Public Document Pack

Integrated Commissioning Sub Committee

Date: **WEDNESDAY, 31 JANUARY 2018**

Time: **10:00am**

Venue: **Tomlinson Centre, Queensbridge Road, E8 3ND**

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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 31 January 2018 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 ICB Register of Interests	1-8	
3.	Questions from the Public	Chair	Verbal	-	
4.	Minutes of the Previous Meeting	Chair *For approval* *For noting*	 4.1 Minutes of Joint ICBs meeting in common, 13 December 2017 4.2 ICBs Action Log	 9-19 20	
5.	Terms of Reference for the single Integrated Commissioning Board	Devora Wolfson *For endorsement*	5 - Terms of Reference for the single Integrated Commissioning Board	21-32	10.10
6.	City Adult Social Care Budget	Simon Cribbens *To discuss and endorse* **City ICB only**	6 - City Adult Social Care Budget	33-35	10.15

7.	Re-procurement of LBH Advocacy Services	Anne Canning *To discuss and endorse* **Hackney ICB only**	7 - Re-procurement of LBH Advocacy Services	36-44	10.30
8.	Mental Health 2018/19 Recurrent Investments	David Maher *To discuss and endorse*	8.1 - Mental Health 2018/19 Recurrent Investments - ELFT 8.2 - Mental Health 2018/19 Recurrent Investments - HUHFT	45-59 60-71	10.45
9.	Progress Report on Piloting of Perfomance Management Processes	Anna Garner *For noting*	9 - Progress Report on Piloting Perfomance Management Processes	72-76	11.00
10.	Hackney Stop Smoking Service Procurement	Anne Canning *For noting* **Hackney ICB only**	10 - Hackney Stop Smoking Service Procurement	77-103	11.10
11.	Integrated Finance Report - Month 8	Philippa Lowe / Ian Williams / Mark Jarvis *For noting*	11 - Integrated Finance Report - Month 8	104-116	11.25
12.	Integrated Commissioning Risk Management	Devora Wolfson / Matt Hopkinson *To discuss and approve*	12 - Integrated Commissioning Risk Management	117-130	11.35
13.	Update from Transformation Board	David Maher *For noting*	Verbal	-	11.45
14.	Reflections on Meeting	Chair *For discussion*	Verbal	-	11.50
15.	AOB	Chair	Verbal	-	11.55
	Attached for Information - Integrated Commissioning Boards Forward Plan (Paper 15, page 131)				

Integrated Commissioning
2017/2018 Register of Interests

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Jon	Williams	29/03/2017	Transformation Board Member - Healthwatch Hackney Attendee - Hackney Integrated Commisioning Board	Healthwatch Hackney	Director Hackney Council Core and Signposting Grant - CHCCG NHS One Hackney & City Patient Support Contract - CHCCG NHS Community Voice Contract - CHCCG Patient User Experience Group Contract - CHCCG Devolution Communications and Engagment Contract Hosted by Hackney CVS at the Adiaha Antigha Centre, 24-30 Dalston Lane	Pecuniary Interest
Simon	Cribbens	27/03/2017	Transformation Board Member - CoLC	City of London Corporation	Acting Assistant Director - Commissioning & Partnerships, Community & Children's Services	Pecuniary Interest
				Porvidence Row	Trustee	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of 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
				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

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of 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
				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
Mark	Jarvis	10/04/2017	Transformation Board Member - CoLC	City of London Corporation	Head of Finance	Pecuniary Interest
Anne	Canning	31/03/2017	Transformation Board Member - LBH LBC/CCG ICB Attendee - LBH	London Borough of Hackney	Group Director - Children, Adults & Community Health	Pecuniary Interest
				Petchey Academy & Hackney/Tower Hamlets College	Governing Body Member	Non-Pecuniary Interest
					Spouse works at Our Lady's Convent School, N16	Indirect interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Honor	Rhodes	05/04/2017	Member - City / Hackney Integrated Commissioning Boards	Tavistock Relationships	Director of Strategic Devleopment	Pecuniary Interest
				City & Hackney Clinical Commissioning Group	Lay Member for Governance	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
				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

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Haren	Patel	10/04/2017	GP Member of the City & Hackney CCG Governing Body	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				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
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

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of 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
				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

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
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
David	Maher	20/01/2017	Joint Deputy Chief Officer & Programme Director	City and Hackney Clinical Commissioning Group	Member of Cross sector Social Value Steering Group	Non-Pecuniary Interest
					Board member: Global Action Plan	Non-Pecuniary Interest
					Social Value and Commissioning Ambassador: NHS England, Sustainable Development Unit	Non-Pecuniary Interest
					Council member: Social Value UK	Non-Pecuniary Interest
Rebecca	Rennison	11/12/2017	Member - Hackney Integrated Commissioning Board	Target Ovarian Cancer	Director of Public Affairs and Services	Pecuniary Interest
				Hackney Council	Cabinet Member for Finance and Housing Needs	Pecuniary Interest
				Clapton Park Management Organisation	Board Member	Non-Pecuniary Interest
				North London Waste Authority	Board Member	Non-Pecuniary Interest
					Land Interests - Residential property, Angel Wharf	Non-Pecuniary Interest
					Residential Property, Shepherdess Walk, N1	Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Fabian Society	Member	Non-Pecuniary Interest
				English Heritage	Member	Non-Pecuniary Interest
				Chats Palace	Board Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Ruby	Sayed	13/12/2017	Member - City Integrated Commissioning Board	City of London Corporation	Elected member	Pecuniary Interest
				Sel-employed	Barrister	Pecuniary Interest
				Nirvana Capital Ltd	Founder & Shareholder	Pecuniary Interest
				Lavenham Priory, Suffolk	Owner/Proprietor	Pecuniary Interest
				Transition Finance (Lavenham) Ltd	Director & Shareholder	Pecuniary Interest
				Gaia Re Ltd	Non-Executive Director	Pecuniary Interest
				Folk2Folk Ltf	Spousal Interest	Indirect interest
				Asian Women's Resource Centre	Trustee and Chair	Non-Pecuniary Interest
				Bury St Edmonds Womens Aid	Trustee	Non-Pecuniary Interest
Jane	Milligan	02/01/2018	Member - Integrated Commissioning Board	NHS North East London Commissioning Alliance (City & Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge CCGs)	Accountable Officer	Pecuniary Interest
				North East London Sustainability and Transformation Partnership	Senior Responsible Officer	Pecuniary Interest
				n/a	Chartered Physiotherapist (non-practicing)	Pecuniary Interest
				n/a	Partner is employed substantively by NELCSU as Director of Business Development from 2 January 2018 on secondment to NHSE as London Regional Director for Primary Care	Indirect Interest
				Family Mosaic Housing Association	Non-Executive Director	Non-Pecuniary Interest
				Stonewall	Ambassador	Non-Pecuniary Interest
				Peabody Housing Association Board	Non-Executive Director	Non-pecuniary interest

