT work at an integrated local level - Test a model for identifying and support patients identified as high risk (complex/vulnerable) or at high risk of admission - Agree neighbourhood specific improvement projects using QI methodology and agreed support model based on local neighbourhood data

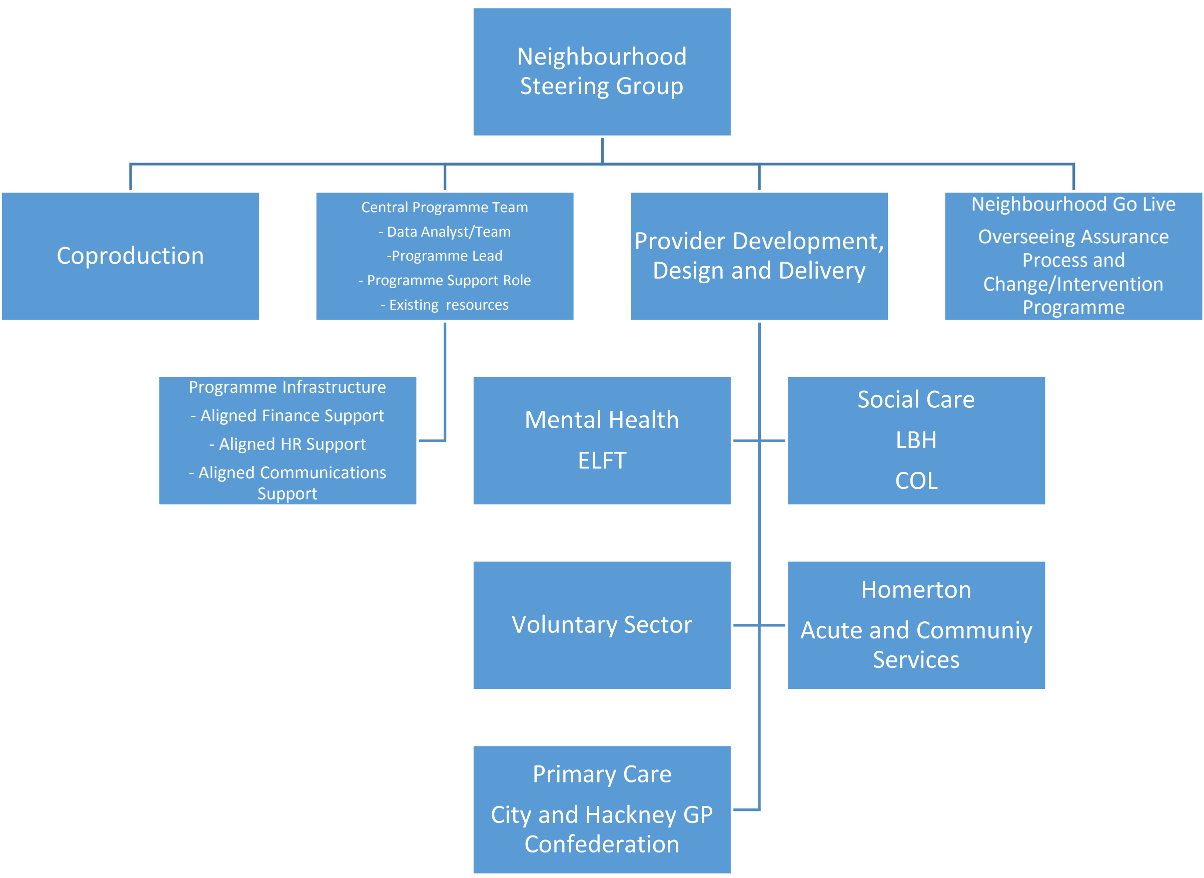
10iii. How will we manage the programme to deliver these outcomes and ensure best value for money and excellent use of all additional resources?

The overall governance of the programme is currently being reviewed to ensure that it is the best possible structure for the scale and complexity of the programme. The current steering group must also develop to ensure representation from each of the four work streams while also enabling decisive and effective decision making. The best way to balance the potential size off the steering group is currently being considered with a particular focus on how the steering group is best configured in the future.

The programme is complex with a number of longer term work streams and some shorter term task and finish groups. There needs to be excellent and robust governance arrangements to have appropriate oversight and scrutiny of these work streams, allow early identification of any issues/delays and provide a clear and effective route for the escalation of issues with appropriate timely decision making and intervention.

A summary of how the requested resources/posts will be managed in the initial phase of the Neighbourhood Model is set out below. It is important to note that the composition, configuration and terms of reference of the steering group are subject to review.

Diagram 3: Governance of programme and provider resources



The neighbourhood programme remains hosted by the Unplanned Care Programme Board (UPCB) and will report formally on progress into the Transformation Board (and Integrated Commissioning Boards) via the UPCB.

11. Formal Governance arrangements to support neighbourhood working

In order to ensure that there are robust governance arrangements to support neighbourhood working the programme anticipates using a Memorandum of Understanding (MOU) across each neighbourhood. While this is not a formal contract it is a method of:

- Creating a shared agreement about how providers will work together
- Creating a shared agreement about the outcomes to be delivered
- Developing a platform which articulates the way it expects providers to work together
- Agreeing how providers will approach risks and conflict

- Providing a way of clearly articulating the shared vision and objectives of neighbourhoods

By working with providers and patients to coproduce this MOU, it will also help test all elements of the neighbourhood model and the delivery plan.

While the detailed specification of the operational neighbourhood model is being worked through by providers, there are no expected changes to existing contractual arrangements. The programme team is mindful that in time there may be changes to the way that services are provided which may necessitate contractual changes however we anticipate that these changes are longer term while the current investment focuses on the short to medium term.

Where cross provider posts are required such as neighbourhood leadership posts and programme management functions, a fund holder will be identified to manage the fixed term financial management required.

In the longer term the MOU may develop into more formal contracting arrangements for neighbourhoods. Work nationally suggests that a number of areas are currently in the early stages of exploring what these formal contractual arrangements might look like and the team will continue to use national (and international) good practice to inform the development of the local model wherever possible.

12. Risks of not approving the requested costs

If this proposal for investment is not approved, it is likely to have the following consequences:

- There will be no dedicated programme management resources to support the delivery of the neighbourhood model
    - The evidence referred to throughout this business case suggests that the programme management function or “engine room” is critical to the successful delivery of a large scale change programme
    - If the model relies on existing resources from staff with existing “day jobs” it is likely to put the delivery of the programme at risk and significantly impact on the pace and scale of the programme
- There will be no dedicated provider resources for planning, design and delivery. This will mean that providers have very limited clinical/practitioner time to critically look at the way community services will work within neighbourhoods significantly impacting on the ability to change the way that services are provided to deliver integrated local care.
- No investment in coproduction will severely limit the way the ability of patients/carers to contribute in a meaningful way to the changes proposed. It is likely that this will significantly impact on the ability to deliver a true co-production model and mean that the model does not respond to the identified patient issues and challenges with unplanned care
- A lack of investment in resources for planning, design and delivery will have a significant impact on the ability to deliver the benefits and outcomes outlined in Section 5. Without the work outlined in this case, it is highly likely that there will be very limited system change and therefore no tangible improvement to the outcomes.
- A lack of investment in the resources for planning, design and delivery of the neighbourhoods will impact on any long term financial benefits expected from the model
- If the business case is not approved it will also mean that best/good practice that is available from elsewhere in the system is not applied locally and residents don’t receive the quality and

level of care they could be. Significant research has been undertaken to develop the neighbourhood model and adjust national good practice to deliver a model of care that is right for Hackney and City

- Without investment the main delivery of services/care will remain unchanged. This would leave Hackney and City out of line with the Five Year Forward View and STP plans which prioritise the delivery of integrated working at a local level.
    - The NHS Five Year Forward View sets out a clear direction for the NHS to develop new models of care that will provide more integrated services. To make this happen, barriers between hospital, community and primary care will need to be removed so the focus is on patients and systems of care rather than individual organisations

13. Conclusions and next steps

The Transformation Board is asked to do the following:

- Consider and endorse this proposal for a partial investment of the 2017/2018 Better Care Fund into the planning, design and delivery of the first 15 months of the neighbourhood programme
- Make a recommendation to the Integrated Commission Board to approve the release of the Better Care Funds as set out in this Business Case
- Note that there is expected to be a further request for expenditure from the BCF budget for 2018/2019 as more detailed specifications are developed for new ways of working within neighbourhoods

The Hackney Integrated Commissioning Board is asked to:

- **ENDORSE** the proposed Neighbourhoods service model and implementation plan;
- **APPROVE** the Business Case for initial planning and design and delivery costs; and
- **APPROVE** expenditure of £818,314 unallocated component of the Hackney BCF to implement the model.