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

Hackney Integrated Commissioning Board

and the

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

City Integrated Commissioning Board

Meeting of 13 December 2017

ATTENDANCE FOR HACKNEY ICB

MEMBERS

Hackney Integrated Commissioning Committee

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

Cllr Rebecca Rennison, Cabinet Member for Finance & Housing Needs

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

City and Hackney CCG Integrated Commissioning Committee

Jane Milligan, Accountable Officer, City & Hackney CCG

Haren Patel – GP Member, 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

Mark Rickets - GP Member, City & Hackney CCG Governing Body

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

STANDING INVITEES

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

Jake Ferguson – Chief Executive, Hackney Council for Voluntary Services

Jon Williams – Director, Hackney Healthwatch

OFFICERS PRESENT

Devora Wolfson – Programme Director, Integrated Commissioning

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

Nina Griffith – Workstream Director – Unplanned Care

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

APOLOGIES

Clare Highton - Chair, City & Hackney CCG Governing Body

ATTENDANCE FOR CITY ICB

MEMBERS

City Integrated Commissioning Committee

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

Cllr Ruby Sayed – Member, Community and Children's Services Committee, City of London Corporation

Cllr Marianne Fredericks – Member, Community and Children's Services Committee, City of London Corporation

City and Hackney CCG Integrated Commissioning Committee

Jane Milligan - Accountable Officer, City & Hackney CCG

Haren Patel – GP Member, 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

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

Mark Rickets - GP Member, City & Hackney CCG Governing Body

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

Geoffrey Rivett - City of London Healthwatch

OFFICERS PRESENT

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

Nina Griffith – Workstream Director – Unplanned Care

Matt Hopkinson - Integrated Commissioning Governance Manager (minutes)

APOLOGIES

Clare Highton - Chair, City & Hackney CCG Governing Body

1. Introductions

1.1.1. Randall Anderson 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 Randall Anderson of the City 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.

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 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 City Integrated Commissioning Board:

- **APPROVED** the minutes of the Joint ICB meeting on 15 November 2017; and
- **NOTED** progress on actions recorded on the action log

4.2. The Hackney Integrated Commissioning Board:

- **RATIFIED** the recommendations and endorsements made at the Joint ICB meeting on 15 November 2017;
- **APPROVED** the minutes of the Joint ICB meeting on 15 November 2017; and
- **NOTED** progress on actions recorded on the action log

4.3. **ACTION ICB DEC17-1**: To circulate the prioritization process exclusion criteria, as a reminder to members. (Anna Garner)

5. Care Workstream Assurance Review Point 1 – Children, Young People and Maternity Workstream

5.1. Amy Wilkinson presented an update on progress made to date by the Children & Young People and Maternity (CYPM) Care Workstream, since it began its work in October 2017. The paper aimed to provide assurance on the proposed governance, membership, delivery framework, key principles and identification of the transformation priorities. It set out the financial position and workstream budget, and options for future financial arrangements.

5.2. The paper had been discussed and endorsed by the Transformation Board on 8 December, and key points had been raised on the governance arrangements and workstream priorities, including affirmation of the principle that workstreams are led equally by the Senior Responsible Officer (SRO), the Clinical Lead and the Patient/Public Representative. It had been agreed that the business as usual elements of community health services and hospital paediatrics should be fully reflected in the workstream workplan.

5.3. Amy Wilkinson reported that each priority area would have key lines relating to the City of London. A meeting at CoLC was taking place later that day to discuss the matter.

5.4. Jake Ferguson endorsed the priorities set out in the report, and suggested that in order to help improve the alignment of the voluntary and public sector, he

would welcome the opportunity to host a meeting with the CYPM workstream leads in the new year.

5.5. **ACTION ICB DEC17-2:** To set up a meeting with the CYPM workstream leads in the new year. (Jake Ferguson)

5.6. The following key points were noted:

- Wider work on the overlap with safeguarding is ongoing, and this was discussed at the Safeguarding Children Board on 12 December. Nevertheless, the Boards noted that the workstream submission could have more explicitly referenced safeguarding.
- A pathway should be developed for supporting parents and young people to become more resilient.
- Adverse childhood experience should be considered in formulating the desired outcomes for the workstream.
- Emphasis should be given to the need for links with primary care, and on the need for awareness of potential impact on areas which are not priorities within the workstream (such as diabetes and asthma).

5.7. The City Integrated Commissioning Board:

- **APPROVED** 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;
- **APPROVED** 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; and
- **APPROVED** the priorities being taken forward by the workstream, noting that they are broadly aligned to our strategic priorities.

5.8. The Hackney Integrated Commissioning Board:

- **APPROVED** 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;
- **APPROVED** 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; and

- **APPROVED** the priorities being taken forward by the workstream, noting that they are broadly aligned to our strategic priorities.

6. Discharge to Assess Pilot

6.1. Nina Griffith presented the report, which sought approval to use the Hackney Better Care Fund money, for an initial period of 12 months, at a cost of £341,341 for the proposed Discharge to Assess (D2A) Pilot project; it will operate as an extension to the Integrated Independence Team. Discharge to Assess will help to improve Delayed Transfers of Care (DToC) performance.

6.2. It is important that the pilot includes strong patient feedback and that patient experience of the service is good. It was noted that the Unplanned Care team have already discussed this pilot at the Patient User Engagement Group. With regards to user experience, Nina noted that this had been to the Older People's Reference Group and that all of the feedback received was in favour of D2A. The main driver for this work is the strong evidence showing the positive impact of early discharge on recovery times.

6.3. Neal Hounsell noted that this was useful from a City of London point of view, as it would provide useful benchmarking data for comparison with the scheme in place in the City.

6.4. Jane Milligan noted that this was an opportunity to look at other capacity for step-up / step-down beds to improve the quality of outcomes for patients.

6.5. Hackney Integrated Commissioning Board:

- **AGREED** the proposal to implement a Discharge to Assess model of care across Hackney, to run for 12 months
- **APPROVED** the Business Case for Discharge to Assess
- **APPROVED** expenditure of £341,314 of the Hackney BCF to implement the model.

7. Neighbourhood Development Business Case

7.1. Tracey Fletcher and Nina Griffith presented a business case to support the planning and design phase for the City & Hackney Neighbourhood Programme. It is intended that a further business case will be submitted for the programme once a detailed specification has been worked up following this initial phase. The programme would involve fundamental changes to service delivery around population segments of 30-50,000. This was small enough to allow detailed understanding of local health needs, but big enough to allow for provision of a

broad range of services. The model would deliver on all four Better Care Fund (BCF) metrics, quality metrics and sustainability needs, and funding for the programme would come from the Hackney BCF and the City BCF.

7.2. The set-up phase would be funded non-recurrently and it was intended that detail on financial sustainability and system-wide savings to be generated by the new ways of working would be available by March 2018. It was not anticipated that the programme would have recurrent costs. It was emphasised that investment was not to supplement core services, but to transform care delivered at a local level.

7.3. The Transformation Board had discussed the report on 8 December and had raised a question about the need to confirm the contracting model, since any resources will need to flow through a contract and such a contract would set out accountability, etc. Tracey Fletcher noted that the long term contracting structure would be confirmed, subject to further discussions and the development of the programme.

7.4. The Transformation Board also voiced a concern that Neighbourhoods would run as a parallel system to care workstreams and this would lead to duplication of cost and effort. Tracey Fletcher noted that while the neighbourhood programme is being led by the Unplanned Care workstream, it involves all four workstreams. The Neighbourhood Steering Group membership is being expanded to include representation from each of the workstreams, and a mapping exercise will be undertaken in relation to the workstream and neighbourhood structures and arrangements. The Senior Responsible Officers of the Planned Care and Prevention workstreams both endorsed the Neighbourhoods model, whilst noting the complexity of the overlaps between workstreams relating to the programme. The Boards noted that workstream alignment is critical to success.

7.5. Jonathan McShane strongly advocated the proposals as the building blocks for future delivery, and noted that it is important that sufficient time and space is given to develop the approach.

7.6. Mark Rickets questioned the Value for Money assumptions in the business case, since Hackney and City have already seen significant investment in improving primary care (through the GP Confederation, etc.) and the impact would not, therefore, be as significant as it has been in benchmarked areas where the starting position was poorer. Tracey Fletcher responded that this is an evolving approach, and that the Transformation Board will be kept up to date to ensure satisfaction with the direction and outcomes of the programme including value for money.

7.7. Members welcomed the intention set out in the business case for engaging with the voluntary sector.

7.8. Neal Hounsell expressed support for the proposal from a City of London point of view, as neighbourhoods would give City residents and workers greater clarity on local service pathways, and the ability to tailor local services would suit the City's high proportion of older residents.

7.9. Whilst recognising that the development and design of the neighbourhood model would take time to develop, Jon Williams noted that there is an urgent need to be able to describe this approach to residents; particularly as this is potentially the first tangible manifestation of the integrated commissioning approach which local people can engage with and be excited about.

7.10. Honor Rhodes noted that the success of a pilot would depend on a robust IT structure with compatibility between partner systems. Tracey Fletcher responded that the IT Enabler Group has been leading on development of approaches to resolving these issues, and discussions are beginning with the workstreams to understand what they need in order to deliver their priorities. Jon Williams advised that the Discovery Programme is being developed, which will deliver a central repository and resource to enable better understanding the relationship between input and outcomes and will support connectivity between acute and primary care.

7.11. The Hackney ICB:

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

7.12. The City ICB is asked to:

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

8. Better Care Fund Performance Update - Quarter 2

City of London

8.1. Neal Hounsell introduced the update on the position of the City of London's performance against Better Care Fund (BCF) targets at Quarter 2. Performance

for the City is generally good. The paper showed poor performance on Delayed Transfer of Care (DToC); however, since the Q2 report was submitted to NHSE, over 200 days had been successfully challenged as being wrongly attributed to the City, and these would be removed from the figures.

8.2. Geoffrey Rivett noted that City of London Healthwatch would like to be able to support individual patients with delayed transfers of care. It was noted that patient identifiable information could not be included in reports, but if patients consented, then they might be contacted by Healthwatch. This was a matter to be taken up outside of the ICBs.

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

Hackney

8.4. Anne Canning introduced the report on the position of Hackney's performance against Better Care Fund (BCF) targets at Quarter 2. Performance on three of the four metrics was good, with targets being met or exceeded. Metric 4, Delayed Transfers of Care (DToC), remains an area of challenge for Hackney as a health and care system. A plan has been developed by the partnership to deliver and sustain improved performance, both through management actions and transformational change. It was noted that more recent performance in relation to this target has improved. It was expected that the Discharge to Assess pilot scheme would lead to improved performance in this area.

8.5. Jon Williams stressed the importance of step-up / step-down provision and involving patients as much as possible. Given the choice, many patients would rather receive treatment at home rather than be admitted to hospital.