The City Integrated Commissioning Board is asked to:

- **ENDORSE** the proposed Neighbourhoods service model and implementation plan, and to confirm it is comfortable that the model will meet the interests of the City.
- **APPROVE** the Business Case for initial planning and design and delivery costs; and
- **APPROVE** expenditure of £40,081 unallocated component of the City BCF to implement the model.

Author: Jennifer Walker (Lead) and Neighbourhood Steering Group

Endorsed by: Unplanned Care Programme Board

Date: 30/11/17

APPENDIX 1

Principles

Where ever possible we aim to use the existing workforce to support the development of neighbourhoods
Where appropriate we aim to use existing skills and expertise from within Hackney and City
We encourage secondments from teams to support programme planning and design
We recognise that there are many of the skills we need within the system to successfully implement this work
We will be flexible and reactive based on the learning from the design and planning phase of this work which will inform subsequent phases of work

Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
PROGRAMME MANAGEMENT FUNCTIONS AND COSTINGS INVOLVED IN ALL PHASES OF PROGRAMME					
Bespoke analytical support	Additional senior data analysis capacity	- Design neighbourhood dashboard using integrated data from all main providers - Produce monthly neighbourhood dashboard for use and testing in each neighbourhood area - Early developmental and scoping work to support plan to develop health economic analysis of each neighbourhood - Create specification for ongoing dashboard development so that this can be built into business as usual in terms - Ability to perform specific/bespoke data analysis based on review of neighbourhood data and pathways where it looks like	**Benefits** Measurement of impact of interventions Evidence based focus for improvement work Targeted focus of effort in a financially challenged environment Increased understanding of patient population and needs Use of health economics to understand impact **Risk** No other resource/capacity to produce this work	0.5 WTE Potential for this to be provided by investing in existing teams (CSU/CEG) or consider independent hosted role	**Total - 63,750** Jan 18 to March 18 assuming agency costs while advertise fixed term support or work with existing teams to assess capacity – **18,750** April 18 to March 19 – **45,000** (working with existing teams/fixed term post. Assumes 8B level post and on costs.

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		there is scope for improvement			
Initial patient co-production costs	Non Pay Costs Potential for limited project management/ Administration costs to support more detailed proposal for ongoing coproduction costs/model	- Establishment of a patient panel for the neighbourhood development programme with monthly meetings and agreed work programme - Development of a plan and business case for the creation of a co-production model within each neighbourhood and how this can be scaled up for the system - All work will be fully linked into the co-production charter and the programme will be working closely with the patient enablement group ***A second business case is expected for longer term costs when these have been fully scoped.***	**Benefits** Establishes robust foundation and structure for ongoing coproduction model within neighbourhood steering group Potential for this to be expanded as the programme develops Initial costs only so flexible to change and responsive to need **Risks** Unable to have number of patient representatives currently identified (3) and support costs Unable to create a meaningful plan for ongoing coproduction for significant	Non Pay Costs for patient representative Limited project management support to create case for longer term coproduction model	**5,000** Jan 18 – Jun 19

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
			system transformation programme with considerable impact for patients		
Overall Clinical/Practitioner Lead Potential for this to be a job-share between clinician and a senior practitioner (e.g. Social Worker)	2 sessions a week overall leadership post for the programme Job description to be completed and role advertised	- Provision of overall clinical/practitioner leadership to the programme not aligned to provider - Monthly chair of the neighbourhood steering group - Clinical/practitioner oversight and supervision to neighbourhood leadership teams - Joint lead for evaluation and QI work streams - Application of up to date research and evidence as new models of care develop - Expected to bring independent expertise and appropriate challenge to the programme with appropriate frontline experience	**Benefits** Independent senior/expert clinical/practitioner input into major system redesign programme Credibility during design and planning process with colleagues across providers Continuity of ring fenced clinical opinion **Risks** Core Project Team will have limited access to independent senior clinical/practitioner input to test ongoing work programme/models of care	Initially 2 sessions a week To be reviewed at six months	**Maximum Total - 39,000** Assuming maximum potential clinical sessional cost of £325 Costs may reduce after initial intensive design and planning phase and total cost may be less dependent on experience and pay scale of person appointed

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		- This mirrors the agreed governance for the unplanned care board using clinical leads for each major improvement work stream			
Central Programme Management Costs 1 x Programme Lead 1 x Programme Support Core Project Team will also use existing resources. 0.5 days a week of work stream support office will	1 x Programme Lead 1 x Programme Support	- Creation of MOU development and engagement work with providers - Creating a neighbourhood leadership model (job descriptions etc.) - Oversight of the development of a neighbourhood dashboard - Oversight of the information work stream - Working with neighbourhoods to agree a high cost/high risk patient management model - Working with neighbourhoods to agree an approach to case finding/risk stratification	**Benefits** There is extensive evidence from the Kings Fund, Health Foundation and National Audit Office which clearly demonstrates the need to adequately and appropriately resource large scale change programmes with appropriate programme/project management resources These posts will be the backbone of the change programme driving forward the work streams, milestones and delivery of the neighbourhood model	1 WTE Programme Lead 1 WTE Programme Support Job descriptions to be completed and advertised. This will determine banding of	**Total – 175,682** Programme Lead Banding Range 8C – 8D (agenda for change) **100,000** maximum WTE cost for 12 months including 30% on costs (standard practice) Current post holder funded until March 18 Programme Support

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
be ring-fenced for this programme to provide logistical and administration support in addition to project management support.		- Developing a QI support model for neighbourhoods/linking into system work on QI in partnership with the clinical/practitioner lead - Developing a specification for economic and quantitative evaluation of the neighbourhood model in partnership with the clinical/practitioner lead - Developing an assurance process to assess neighbourhoods readiness to take on improvement work, changes to models of care with integrated teams - Ongoing project management functions – programme plan, risk register, reporting - Developing an organisation development model to support	These posts will be the “doers” supporting busy clinical teams and provider teams in delivering the changes they want to make The post holders will provide excellent programme governance which is an essential part of a robust and ambitious change programme **Risks** Without these posts there will be no overall dedicated coordinating function which puts the delivery of the programme at significant risk Not recruiting to these posts goes against national and international evidence which argues that successful large scale change programmes need appropriate dedicated and skilled resources	posts. Costs may be reduced slightly if posts not full time Posts to be advertised on fixed term contracts to avoid costly agency fees	Banding Range 8A – 8B (Agenda for Change) **75,682** maximum WTE cost for 12 months including 30% on costs (standard practice)

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		neighbourhood development with CEPN team - Creation of a detailed specification for neighbourhoods to support financial forecasting/planning – full business case with expected economic benefit - Supporting all the neighbourhood development meetings from initial primary care work to full operation of MDT team - Linking with other work streams to scope priority areas where neighbourhoods can align and support strategic directives - Focused work with the Children's and Young Peoples work stream to create a framework for working which respects previous work and			