8.6. The Hackney ICB **NOTED** the report.

9. Development of City and Hackney System Outcomes Framework

9.1. Anna Garner presented a high level proposal for the development of a City & Hackney outcomes framework, including principles, engagement plan, ambitions and outputs. The Transformation Board discussed the paper at its December meeting and noted that this approach is at the heart of City & Hackney's journey towards being an effective Accountable Care System that is engaged in improving outcomes and experience for local communities. A workshop is being planned to consider the way forward in detail.

9.2. The City ICB:

- **CONSIDERED** the recommendations on the method for drafting an outcomes framework
- **APPROVED** the consultation process and timelines.

9.3. The Hackney ICB:

- **CONSIDERED** the recommendations on the method for drafting an outcomes framework
- **APPROVED** the consultation process and timelines.

10. Update on Transformation Board

10.1. David Maher gave a brief update on the discussions at the Transformation Board meeting on 8 December.

11. Reflections on ICBs Meeting

11.1. It was noted that the ICB had not received the Month 7 Finance Report in the paper this month, though it had been discussed at the Transformation Board. It was noted that this would be included on future ICB agendas as a standing item. Consideration should be given to the nature of this report, since it would be more useful to focus on the pooled budget areas.

11.2. **ACTION ICB DEC17-3:** To consider the format of future finance reports to the ICB and how they can be focused on Integrated Commissioning. (Philippa Lowe)

11.3. **ACTION ICBDEC17-4:** To bring proposals to the ICBs in February on how best to engage with the public around the outcomes of Integrated Commissioning. (Jon Williams / Catherine Macadam)

12. Any Other Business

12.1. The Board thanked Neal Hounsell for his outstanding contribution to Integrated Commissioning and congratulated him on his retirement.

PART 2 - SESSION CONDUCTED IN PRIVATE

13. Contract Award Recommendation for the Evaluation of Integrated Commissioning in City & Hackney

13.1. Anna Garner presented a report outlining the procurement process and recommendations for the provision of evaluation services for Integrated Commissioning in City and Hackney.

13.2. Following a full procurement exercise, the report sought the ICBs' approval of the contract award to Cordis Bright for a three year term.

13.3. It was noted that the evaluation would be a continuous one, over a three year period, which would enable the evaluation to influence change and improvement as the Integrated Commissioning programme progressed.

13.4. Members stated that the evaluation team must be encouraged to pay particular attention to the patient involvement elements of the evaluation. It was noted that there would be clear key performance indicators built into the contract and the Evaluation Steering Group would oversee performance in this and all areas.

13.5. Honor Rhodes noted that the evaluation needs to be an iterative process over the whole of the programme. Given that there is little or no evidence-based literature on this kind of health system transformation, it would be good if City and Hackney was one of the first areas to contribute this. As a member of the Evaluation Steering Group, Honor was pleased and impressed with the procurement process and result.

13.6. The City ICB:

- **ENDORSED** the procurement process as robust enough to be assured of the capability of the highest scoring provider in carrying out the evaluation; and
- **APPROVED** proceeding to contract discussion and the contract award of £350k to Cordis Bright.

13.7. The Hackney ICB:

- **ENDORSED** the procurement process as robust enough to be assured of the capability of the highest scoring provider in carrying out the evaluation; and
- **APPROVED** proceeding to contract discussion and the contract award of £350k to Cordis Bright.

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
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 February 2018	Devora Wolfson/Ellie Ward
HICB 1709-1	To present an analysis of the impact of Universal Credit 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	Ian Williams
ICB 1711-2	To bring a paper back to the ICBs with proposals for piloting of new performance management processes.	Anna Garner	Joint Integrated Commissioning Boards	15/11/2017	31/01/2018	Complete	Please refer to Agenda Item 9.	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		Complete	Commissioners have considered the issue of liaising with neighbouring boroughs where our City and Hackney children may be attending 'out of borough' schools (in terms of the procurement and delivery of the school based health service and family nurse partnership). We have the following in place: 1. An underlying principle of service delivery that states that services work closely with partners from across health, including primary care to ensure our residents receive the health care they need, whether they are a pupil at a Hackney and City school, or at a school in a neighbouring borough. 2. A number of specific requirements within the specifications that stipulate: - FNP clients are followed by the service, or transferred to a neighbouring FNP where this exists - The SBHS works with all resident children at a number of key transition points, and there is an explicit requirement to support children at school entry, transition between schools, transition in from other areas and from early years services, and leaving school - the SBHS delivers on specific requirements around timescales for record transfers, information sharing with partners and GPs, and information sharing when children live or move out of borough.	
ICB Dec17-1	To circulate the prioritization process exclusion criteria, as a reminder to members.	Anna Garner	Joint Integrated Commissioning Boards	13/12/2017	31/01/2018	Complete		
ICB Dec17-2	To set up a meeting with the CYPM workstream leads in the new year.	Jake Ferguson	Joint Integrated Commissioning Boards	13/12/2017	31/01/2018	Open		
ICB Dec17-3	To consider the format of future finance reports to the ICB and how they can be focused on Integrated Commissioning	Philippa Lowe	Joint Integrated Commissioning Boards	13/12/2017	31/01/2018	Open		
ICB Dec17-4	To bring proposals to the ICBs on how best to engage with the public around the outcomes of Integrated Commissioning.	Jon Williams / Catherine Macadam	Joint Integrated Commissioning Boards	13/12/2017	28/02/2018	Open	This has added to the Forward Plan for February 2018.	

Title:	Revised Integrated Commissioning Board Terms of Reference
Date:	31 January 2018
Lead Officer:	Devora Wolfson, Integrated Commissioning Programme Director
Author:	Devora Wolfson, Integrated Commissioning Programme Director Matt Hopkinson, Integrated Commissioning Governance Manager
Committee(s):	CCG Governing Body - 22 December 2017 City of London Community and Children's Services Committee – 12 January 2018 London Borough of Hackney Council - 24 January 2018
Public / Non-public	Public

Executive Summary:

In March 2017, the statutory bodies (London Borough of Hackney, City of London Corporation and City & Hackney CCG) approved amendments to their respective constitutions to reflect the establishment of the Hackney Integrated Commissioning Board and the City Integrated Commissioning Board.

The LBH Integrated Commissioning Committee and the NHS City and Hackney Clinical Commissioning Group (CCG) Integrated Commissioning Committee meet in common and are known together as the Hackney Integrated Commissioning Board. There is a parallel arrangement in place in the City in which the City of London Corporation Integrated Commissioning Sub-Committee and the CCG Commissioning Committee meet in common as the City Integrated Commissioning Board. This arrangement has been in place for nine months.

Each of the three Integrated Commissioning Committees agree that there would be benefit in the three committees meeting in common given that the majority of discussions at the boards are of interest to all three partners. It will also reduce unnecessary bureaucracy. This report sets out proposals that rather than meet as a Hackney ICB (LBH Integrated Commissioning Committee and CCG Integrated Commissioning Committee) and City ICB (CoLC Integrated Commissioning Committee and CCG Integrated Commissioning Committee), a single Integrated Commissioning Board is established, made up of the three committees, although each of the committees making up the Integrated Commissioning Board decisions will continue to reach its own decision on matters under consideration.

These proposals were approved by the CCG Governing Body on 22 December and by the City of London Community and Children's Services Committee on 12 January. Proposals will be submitted for approval by London Borough of Hackney Council on 24 January.

The report asks the Integrated Commissioning Boards to note the revised terms of reference for the single ICB, and arrangements that any member of the Board who is unable to attend an ICB meeting may appoint a deputy who is a member of their organisation of the same standing (an elected member of LBH or CoLC or a member of the CCG Governing Body).

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the revised Terms of Reference for the Integrated Commissioning Board as attached at Appendix 1;
- To **NOTE** that any member of the CoLC Committee who is unable to attend an ICB meeting may appoint a deputy who is a Community and Children's Services Committee Member.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the revised Terms of Reference for the Integrated Commissioning Board as attached at Appendix 1;
- To **NOTE** that any member of the LBH Committee who is unable to attend an ICB meeting may appoint a deputy who is a Cabinet Member;
- To **NOTE** that any member of the CCG Committee who is unable to attend an ICB meeting may appoint a deputy who is a Governing Body Member.

Links to Key Priorities:

N/A

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Impact on / Overlap with Existing Services:

N/A

Main Report

1. Background

3.1 At its meeting on 27th February 2017, Cabinet approved a report proposing that the council enters into an integrated commissioning arrangements for health, social care and public health with the NHS City and Hackney Clinical Commissioning Group.

3.2 The current integrated commissioning governance is that the LBH Integrated Commissioning Committee and the CCG Integrated Commissioning Committee meet in common and are known together as the Hackney Integrated Commissioning Board. There is a similar arrangement in place in the CoLC Integrated Commissioning Sub-Committee and the CCG Commissioning Committee meet in common as the City Integrated Commissioning Board.

3.3 The integrated commissioning structure has been in place since 1 April 2017 and both the Hackney Integrated Commissioning Board and the City Integrated Board have met monthly since their first meeting in May 2017.

4 Establishment of a Single Integrated Commissioning Board

4.1 The terms of reference for the single Integrated Commissioning Board have been developed by the legal teams of the two local authorities and the legal advisers for the CCG.

4.2 Whilst it is being proposed that the LBH Integrated Commissioning Committee, the CoLC Integrated Commissioning Sub-Committee and the CCG Integrated Commissioning Committee meet in common as the Integrated Commissioning Board, each Integrated Commissioning Committee will continue to reach its own decisions on any matter under consideration. Therefore, for example, the LBH Integrated Commissioning Committee will continue to have the authority to make decisions on behalf of LBH in line with the terms of reference and the scheme of delegation.

4.3 The members for Hackney will continue to manage the Pooled Funds for which they have been assigned authority in accordance with a section 75 agreement in place between LBH and the CCG ("Hackney Pooled Funds") and shall have no authority in respect of City Pooled Funds. Similarly the members of the COLC Committee and the CCG Committee will manage the Pooled Funds for which they have been assigned authority in accordance with a section 75 agreement in place between COLC and the CCG ("City Pooled Funds") and shall have no authority in respect of Hackney Pooled Funds.

4.4 The quorum for the LBH Integrated Commissioning Committee is two of the three Council members. The revised Terms of Reference provide that any member of the LBH Committee who is unable to attend an ICB meeting may appoint a deputy who is a Cabinet Member.

4.5 The quorum for the City Integrated Commissioning Committee is three Council Members. The revised Terms of Reference provide that any member of the CoLC Committee who is unable to attend an ICB meeting may appoint a deputy who is a Community and Children's Services Committee Member.

Supporting Papers and Evidence:

Appendix 1 - Terms of Reference of the City of London Corporation Integrated Commissioning Sub-Committee, the London Borough of Hackney Integrated Commissioning Committee and the NHS City & Hackney Clinical Commissioning Group Integrated Commissioning Committee (known collectively as the "Integrated Commissioning Board")

Sign-off:

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

NHS CITY & HACKNEY CLINICAL COMMISSIONING GROUP, LONDON BOROUGH OF HACKNEY AND THE CITY OF LONDON CORPORATION

Terms of Reference of the City of London Corporation Integrated Commissioning Sub-Committee, the London Borough of Hackney Integrated Commissioning Committee and the NHS City & Hackney Clinical Commissioning Group Integrated Commissioning Committee (known collectively as the "Integrated Commissioning Board")

The City of London Corporation ("COLC") has established an Integrated Commissioning Sub-Committee ("the COLC Committee") under its Community and Children's Services Committee. The London Borough of Hackney ("LBH") has established an Integrated Commissioning Sub-Committee reporting to its Cabinet ("the LBH Committee") and NHS City & Hackney Clinical Commissioning Group ("the CCG") has also established an Integrated Commissioning Committee ("the CCG Committee"). These committees are the principal fora through which the CCG, LBH and COLC will integrate their commissioning of certain services.

This document is the terms of reference for the CCG Committee, the COLC Committee, and the LBH Committee.