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		service configurations while developing the neighbourhood model - Lead and oversight of coproduction work stream - Chair of patient panel - Development of performance framework - Oversight and assurance of provider work streams for neighbourhoods			
PROGRAMME MANAGEMENT COSTS TOTAL **283,252**					
PROVIDER PLANNING, DESIGN AND INITIAL DELIVERY COSTS					
Initial Neighbourhood Primary Care Leadership/ Development	8 x primary care neighbourhood development leads	- Taking initial lead for primary care development work – ensuring that the GP clusters within each neighbourhood work effectively together	**Benefits** Primary care clinical/practitioner leadership model for each neighbourhood essential for creating a	Initially 1 session per week for each clinical/practitioner need	**Total - 62,400** Assumes maximum clinical sessional rate of £325 which is in line

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
Costs		- Charing GP/practice neighbourhood meetings during development phase - Working closely with GP confederation leadership team to ensure all neighbourhood primary care teams achieve require standards - Coordinating primary care development work programme to create functioning clusters of practices within each neighbourhood - Providing peer support - Overseeing completion of a map of services from primary care across clusters to understand resources within neighbourhoods - Creation of a detailed analysis of the strengths, opportunities, challenges and weaknesses for	unified primary care approach across practices within neighbourhoods This is a model which has been used in other primary care home sites and locality models with reported benefits Important to have locally credible and appointed leadership that can represent all GP practices **Risks** Without an appointed primary care lead, it will be very challenging to create a unified primary care provision within neighbourhoods	across the 8 neighbourhoo ds	with CCG pay rates for 8 neighbourhood areas. 6 month duration.

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		primary care in each neighbourhood and an agreed action plan These are developmental posts only – it is expected that an overall neighbourhood lead post will be advertised following the design and planning phase which could be any professional within the neighbourhood team			
Provider Costs Social Care - LBH	Social Care – Expert Practitioner and Programme Delivery	- Develop understanding of existing pathways and redesign initiatives across ASC and how these would interface with the Neighbourhood model including developments of new pathways such as D2A and re-designs in ASC front door and community based services which are currently underway.	**Benefits** This is a significant change programme for social care which potentially means a significant reconfiguration of existing resources The learning from One Hackney and City indicated that social work presence/contribution in primary care	1 WTE Senior Social Worker Review at Six Months	**Total Cost - 83,279** Senior Social Worker Banding including on costs Monthly Cost – 6440

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		- Development of a model of working which aligns social work teams to neighbourhoods and creates identifiable teams for each neighbourhoods - Produces an options appraisal/model for social work support model within practices being clear what is expected from the role and the benefit - Agreement of the model of care for high risk/high costs patients and those identified at significant risk of admission - Review of central advice and guidance function and identify whether there is the potential to devolve this function to a neighbourhood level - Lead for link to council housing and linked neighbourhood model	was highly valued and effective and creating closer links to social care and a clear local/integrated model is a priority for the neighbourhood model The scale of this redesign work cannot be met by using existing members of staff with full time jobs. As above national evidence on good practice in large scale system transformational change shows that dedicated resources are required for successful delivery **Risks** It is likely to be impossible to undertake the work required to redesign the provision of social care without dedicated resources If social care cannot be integrated into		

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		- Scope potential neighbourhood links and opportunities to enhance working with formal carers and care agencies - Attendance at neighbourhood leadership MDT and development of long term leadership model Project management and delivery of agreed model when ready to launch	neighbourhoods then the full benefits of the model are highly unlikely to be realised		
Provider Costs ELFT	Sessional input into neighbourhood teams plus overseeing project management support	- Clinical and Practitioner sessional input into the development of neighbourhood model for ELFT Teams - Creation of integrated neighbourhood mental health model for the 8 neighbourhoods - Clinical and Practitioner input into the development of the high risk/high costs patient	**Benefits** Senior clinical/nursing/practitioner leadership into at a local neighbourhood level which will create strong working relationships and trust Ability to create a localised model of mental health based on local data/knowledge and needs	Senior sessional Clinical Input into the design and delivery of the ELFT neighbourhood model Nurse/ practitioner	**TOTAL – 104,375** **58,125** – Clinical Input into neighbourhoods – Jan 17 to Mar 19 (15 months) **30,000** – Senior Nurse/Practitioner input into neighbourhoods – Jan 17 to Mar 19 (15

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		management model - Project Management support to coordinate feedback and approach across the neighbourhoods - Delivery of actions into neighbourhoods from mental health workshop to be held in late January/February Project management and delivery of agreed model when ready to launch	Scale of redesign requires **Risks** The scale of system change requires dedicated ring fenced and dedicated resources If a full redesign process has not been undertaken and mental health is not integrated in neighbourhood teams then it will be impossible to realise the full benefits of the neighbourhood model	sessional input into the design and delivery 0.2 WTE project management support/for the neighbourhood development programme	months) **16, 250**– Project Manager support – Jan 17 to Mar 19 (15 months) Review model at six months
Provider Costs GP Confederation	Expert Clinical/Senior Management Session Primary Care	Expert Clinical/Senior Management Session - Oversee primary care development programme for GP practices and provide senior expertise/challenge and time	**Benefits** Essential to have strong structure to support primary care development as they sit at the heart of neighbourhoods	1 session per week senior clinician/manager	**Total – 104,417** Senior Clinician/ Manager Costs Maximum 325 per

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
	Development Officer	for individual practice/cluster discussions - Attend as required GP practice neighbourhood meetings - Contribute and lead the process for development of a primary care lead role for neighbourhoods - Maintain a strategic overview of state of readiness of GP clusters within neighbourhoods - Provide senior advice, support - Senior facilitation for meetings as required for specific neighbourhoods - 1:1 work with GPs as required Primary Care Development Officer - To attend all GP primary care neighbourhood meetings and take minutes, record actions and oversee delivery of actions - To collate the completion of a	Senior expertise and guidance will be required to support development of joint working within neighbourhoods Trust and experience in place which will increase pace of change **<u>Risks</u>** Without this input, it is likely that it will take considerably longer to get GP practices working together effectively in neighbourhoods	1 WTE Primary Care Development Office Review at 6 months	session for 15 months – **19,500** Primary Care Development Officer – Banding Range 7 to 8A **84,917**– Jan 18 to Mar 19 This includes on costs

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		primary register of services across all practices - To collate and complete the SWOT analysis of primary care across all neighbourhoods - To complete an action plan to ensure all GP clusters within neighbourhoods achieve expected standard - To provide specific support and advice to neighbourhoods based on SWOT analysis and state of readiness			
Provider Costs Homerton	1 x Nursing Lead Geriatrician Sessions	Funding for nursing or equivalent support to provide operational support in order to release the Divisional Head of Nursing or their deputy to provide strategic community nursing input to the Neighbourhood work. Geriatrician - Expenses/costs to allow a senior Geriatrician to support the	**Benefits** Committed strategic clinical resource for the design stage with strong working knowledge of the acute and community services interface. Ability to link this programme to other key strategic projects such as the	Nursing Lead – 1 WTE (Band 7) Geriatrician Session – 1 session per week Jan to Mar 18 (3	**TOTAL – 110,591** Nursing Costs **67,620** Jan 18 to March 19 (15 months) includes on costs Geriatrician Costs - **4,775** Jan to Mar 18 (3

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		design work and the steering group. The time is based on the quantity of services that Homerton provide and the complexity of the interface. - Development of a model for integrated community nursing model in neighbourhoods based on learning from SW neighbourhood CEPN pilot - Model of community nursing input into neighbourhood leadership team - Community nursing support for high risk/high cost patients and those at high risk of admission - Geriatrician contribution to MDT working and care planning for high risk/high cost patients and those at risk of admission - Geriatrician lead/input into development of evaluation and	practice-based nursing team pilot. Senior clinician input for this significant change programme to support the appropriate reconfiguration of existing services. Quality improvement implementation experience **Risks** Without dedicated input the scale of system redesign and change cannot be delivered. Quality improvement methodology is not embedded and the programme risks not being able to demonstrate its impact/value.	months) – 2 sessions per week Apr 18 - Mar 19 (12 months)	months) - **38,196** Apr 18 - Mar 19 (12 months)