The COLC Committee, the LBH Committee and the CCG Committee will meet in common and shall when doing so be known together as the Integrated Commissioning Board ("the ICB").

The COLC Committee has authority to make decisions on behalf of COLC, which shall be binding on COLC, in accordance with these terms of reference and the scheme of delegation and reservation for the integrated commissioning arrangements.

The LBH Committee has authority to make decisions on behalf of LBH, which shall be binding on LBH, in accordance with these terms of reference and the scheme of delegation and reservation for the integrated commissioning arrangements.

The CCG Committee has authority to make decisions on behalf of the CCG, which shall be binding on the CCG, in accordance with these terms of reference and the scheme of delegation and reservation for the integrated commissioning arrangements.

Except where stated otherwise (in which case the terms "the COLC Committee" and/or "the LBH Committee" and/or "the CCG Committee" or "the committees" are/is used), all references in this document to the "ICB" refer collectively to the three committees described above. The Role and Responsibilities of the ICB, as described below, are the roles and responsibilities of the individual committees insofar as they relate to the individual committee's authority.

The members of the COLC Committee and the CCG Committee will manage the Pooled Funds for which they have been assigned authority in accordance with a section 75 agreement in place between COLC and the CCG ("City Pooled Funds").

The members of the LBH Committee and the CCG Committee will manage the Pooled Funds for which they have been assigned authority in accordance with a section 75 agreement in place between LBH and the CCG ("Hackney Pooled Funds").

The LBH Committee shall have no authority in respect of City Pooled Funds. The management of City Pooled Funds is assigned to the CCG Committee and the COLC Committee. The COLC Committee shall have no authority in respect of Hackney Pooled Funds. The management of Hackney Pooled Funds is assigned to the CCG Committee and the LBH Committee.

For Aligned Fund services the ICB acts as an advisory group making recommendations to the CCG Governing Body, or the COLC Community and Children's Services Committee, or the LBH Cabinet as appropriate, in accordance with the relevant s75 agreement.

Role and Responsibilities

The ICB is the principal forum to ensure that commissioning improves local services and outcomes and achieves integration of service provision and of commissioning and delivers the North East London Sustainability and Transformation Plan (NEL STP). It is the forum for decision making and monitoring of activity to integrate the commissioning activities of the CCG, COLC and LBH (to the extent defined in the s75 agreement).

The ICB's remit is in respect of services that are commissioned using Pooled Funds (including the Better Care Fund budgets) within the Integrated Commissioning Fund (ICF). The ICB also has a remit with regard to Aligned Funds, whereby it is an advisory group making recommendations to the CCG Governing Body or the LBH Cabinet or the COLC Community and Children's Services Committee as appropriate.

The CCG and COLC, and the CCG and LBH, shall determine the funds, and therefore the services, that are to be the City Pooled Funds and the Hackney Pooled Funds respectively (to include requirements in respect of Better Care Fund budgets) subject to the s75 agreements between the CCG and COLC and the CCG and LBH. The CCG and the COLC, and the CCG and LBH, shall determine their respective Aligned Funds. Once defined, the remit will be stated in these Terms of Reference or in another appropriate document that is provided to the ICB.

In performing its role the ICB will exercise its functions in accordance with, and to support the delivery of, the City and Hackney Locality Plan and the City of London supplement and the North East London Sustainability and Transformation Plan (NEL STP).

In carrying out its role the ICB will be supported by the Transformation Board.

The duties of the ICB defined below are subject to the Scheme of Delegation, and subject to the financial framework (a schedule in each of the two s75 agreements). The s75 agreements define the budgets that are City Pooled Funds, Hackney Pooled Funds, and Aligned Funds.

Specifically, the ICB will:

Commissioning strategies and plans

- Lead the commissioning agenda of the locality, including inputs from, and relationships with, all partners
- Ensure financial sustainability and drive local transformation programmes and initiatives
- Determine and advise on the local impacts of commissioning recommendations and decisions taken at a NEL level
- Ensure that the Locality plan is delivering the local contribution to the ambitions of the NEL STP

- Lead the development and scrutiny of annual commissioning intentions as set out in the Integrated Commissioning Strategy, including the monitoring, review, commissioning and decommissioning of activities
- Provide advice to the CCG about core primary care and make recommendation to the CCG's Local GP Provider Contracts Committee
- Ensure that the locality plan delivers constitutional requirements, financial balance, and supports the improvement in performance and outcomes established by the Health and Wellbeing Boards
- Promote health and wellbeing, reduce health inequalities, and address the public health and health improvement agendas in making commissioning recommendations
- Ensure commissioning decisions are made by the ICB in a timely manner that address financial challenges of both the in-year and longer term plans.
- Ensure that local plans can demonstrate their impact on City residents and City workers where appropriate.

Service re-design

- Approve all clinical and social care guidelines, pathways, service specifications, and new models of care
- Ensure all local guidelines and service specifications and pathways are developed in line with NICE and other national evidence, best practice and benchmarked performance
- Drive continuous improvement in all areas of commissioning, pathway and service redesign delivering increased quality performance and improved outcomes
- Ensure that services are designed and delivered, using “design lab” principles – i.e. co-developed by residents and practitioners working together

Contracting and performance

- Oversee the annual contracting and planning processes and ensure that contractual arrangements are supporting the ambitions of the CCG, LBH and COLC to transform services, ensure integrated delivery and improve outcomes
- Oversee local financial and operational performance and decisions in respect of investment and disinvestment plans

Stakeholder engagement

- Ensure adequate structures are in place to support patient, public, service user, and carer involvement at all levels and that the equalities agenda is delivered
- Ensure that arrangements are in place to support collaboration with other localities when it has been identified that such collaborative arrangements would be in the best interests of local patients, public, service users, and carers
- Ensure and monitor on-going discussion between the ICB and provider organisations about long-term strategy and plans

Programme management

- Oversee the work of the Transformation Board including their work on the workstreams and enabler groups ensuring system wide implications are considered
- Ensure that risks associated with integrated commissioning are identified and managed, including to the extent necessary through risk management arrangements established by the CCG, LBH and COLC.

Safeguarding

- In discharging its duties, act such that it supports the CCG, LBH and COLC to comply with the statutory duties that apply to them in respect of safeguarding patients and service users.

Geographical Coverage

The responsibilities for the ICB will cover the geographical area of the LBH and COLC. It is noted that there will need to be decisions made about how to address the issues of resident and registered populations across the CCG and COLC and LBH and workers who travel into the city.

Membership

The membership of the COLC Committee shall be as follows:

- The Chairman of the Community and Children's Services Committee (Chair of the COLC Committee)
- The Deputy Chairman of the Community and Children's Services Committee
- 1 other Member from the Community and Children's Services Committee

The membership of the LBH Committee shall be as follows:

- LBH Lead Member for Health, Social Care and Devolution (Chair of the LBH Committee)
- LBH Lead Member for Children's Services
- LBH Lead Member of Finance and Corporate Services

The membership of the CCG Committee shall be as follows:

- Chair of the CCG (Chair of the CCG Committee)
- CCG Governing Body Lay Member
- CCG Accountable Officer

As the three committees shall meet in common, the members of each committee shall be in attendance at the meetings of the other two committees.

Any member of the CCG Committee who is unable to attend a meeting of the ICB may appoint a deputy, who shall be a GP member of the CCG's Governing Body, provided that the deputy has authority equivalent to the member that he/she represents.

Any member of the LBH Committee may appoint a deputy who is a Cabinet Member.

The COLC Community and Children's Services Committee may each year appoint up to three of its members to deputise for any member of the COLC Committee. Any such deputies appointed have full voting rights on the COLC Committee.

Any member appointing a deputy for a particular meeting of the ICB must give prior notification of this to the Chair.

The following shall be expected to attend the meetings of the ICB, contribute to all discussion and debate, but will not participate in decision-making:

- CCG Managing Director
- CCG Chief Financial Officer
- The Director of Community and Children's services (Authorised Officer for COLC)
- The City of London Corporation Chamberlain
- LBH Group Director – Finance and Corporate Services
- LBH Group Director – Children, Adults and Community Services

The following will have a standing invitation to attend the meetings of the ICB, contribute to all discussion and debate, but will not participate in decision-making:

- LBH and COLC Director of Public Health (which is a joint post)
- A person nominated by the Chief Financial Officers of the CCG and COLC
- Representative of City of London Healthwatch
- A person nominated by the Chief Financial Officers of the CCG and LBH
- Representative of London Borough of Hackney Healthwatch
- Representative of Hackney Voluntary and Community Services.

When the three committees are meeting in common as the ICB, the Chair of the LBH Committee shall lead and facilitate the discussions of the ICB for the first six months after its formation; the Chair of the CCG Committee shall perform the same role for the following six months; and the Chair of the COLC shall perform the same role for the six months after that. Thereafter the role shall swap between three Chairs, with each performing it for six months at a time.

If the Chair nominated to lead and facilitate discussions in a particular meeting or on a particular matter is absent for any reason – for example, due to a conflict of interests – another of the committees' Chairs shall perform that role. If all three Chairs are absent for any reason, the members of the COLC Committee, the LBH Committee and the CCG Committee shall together select a person to lead and facilitate for the whole or part of the meeting concerned.

The membership will be kept under review and through approval from the CCG's Governing Body, COLC's Community and Children's Services Committee and LBH's elected Mayor as appropriate. Other parties may be invited to send representatives to attend the ICB's meetings in a non-decision making capacity.

The ICB may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

Meetings

The ICB's members will be given no less than five clear working days' notice of its meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than five clear days before the date of the meeting. In urgent circumstances the requirement for five clear days' notice may be truncated.

The ICB shall meet whenever COLC, LBH and the CCG consider it appropriate that it should do so but the 3 committees meeting as the ICB would usually meet every month. When the Chairs of the CCG, LBH and COLC Committees deem it necessary in light of urgent circumstances to call a meeting at short notice this notice period shall be such as they shall specify.

Meetings of the ICB shall be held in accordance with Access to Information procedures for COLC, LBH and the CCG, rules and other relevant constitutional requirements. The dates of the meetings will be published by the CCG, LBH and COLC. The meetings of the ICB will be held in public, subject to any exemption provided by law or any matters that are confidential or commercially sensitive. This should only occur in exceptional circumstances and is in accordance with the open and accountable local government guidance (June 2014).

Secretarial support will be provided to the ICB and minutes shall be taken of all of the its meetings; the CCG, COLC and LBH shall agree between them the format of the joint minutes of the ICB which will separately record the membership and the decisions taken by the CCG Committee, the COLC Committee and the LBH Committee. Agenda, decisions and minutes shall be published in accordance with partners' access to Information procedures rules.

Decisions made by the CoLC Committee may be subject to referral to the Court of Common Council in accordance with COLC's constitution. Executive decisions made by the LBH committee may be subject to call-in by members of the Council in accordance with LBH's constitution. Executive decisions made by the CCG committee may be subject to review by the CCG's Governing Body and/or Members Forum in accordance with CCG's constitution. However, the CCG, LBH and COLC will manage the business of the ICB, including consultation with relevant fora and/or officers within those organisations, such that the incidence of decisions being reviewed or referred is minimised.

Decision making

Each of the COLC, LBH and CCG committees must reach its own decision on any matter under consideration, and will do so by consensus of its members where possible. If consensus within a committee is impossible, that committee may take its decision by simple majority, and the Chair's casting vote if necessary.

The COLC Committee, the LBH Committee and CCG Committee will each aim to reach compatible decisions.

Matters for consideration by the three committees meeting in common as the ICB may be identified in meeting papers as requiring positive approval from all three committees in order to proceed. Any matter identified as such may not proceed without positive approval from all of the COLC Committee, the LBH Committee and the CCG Committee.

These decision-making arrangements shall be included in the review of these terms of reference as set out below.

Quorum

For the CCG committee the quorum will be two of the three members (or deputies duly authorised in accordance with these terms of reference).