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		QI model for neighbourhoods - Contribution to pathway development for neighbourhoods – frailty			
Provider Costs City of London	Planning and Design Costs	The City of London have assessed the need for design work to develop how the model would work for the City of London. Will supplement post with internal resources. Emphasis on the fact that the design work across the two local authorities (Hackney and City of London) interacts and shares knowledge / ideas where ever possible.	**Benefits** The City of London is in a unique position with different provider relationships for some services requiring careful thought about how to maximise the benefit of neighbourhood working for its residents whilst maintaining existing pathways The population of the City has some unique challenges in terms of service provision which will also be considered during this design and planning phase **Risks** Without specific resource for the City of	2 days a week for 3 months initially subject to review	**Total – 20,000**

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
			London the model may not be sufficiently developed to maximise the benefits for this cohort of patients		
Provider Costs Voluntary Sector	Voluntary Sector Development	Allocation of project management resources to allow voluntary sector expertise to support design/delivery of voluntary sector contribution to neighbourhoods. Resources to support voluntary sector organisations (representative of the sector) to contribute to the design and planning of how neighbourhoods will connect and work with the voluntary sector.	Benefits Requires specific voluntary sector expertise and experience to help design a sustainable long term model for neighbourhoods Sector will require additional capacity to support planning and design Evidence shows that voluntary sector organisations can help people be discharged sooner, be more connected (less isolated) and therefore have better health outcomes and support independence at home Risks		**TOTAL - 35,000** Split between specific project management input and voluntary sector expertise and support to local 3rd sector organisations

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
			Without resources, it will be very difficult for the voluntary sector to contribute meaningfully to the design process Whole system transformation requires active engagement and partnership working with the voluntary sector		
PROVIDER PLANNING, DESIGN AND INITIAL DELIVERY COSTS **TOTAL COSTS – 520,062**					
PROGRAMME INFRASTRUCTURE AND LOGISTIC COSTS					
Non Pay Costs	Room hire Facilitation support Stationery IT infrastructure	Essential non pay cost to support planning and design process Room Hire - Budget for neighbourhood leadership and development meetings only where existing rooms cannot be sourced - Budget for system workshops		Budget to be held centrally and signed off by Programme Lead and Clinical Lead for small items and Steering Group for	**15,000** – Jan 18 to Jun 19 (6 months) To be reviewed at six months

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		where large rooms are required such as mental health Facilitation Support - Where identified and essential external facilitation support for system workshops/redesign work - Where essential due to identification of significant relationship challenges across teams/providers – ability to bring in skilled facilitation/mediation Stationery - Contribution to stationery costs at host organisation associated with neighbourhood development work		large items	

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
		IT infrastructure - Potential for 2 x new computers for PMO team plus phones			
Aligned support	Access to: Communications Expertise (1 day a week) Finance Expertise (1 day a week) HR Expertise (1 day a week initially and then likely to reduce) This will ideally be drawn from existing resources to reduce costs				Assuming can be met by existing teams with agreement
PROGRAMME INFRASTRUCTURE AND LOGISTICS TOTAL COSTS – 15,000					
OVERALL TOTAL					**818,314**

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Design and Planning Costs - Area	Description of post	Expected outcomes/role description	Expected benefits/risk of not resourcing	Detail	Cost (Overall and Detail)
COSTS					

Title:	**Better Care Fund Performance Update Q2**
Date:	13 December 2017
Lead Officer:	Chris Pelham, Assistant Director of People Services Siobhan Harper, Director Planned Care Workstream
Author:	Cindy Fischer & Ellie Ward
Committee(s):	City of London Integrated Commissioning Board
Public / Non-public	Public

Executive Summary:

The purpose of this report is to update the City Integrated Commissioning Board on the position of the City of London's performance against Better Care Fund (BCF) targets at Quarter 2.

The Better Care Fund Narrative plan was submitted to the London team in September 2017, and was approved by the team in November 2017.

Due to the delays from central government on the publishing of this year's BCF guidelines and planning arrangements a Quarter 1 performance report was not required. Deputy Joyce Nash, Chair of the City of London Health and Wellbeing Board signed off the Quarter 2 report, which was submitted on the 17th November.

There are four metrics monitored in the BCF:

1. Non-elective admissions (General and Acute)
2. Admissions to residential and care homes
3. Effectiveness of Reablement
4. Delayed transfers of care

Performance on metric 1 was over the target for Q2; however taking into account Q1 our year to date performance is positive. We are more than meeting targets for metrics 2 and 3. Looking at published data for metric 4, Delayed Transfer of Care (DToC) appears to be performing poorly; however, since the Q2 report was submitted to NHSE, we have challenged over 200 days which will be removed from figures.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the contents of the paper.

CITY OF LONDON

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Links to Key Priorities:

This work links to Objective 4 of the City of London Joint Health & Wellbeing Strategy:

'Effective Health and Social Care Integration'
This also directly contributed to the Unplanned Care workstream 'big ticket item', Integrated Hospital Discharge.

Specific implications for City

The Department for Central and Local Government (DCLG) and Department of Health (DoH) stated that they reserve the right to reduce the published iBCF allocation for areas where DToC performance does not improve and meet targets. It is likely that funding will continue; however, it will be tied to implementation of high impact change model action plans.

Specific implications for Hackney

There is a separate report covering the London Borough of Hackney's performance against BCF metrics.

Patient and Public Involvement and Impact:

Service specifications, new service developments and challenges with performance are presented to the Patient and User Experience Group (PUEG), which was developed when the Better Care Fund was established.

PUEG has been involved in discussions since One Hackney and City ended, and has fed into the development of the Neighbourhood model.

The group also discussed local issues with delayed transfers of care and targets set by NHSE. The group expressed their concern at the targets set and expressed the view they were unrealistic. Representatives also stated that intermediate care beds needs to be part of the options available to patients as not all people could be cared for at home.

Representatives wanted to ensure consultation continued and service users were part of ongoing work related to discharge.

A patient rep has now joined the monthly hospital discharge group and other elements of the work, will be co-produced with patients and families.

Clinical/practitioner input and engagement:

Clinicians and practitioners are involved in the development and implementation of the high impact change model action plan.

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Impact Impact on / Overlap with Existing Services:

The high impact change model action plan is not a service in itself; however it aims to improve how services and processes work better. This will have a positive impact on the overall health economy.

Sign-off:

Workstream SRO: Tracey Fletcher, Chief Executive, Homerton University Hospital, NHS Foundation Trust City of London Corporation: Neal Hounsell, Assistant Director Commissioning and Partnerships City & Hackney CCG: David Maher, Deputy Chief Officer

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Better Care Fund Performance

Activity Performance against Metric 1-4

4.1 HWB NEA Activity Plan

	Q1 17/18 Plan	Q2 17/18 Plan	Q3 17/18 Plan	Q4 17/18 Plan	Q1 17/18 Actual	Q2 17/18 Actual	17/18 Year to date
HWB Non-Elective Admission Plan Totals	**160**	**165**	**190**	**198**	**130**	**171**	**301**

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	Q1 17/18 Actual	Q2 17/18 Actual	17/18 Year to date
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	808.8	825.4	733.9	0	0	0
	Numerator	11	11	10	0	0	0
	Denominator	1,360	1,333	1,362	1,362	1,362	1,362

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	Q1 17/18 Actual	Q2 17/18 Actual	17/18 Year to date
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	87.5%	85.0%	90.0%	89%	100%	94.5%
	Numerator	7	9	9	8	7	15
	Denominator	8	10	10	9	7	16

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4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				17-18 Actuals		
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 Actual	Q2 Actual	17/18 Year to date
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	4180.3	2460.6	1600.7	2234.8	1182.3	1039.4	435.3	403.1	1182.3	2936.4	4118.5
	Numerator (total)	316	186	121	172	91	80	34	32	91	226	317
	Denominator	7,559	7,559	7,559	7,697	7,697	7,697	7,697	7,814	7,697	7,697	7697

Performance Narrative against Metric 1-4:

Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
Reduction in non-elective admissions	Not on track to meet target	The planned target for the quarter was 165 but there were 171 NEAs. Most City residents are taken to out of area hospitals where the rate of admissions of City and Hackney registered patients is higher than than other Trusts and higher than the NEL average. There is currently work underway to do a case notes review at one of these hospitals to understand any system issues and aim to reduce admissions	The case notes review will build on work that has been carried out at Homerton Hospital
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	7 out of 7 people (100%) were still at home 91 ones after admission	Our in house reablement service is effective and responsive. We have also been diligent in getting the relevant community support services for residents to maintain and build on gains made through reablement when this has sometimes been difficult.

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Delayed Transfers of Care (delayed days)	Not on track to meet target	In Q2 there were 226 days of delayed transfers of care. This is 146 days above target. However, we are disputing a number of these figures as we do not believe they are correct. It is a challenge and a resource implication to follow up on DTOCs from unexpected settings. Although we have arrangements in place with the local hospitals that we use, we cannot predict where unexpected DTOC figures which are incorrect are going to come from.	Although these figures have not yet been corrected, we have been tenacious in pursuing incorrect figures on DTOCs. All of the ones that have been reported are mental health DTOCs and this is an area of work we have started to look at as a local system. As part of our integrated commissioning arrangements, we have also agreed and started to work towards seeing DTOCs as a system wide issue rather than just the responsibility of one organisation to enable organisations to work together to address the DTOCs

Narrative report against High Impact Change Model:

National partners (LGA, ADASS, NHSE, DH, ECIP and NHSi) developed the HICM to support local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions. The model offers a practical approach to manage patient flow and discharge, and local systems were asked to self-assess how they were currently working and to develop a plan for action to reduce delays throughout the year.

The maturity assessment included the following options:

- Not yet established
- Plans in place
- Establised
- Mature
- Exemplary

		Maturity Assessment				
		Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges
Chg 1	**Early discharge planning**	Mature	Exemplary	Exemplary	This begins as soon as a notification is received from the hospital. We have a care navigator who visits any relevant patients on the ward and carries out an initial assessment.	Limited access to bed based intermediate care and ongoing issues about communication from some providers and technical issues about sharing information accordingly.
Chg 2	**Systems to monitor patient flow**	Not yet establish ed	Not yet established	Not yet established		This is not applicable as we do not have any acute hospitals within the City of London boundaries
Chg 3	**Multi-disciplinar y/multi-agency discharge teams**	Mature	Mature	Mature	There is good multi-disciplinary team working including reports from the hospital OT to ASC on needs of person being discharged. The Care Navigator and ASC attend practice MDTs	Going forward, the local system is looking at developing a neighbourhood model which could strengthen mutli-disciplinary team working further

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Chg 4	**Home first/discharge to assess**	Mature	Exemplary	Exemplary	We have a reablement plus service which can provide 24 hour social care support for up to 72 hours.	We are currently developing a placement without prejudice protocol
Chg 5	**Seven-day service**	Established	Established	Established		None identified
Chg 6	**Trusted assessors**	Not yet established	Plans in place	Established		Joint assessments are being considered as part of the wider system's work and City of London Corporation is linked in with the work that the ADAA network is co-ordinating to streamline discharges
Chg 7	**Focus on choice**	Established	Established	Mature		There are no residential or nursing homes within the City of London boundaries so limited choice for residents who want to remain in the City of London. The City of London spot purchases residential care so choice is not restricted by block contracts. Service users are able to excercise choice through personal budgets and direct payments for care packages although this is sometimes limited by the market available
Chg 8	**Enhancing health in care homes**	Not yet established	Not yet established	Not yet established		This is not applicable as there are no care homes in the City

Summary

Progress against local plan for integration of health and social care
The City of London Corporation, London Borough of Hackney and City & Hackney CCG entered into integrated commissioning arrangements from April 2017. A governance structure has been established and work is being developed through 4 work streams - unplanned care, planned care, prevention and children, young people and maternity services. These work streams have been through two assurance points to agree priorities and action plans. Work streams are looking at both transactional and transformational work.

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Title:	Hackney Better Care Fund Performance Update Q2
Date:	13 December 2017
Lead Officer:	Simon Galczynski, Director of Adult Services Siobhan Harper, Director, Planned Care, CCG
Author:	Mark Watson & Cindy Fischer
Committee(s):	Hackney Integrated Commissioning Board
Public / Non-public	Public

Executive Summary:

The purpose of this report is to update the Hackney Integrated Commissioning Board members of the position of the partnerships performance against Better Care Fund targets at Quarter 2.

The partnerships Better Care Fund Narrative plan was submitted to the London team in September 2017, and was accredited and accepted by the team in November 2017.

Due to the delays from central government on the publishing of this year's BCF guidelines and planning arrangements they have not required a Quarter 1 report.

Therefore Quarter 2 report, which was signed off by the Chair of the Hackney Health and Wellbeing Board, Cllr J. McShane, was submitted on time on the 17th November.

The partnership is monitored on four (4) metrics:

1. Non-elective admissions (General and Acute)
2. Admissions to residential and care homes
3. Effectiveness of Reablement
4. Delayed transfers of care

In summary the partnerships performance on metric 1-3 is good and we are meeting or exceeding targets.

Metric 4, Delayed Transfers of Care (DToC), has been and remains an area of challenge for Hackney as a health and care system.

Very challenging targets were set as part of the Better Care Fund for 2017/18 and 28/19. This effectively shifted the emphasis from looking at Accident and Emergency waits to DToCs by NHS England as a proxy measure for the overall efficacy of a health and care system.

The targets for non-elective admissions were increased above our 2016/17 actuals. Whilst our current performance is under plan, there is the risk that more people will be admitted to hospital throughout the winter, increasing flow through the hospital and numbers of patients requiring discharge.

In Hackney, our DToC performance in 2017 has been below target against both BCF targets and in relationship to comparators. This has led us to be placed in the bottom quartile for rate of DToC (total delayed days per day per 100,000 18+ population).

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Due to this performance we have received a joint letter from the Department of Health and the Department of Communities and Local Government, which said that we will be monitored more closely, and that some of the Improved Better Care Fund money provided to the Local Authority might be at risk.

The letter noted that we will be contacted in November to describe what will happen next. It is therefore imperative that Hackney can demonstrate rapid improvement by the end of November in its DToC Performance.

As members will be aware, a plan has been developed by the partnership to deliver and sustain improved performance, both through management actions and transformational change.

More recent performance against this target has improved.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the contents of the paper.

Links to Key Priorities:

This work links to Objective 4 of the Joint Health & Wellbeing Strategy:

"Caring for people with dementia, ensuring our services are meeting the needs of the older population."

This also directly contributed to the Unplanned Care workstream 'big ticket item':

•integrated hospital discharge.

Specific implications for City

There is a separate report covering the City of London's performance against BCF metrics.

Specific implications for Hackney

Recent communication jointly from the Department of Central and Local Government (DCLG) and Department of Health (DoH) stated that they reserve the right to reduce the published iBCF allocation for should DToC performance fail to improve. The grant conditions are linked to the three key areas outlined above, so it is unlikely that they would withdraw all iBCF funds but this is the worst case scenario for the Local Authority. It is likely that funding will continue; however it will be tied to implementation of high impact change model action plans.

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Patient and Public Involvement and Impact:

Service specifications, new service developments and challenges with performance are presented to the Patient and User Experience Group (PUEG), which was developed when the Better Care Fund was established.

PUEG has been involved in discussions since One Hackney and City ended, and has fed into the development of the Neighbourhood model.

The group also discussed the discharge to assess business case in September 2017. Dialogue included an overview of local issues with delayed transfers of care and targets set by NHSE. The group expressed their concern at the targets set and expressed the view they were unrealistic. They also expressed concern at the capacity of current services to deliver this change safely. Specifically whether there was sufficient staff capacity to manage the shift in service. Representatives also stated that intermediate care beds needs to be part of the options available to patients as not all people could be cared for at home. There was support for the model; however, the group wanted to ensure consultation continued and service users were part of ongoing work related to discharge.

A patient rep has now joined the monthly hospital discharge group and other elements of the work, will be co-produced with patients and families.

Clinical/practitioner input and engagement:

For the hospital and clinical staff, high numbers of DToCs have a significant impact on their ability to run smoothly and there is a strong link between DToCs and patients waiting for extended periods in the A&E department.

Clinicians are involved and taking the lead in the implementation of the high impact change model action plan; specifically the development of the Discharge to Assess model which will have one of the biggest impacts on the improvement of DToC figures.

Impact on / Overlap with Existing Services:

The performance action plan is not a service in itself but is looking at improving how services and processes work so will have a positive impact on the overall health economy. We will be evaluating the roll out of the Discharge to Assess model to see what impact this will have on the wider NHS and Local Authority, acute, GP and community services. The GP Confederation and a number of other partners are being invited to take part in the evaluation process.

Sign-off:

Workstream SRO: Tracey Fletcher, Chief Executive, Homerton University Hospital, NHS Foundation Trust

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

City & Hackney CCG: David Maher, Deputy Chief Officer

City and Hackney
Clinical Commissioning Group

Better Care Fund Performance

Activity Performance against Metric 1-4

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 Actual	Q2 Actual	17/18 Year to date
HWB Non-Elective Admission Plan* Totals	**5500**	**5765**	**5850**	**5952**	**5408**	**5155**	**10563**

		15/16 Actual	16/17 Plan	17/18 Plan	Q1 17/18 Actual	Q2 17/18 Actual	Q3 17/18 Actual	Q4 17/18 Actual	17/18 YTD	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	393.1	335.8	443.7	124.6459	104.7026	0	0	229.3485	418.1
	Numerator	76	66	89	25	21			46	86
	Denominator	19,332	19,655	20,057	20,057	20,057	20,057	20,057	20,057	20,569

		15/16 Actual	16/17 Plan	17/18 Plan	Q1 17/18 Actual	Q2 17/18 Actual	Q3 17/18 Actual	Q4 17/18 Actual	17/18 Actual	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	92.7%	91.2%	91.0%	88.8%	93.8%			91.7%	91.3%
	Numerator	254	238	212	151	212			363	219
	Denominator	274	261	233	170	226			396	240

		16-17 Actuals				17-18 plans					
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 17/18	Q2 17/18
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	742.1	758.1	656.1	845.1	1237.9	943.5	671.4	619.8	1237.9	
	Numerator (total)	1,571	1,605	1,389	1,820	2,666	2,032	1,446	1,357	2,666	
	Denominator	211,704	211,704	211,704	215,361	215,361	215,361	215,361	218,941	215,361	

Performance Narrative against Metric 1-4:

Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
Reduction in non-elective admissions	On track to meet target	No specific challenges	Forecast outturn for the year is less than planned as activity in both Q1 & Q2 is below plan.
Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	No specific challenges	This is on target
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	No specific challenges	This is on target
Delayed Transfers of Care (delayed days)	Not on track to meet target	DToC figures above targets and the target set nationally is very challenging.	We have worked with ELFT to review their coding which has had some positive impact. Assessments completed have also improved. We have established an improvement plan which is being reviewed weekly.

Hackney

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Narrative report against High Impact Change Model:

National partners (LGA, ADASS, NHSE, DH, ECIP and NHSi) developed the HICM to support local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions. The model offers a practical approach to manage patient flow and discharge, and local systems were asked to self-assess how they were currently working and to develop a plan for action to reduce delays throughout the year.

The maturity assessment included the following options:

- Not yet established
- Plans in place
- Establised
- Mature
- Exemplary

		Maturity assessment				
		Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	Challenges	Milestones met during the quarter / Observed impact
Chg 1	**Early discharge planning**	Established	Established	Mature	On track	Project management team assess this target as being over 90% complete. The final action is to review the SW Screener role which will report at the end of December. We have planned a full review as part of the D2A review in 9 months' time. There are also a small number of tasks outstanding with ELFT.
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	On track	50% of all actions have been complete on our HICM Action plan for this element. We have planned a number of small audits including: a DToC coding review to take place at HUH over the next 3 months; A section 5 withdrawal audit and an audit comparing planned discharge date to actual discharge date.
Chg 3	**Multi-disciplinary /multi-agency discharge teams**	Established	Established	Mature	On track	Age UK have been invited to attend Daily DToC Meetings as from 1st December. All other actions complete and we have established MD and MA discharge team.

Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Established	This is a new pilot, recruitment and change in staff culture are issues that have been identified locally.	Task & Finish group is leading on the roll out and evaluation of this work. Pathways are being agreed, recruitment has been started and the database is being amended to monitor this new workflow
Chg 5	**Seven-day service**	Plans in place	Plans in place	Established	Services already working on Saturdays and therefore the main challenge will be carrying out due process in order to change T&Cs including staff and union consultation	Project plan report suggest this is 20% complete, with consultation with staff to change T&Cs to be completed. Target is to start 7 day working from 1st April 2018.
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Established	Work on Trusted assessor with ELFT is a new area we want to develop	Project plan is 80% complete however we need to complete a few more tasks with ELFT.
Chg 7	**Focus on choice**	Plans in place	Plans in place	Established	The challenge will be to ensure the new campaign and literature has the desired effect in reducing delays as a result of patient choice.	A full review of publicity and literature is being planned to include Discharge to Assess.

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Chg 8	**Enhancing health in care homes**	Plans in place	Established	Established	Our self-assessment has shown plans established for some of the care elements; however, this work sits within various programmes /workstreams across the partner	Project plans measure this as 25% complete. Further work with commissioners is planned with a task and finish group to drive this work and complete within the next 3 months

Summary of HICM Self-assessment:

PROJECT OVERVIEW

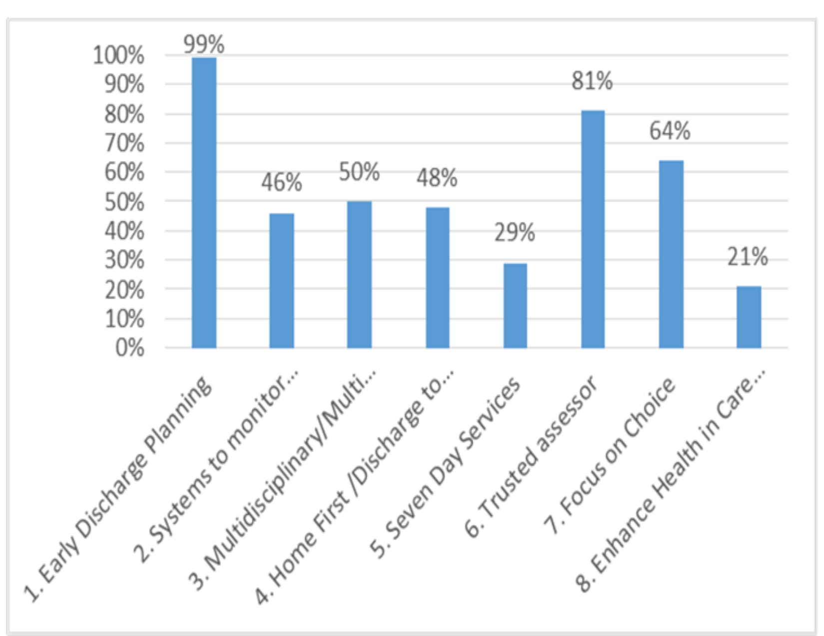
MON 02/01/17	THU 31/05/18

% COMPLETE

64%

% COMPLETE

Status for all top-level tasks. To see the status for subtasks, click on the chart and update the outline level in the Field List.



MILESTONES DUE

Milestones that are coming soon.

Name	Finish
Recruit initial staff	Mon 06/11/17

City and Hackney
Clinical Commissioning Group

Hackney

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NHS
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Clinical Commissioning Group

Summary

Progress against local plan for integration of health and social care
The London Borough of Hackney and City & Hackney CCG entered into integrated commissioning arrangements from April 2017. A governance structure has been established and work is being developed through 4 work streams - unplanned care, planned care, prevention and children, young people and maternity services. These work streams have been through two assurance points to agree priorities and action plans. Work streams are looking at both transactional and transformational work. Hackney is not achieving its DToC targets and we have increased intensity of monitoring and project management to ensure all efforts contribute to reducing DToCs. Weekly teleconferenced headed by the Director are ongoing, with a review of data accuracy - initially concentrating on non-acute DToCs. Our discharge to assess pilot is being developed and recruitment is progressing. We are using a PDSA approach and starting the pilot in 2 wards and building up as we recruit in order to ensure quick impact on our DToC figures. Our efforts to ensure all 8 HICM challenges are being worked on has also stepped up with work progressing on all 8 of the areas. September and October local figures show some improvement of DToC figures but the partnership recognise the targets are extremely challenging.

Integration success story highlight over the past quarter
Rapid assessment process (RAP) piloted on Elderly care unit at the Homerton as a first step toward a more inclusive D2A model. Essentially RAP seeks to identify an initial care package of care (POC) at ward MDT meetings and then to commission it via immediate services. This avoids the need for the completion of a full assessment whilst the service user is in hospital as it can then be completed over the next ten days once the service user is home. Care can be adjusted as needs are confirmed during the ten days to more accurately reflect those support needs. We have already seen some impact on “awaiting assessment” DTOC delays and have been able to reduce some POC’s over the 10 day period.

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Title:	**Development of City and Hackney System Outcomes Framework**
Date:	13 December 2017
Lead Officer:	David Maher, City & Hackney CCG Deputy Chief Officer
Author:	Anna Garner, Head of Performance, City & Hackney CCG
Committee(s):	Transformation Board – 8 December 2017 Integrated Commissioning Board – 13 December 2017
Public / Non-public	Public

Executive Summary:

Proposal for process for development of City and Hackney outcomes framework, including

- Principles
- Engagement plan
- Agreement of ambitions against outcomes
- Outputs

Recommendations:

The Integrated Commissioning Boards are asked:

- To **CONSIDER** the recommendations on the method for drafting an outcomes framework
- To **APPROVE** the consultation process and timelines

Links to Key Priorities:

N/A

Impact on / Overlap with Existing Services:

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

City and Hackney Accountable Care System – development of a local outcomes framework

Local and wider context to consider

NHSE and London Accountable Care principles (Appendix 1)
Aims and objectives of City and Hackney care workstreams (Appendix 2)
NHS England Improvement Payment System (national incentive scheme for Accountable Care Systems)

Draft principles for local outcomes framework

Patient focused

- Developed in collaboration with population (see below)
- 'I' statements alongside metrics that reflect performance against these

Representative of City and Hackney system aims

- Outcomes within framework represent all aims and objectives for City and Hackney 'system': several domains and indicators
- Some indicators rooted in workstreams, some overarching: giving an overarching City and Hackney outcomes framework, and under this sits workstream frameworks (across a number of themes) and individual project outcomes under that
- Reflect different needs of patients at different risk levels
- As these represent the outcomes that are important to residents and overarching system aims, outcomes will range from broad, many influenced outcomes (harder to attribute/less within our control, not all linked to health or care provided – e.g. QoL and mortality/YLL/life expectancy/age at death) to more specific outcomes attributable to specific work
- Align with London ACS principles: healthy behaviours, wider determinants of health, coordinated care, mental and physical health needs addressed together, clear pathways, timely access to care, care closer to home, choice

Timescales

- There needs to be reasonable expectation of timescales of improvements (see below) and have suitable proxies for the short/medium term.
- Process measures very reasonable for the first 1-2 years – evidence base collates what factors needed for successful integration – can use progress towards these as measures. Can decide on milestones for workstreams and how to measure progress towards patient outcomes (services in place, movement of resources, waiting times, CQUIN measures). Gives workstreams time to plan and implement new transformation projects properly
- Some of impact will be qualitative and over and above outcomes framework (assessment of what, how and why different – within aims of the external integrated commissioning evaluation specification).

Incentives attached to outcomes

- Framework needs to allow for incentives attached to national Improvement Payment Scheme and local incentives
- Phased approach/flexibility – amount of incentive linked to outcomes can change over time, as can balance between process/outcome measures and different outcomes

Monitoring and reporting

- For all outcomes, need to have considered:
    - Potential negative impact of incentives/gaming/opportunity cost/loss of focus elsewhere etc
    - What other factors will impact on performance – what is in and out of control of health and social care system?
    - Sources of data
    - Does this need bespoke data collection (e.g. population surveys etc if we can't agree on an existing measure)? Is system up for this (cost and speed implications)?

Consultation and engagement process

1. Agree consultation questions with existing resident groups (Healthwatch, PUEG, LA and CCG engagement routes, VCS, resident reps on workstreams) e.g.
    - What do you value? 'I' statements
    - What would you want from H and SC system
    - What would you want to be different to now?

2. Consult with
    a. Patients/residents
    b. Partners
    c. HWBs
    d. Workstreams

3. Output = 'I' statements, outcome domains (e.g. healthy lives, prevention, empowerment, inequalities, sustainability), metrics within these

Further analysis needed/questions to be answered

- How to best use external integrated commissioning/accountable care system evaluation team and resources to input to this?
- Current performance against metrics (baseline, trend, comparison with peers): assessment of risk and achievability of improvements against identified outcomes
- How to embed achievement of this in responsibility of system partners, workstreams, contracts? How to link payment to these outcomes?
- Should everything we do be framed around these outcomes – i.e. any new investment or new service will need to demonstrate how it will support delivery of these

- How to identify realistic ambitions we hope to achieve over next ?3? years. Who would be involved in collating evidence etc to assess what is realistic?

Sign-off:

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

City & Hackney CCG David Maher, Deputy Chief Officer

Neal Hounsell Assistant Director Commissioning & Partnerships

Appendix 1. Accountable Care principles

NHSE Accountable Care System principles

1. Develop collective governance and decision-making
2. Agree an accountable performance contract with NHS England and NHS Improvement that will include delivering faster efficiency and service improvements than elsewhere in the country (priorities include cancer, primary care, mental health, urgent & emergency care)
3. Together manage funding for the ACS's defined population through a system control total
4. Demonstrate how providers will 'horizontally integrate' whether virtually or through merger or joint management
5. Simultaneously 'vertically integrate' with GP practice formed into locality-based networks or 'hubs' of 30-50,000 populations.
6. Deploy rigorous and validated population health management capabilities
7. Establish mechanisms to ensure patient choice

London Accountable Care System principles and outcomes

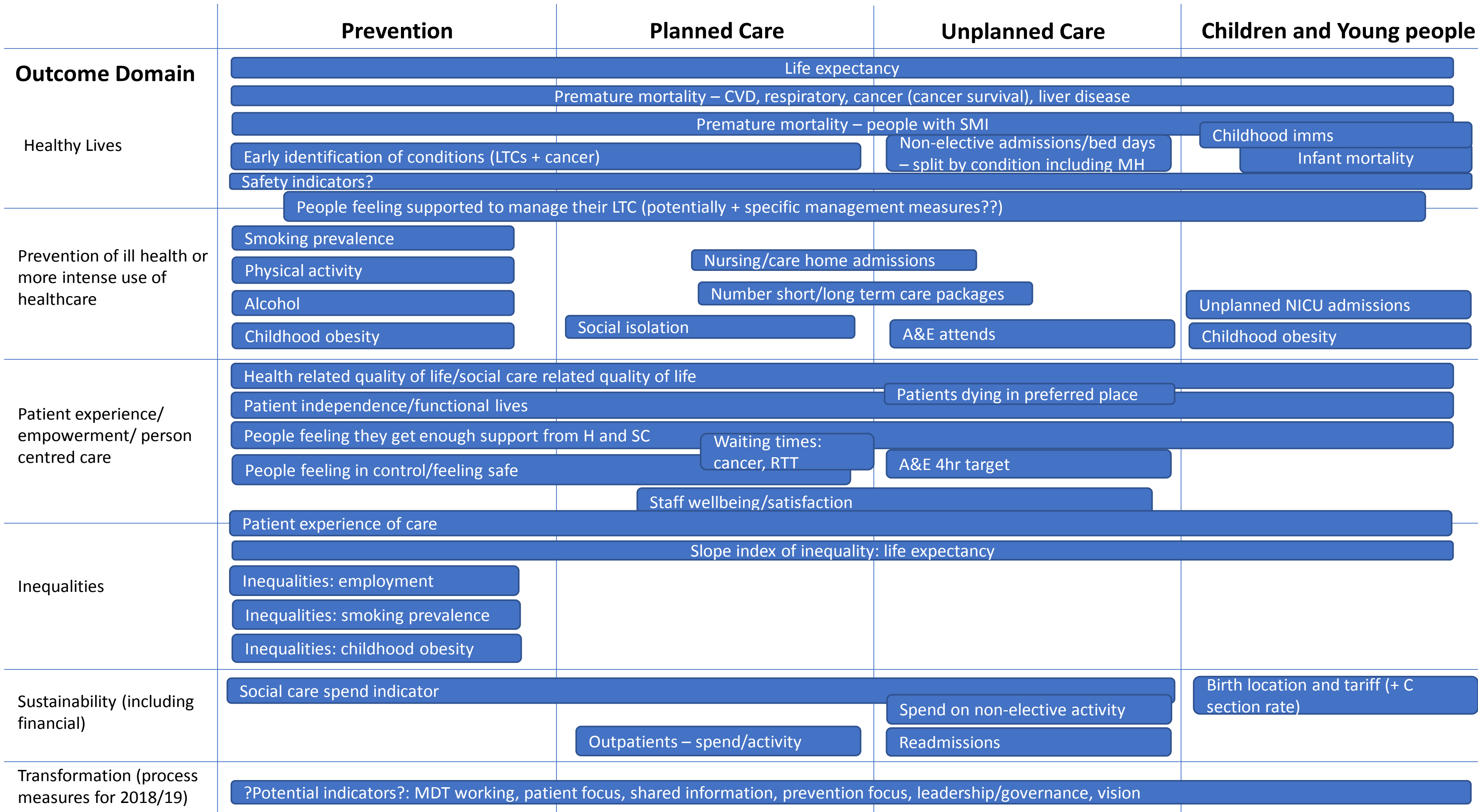
1. ACSs will put Londoners first, with collaborative working enabling partners to better understand and meet the total health and care needs of their population.
2. ACSs will focus on keeping Londoners healthy, with prevention being a fundamental part of the shared vision and becoming an ever greater part of the everyday business of all partner organisations.
3. All parties with a role in improving the health and care of the population will be involved in the ACS, and will be committed to partnership working across organisational boundaries at every level.
4. Partners will take collective responsibility for the needs of their population, and for demonstrating shared outcomes which show tangible improvements for their local communities.
5. Care is of the highest quality possible, in settings which are as close to home as possible, and incentives enable this aim to be realised.
6. ACSs will ensure that partners are collectively meeting needs and adapting to changes through an agreed financial arrangement.
7. ACS arrangements maintain all the fundamental rights of Londoners, including patient choice.

Appendix 2. Aims and objectives of City and Hackney care workstreams

As a system we want to achieve the following and each workstream will need to contribute towards this collective ambition and delivery:

- 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;
- Deliver a shift in focus and resource to prevention and proactive community based care;
- Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value;
- Ensure we deliver parity of esteem between physical and mental health;
- Ensure we have tailored offers to meet the different needs of our diverse communities;
- Promote the integration of health and social care through our local delivery system as a key component of public sector reform;
- Build partnerships between health and social care for the benefit of the population;
- Contribute to growth, in particular through early years services;
- Achieve the ambitions of the NEL STP

Appendix 3. Example format of indicators split across outcome domains and workstreams



Integrated Commissioning Boards Forward Plan, 2017/18					
Title	**Summary of Decision**	**IC Decision Pathway**	**Care Workstream**	**Reporting Lead**	**Notes**
31-Jan-18					
Stop Smoking Service	Paper confirming LBH proposals for the procurment of a new Stop Smoking Service and Single Tender Action to transfer the existing GP Hub element of the service to the GP Confederation for an interim period until end of June 2018 whilst the procurment of the new service is completed.	Transformation Board 12/1/2018 - *For discussion* Cabinet Procurement Committee 13/2/2018 - *For decision*	Prevention	Gareth Wall/Jayne Taylor	
VCS Strategy to support Transformation	To approve the strategy	CWDG - 26 Sept TB - 10 January	All	Sian Penner	
Business Case for Pooling - Prevention	To approve the business cases for further pooling of budgets			Anne Canning / Gareth Wall / Jayne Taylor	
Quality & Performance Report 2017/18 - Quarter 2	Discuss and comment on reporting for Quarter 2	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	Integrated Commissioning	n/a	Anna Garner	
Adult Social Care Services	Asking for more funding for CoLC ASC Department from CoLC Corporate Centre City ICB to discuss and endorse **City ICB only**	CoLC Policy & Resources Centre	n/a	Simon Cribbens	
Analysis of impact of Universal Credit	Discussion and to note		All	Ian Williams	
Reprocurement of LBH Advocacy Services		Transformation Board - 12 January	LBH	Anne Canning	
Progress Report on Performance Management Pilots	Discuss and note progress made to date	Transformation Board - 12 January	All	Anna Garner	
Service Redesign and Clinical Leadership	To approve the proposal	Transformation Board - 12 January	All	Clare Highton, Gary Marlowe, Providers	
Mental Health 2018/19 Recurrent investments	To endorse recommendations to the ICBs	Transformation Board - 12 January CCG Governing Body - 26 January	Mental Health (non-aligned)	Dan Burningham	
Transformation of Outpatients	Approve transformation proposals and business case		Planned Care	Neil Hounsell	
28-Feb-18					
Systems Commissionig Intentions					
Hackney Health Fund	To discuss and make recommendations	Transformation Board - 9 February CCG GB 23 February	Prevention	Gareth Wall/Jayne Taylor	
Integrated Commissioning Governance - 6 Month Review	Review and discuss outcomes of governance review and agree next steps	n/a	All	Devora Wolfson	
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	TB 10 November 2017	Planned Care / Unplanned Care / Prevention	Devora Wolfson / Clara Rutter / Nina Griffiths / Siobhan Harper / Gareth Wall / Jayne Taylor	
Procuring for Social Value	To discuss and endorse	Community and Children's Services Committee - TBC	n/a	Ellie Ward / Simon Cribbens / Devora Wolfson	
Learning Disabilities - New Model	Discuss and endorse	Transformation Board on 10 Nov	Planned Care	Simon Galczynski/ Siobhan Harper	
Care Workstream Assurance Review Point 4	Approve assurance of transfomation capacity and capability	Transformation Board - 9/2/2018 - For disussion and endorsement Governing Body - 30/3/2018 - For assurance	Planned Care / Unplanned Care / Prevention	Devora Wolfson / Nina Griffith / Siobhan Harper / Gareth Wall / Jayne Taylor	
21-Mar-18					
Reprocurement of Carers Services					
London Streaming and Redireciton Model		Unplanned Care Board - Oct	Unplanned Care	Leah Herridge	
Outcome of Review of Commissioning Governance Arrangements	Agree next steps following review of governance arrangements		All	Devora Wolfson	

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