For the COLC committee the quorum will be all three members (or deputies duly authorised in accordance with these terms of reference).

For the LBH committee the quorum will be two of the three Council members (or deputies duly authorised in accordance with these terms of reference).

Conflicts of interests

The partner organisations represented in the ICB are committed to conducting business and delivering services in a fair, transparent, accountable and impartial manner. ICB members will

comply with the Conflicts of Interest policy statement developed for the COLC/CCG committees and the LBH/CCG committees, as well as the arrangements established by the organisations that they represent.

A declaration of interest will be completed by all members and attendees of the ICB and will be kept up to date in line with the policy. Before each meeting each member or attendee will examine the agenda to identify any matters in which he/she has (or may be perceived to have) an interest. Such interests may be in addition to those declared previously. Any such conflicts should be raised with the chair and the secretariat at the earliest possible time.

The Chair will acknowledge the register of interests at the start of the meeting as an item of business. There will be the opportunity for any potential conflicts of interest to be debated and the chair (on the basis of advice where necessary) may give guidance on whether any conflicts of interest exist and, if so, the arrangements through which they may be addressed.

In respect of the CCG Committee, the members will have regard to any such guidance from the Chair and should adopt it upon request to do so. Where a member declines to adopt such guidance it is for the Chair to determine whether a conflict of interests exists and, if so, the arrangements through which it will be managed.

In respect of the COLC Committee, it is for the members to declare any conflicts of interests which exist (taking into account any guidance from the chair) and, if so, to adopt any arrangements which they consider to be appropriate.

In some cases it may be possible for a person with a conflict of interest to participate in a discussion but not the decision that results from it. In other cases, it may be necessary for a person to withdraw from the meeting for the duration of the discussion and decision. Where the Chair (of either committee) or another person selected to lead and facilitate a meeting has a conflict of interests, the arrangements set out above (under Membership) shall apply.

When considering any proposals relating to actual or potential contractual arrangements with local GP providers the ICB will seek independent advice from the CCG Local GP Provider Contracts Committee who provide a scrutiny function for all such matters, particularly that the contract is in the best interests of local people, represents value for money and is being recommended without any conflict of interest from GPs.

All declarations and discussions relating to them will be minuted.

Additional requirements

The members of the ICB have a collective responsibility for the operation of it. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view. They will take advice from the Transformation Board and from other advisors where relevant.

The ICB functions through the scheme of delegation and financial framework agreed by the CCG, COLC and LBH respectively, who remain responsible for their statutory functions and for ensuring that these are met and that the ICB is operating within all relevant requirements.

The ICB may assign tasks to such individuals or committees as it shall see fit, provided that any such assignments are consistent with each parties' relevant governance arrangements, are recorded in a scheme of delegation for the relevant committee, are governed by terms of reference as appropriate, and reflect appropriate arrangements for the management of any actual or perceived conflicts of interest.

Reporting and relationships

The ICB will report to the relevant forum as determined by the CCG, LBH and COLC. The matters on which, and the arrangements through which, the ICB is required to report shall be determined by the CCG, LBH and COLC (and shall include requirements in respect of Better Care Fund budgets). The ICB will present for approval by the CCG, LBH and COLC as appropriate proposals on matters in respect of which authority is reserved to the CCG and/or COLC and/or LBH (including in respect of aligned fund services). The ICB will also provide advice to the CCG about core primary care and make recommendation to the appropriate CCG Committee.

The ICB will receive reports from the CCG, LBH and COLC on decisions made by those bodies where authority for those decisions is retained by them but the matters are relevant to the work of the ICB.

The ICB will provide reports to the Health and Wellbeing Boards and other committees as required.

Review

The terms of reference will be reviewed not later than six months after the date of their approval and then at least annually thereafter.

[Insert dates of approval of these TOR at each relevant forum within the CCG, LBH and COLC] – To be added

14 December 2017

Title:	City of London Adult Social Care Budget
Date:	31 January 2018
Lead Officer:	Simon Cribbens, Assistant Director, Commissioning and Partnerships, City of London Corporation
Author:	Ellie Ward, Integration Programme Manager, City of London Corporation
Committee(s):	City of London Corporation Integrated Commissioning Board
Public / Non-public	Public

Executive Summary:

There is a forecasted overspend in the City of London Corporation Adult Social Care Budget arising from the increased costs of provision and demographic pressures driving the future growth in need for service.

Members agreed to an increase in the service's recurrent budget totalling £400,000 which will be applied incrementally. In 2018/19 there will be an uplift of £265,000 to the recurrent budget rising to £400,000 in 2019/20.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the report

Links to Key Priorities:

Delivering adult social care services contributes to a number of priorities set out in the Departmental Business Plan, the Joint Health and Wellbeing Strategy and the system priorities of the integrated commissioning arrangements.

Specific implications for City

This funding relates only to the City of London Corporation Adult Social Care Budget and therefore the City of London Corporation aligned budgets in the integrated commissioning arrangements.

Specific implications for Hackney

Not applicable - This paper relates to the City ICB only.

Patient and Public Involvement and Impact:

Not applicable

Clinical/practitioner input and engagement:

Not applicable

Impact on / Overlap with Existing Services:

Ensures that existing City of London Corporation ASC Services are fully resourced to meet the increased demands that it faces.

Main Report

Background and Current Position

The City of London Corporation has a statutory duty to provide adult social care (ASC) services to adults needing short or long-term care as a result of disability, illness or the effects of age as an older person.

The escalating cost of care provision and the underlying growth in the size and life expectancy of the adult population in the City of London have placed significant pressures on current budgets.

Members agreed to an increase in the service's recurrent budget totalling £400,000 which will be applied incrementally. In 2018/19 there will be an uplift of £265,000 to the recurrent budget rising to £400,000 in 2019/20.

This uplift will now be included in aligned budgets going forward.

Conclusion

The approval of the uplift to the budget will ensure that the City of London ASC services are fully resourced to meet the increased demands that it faces, and as such continue its work to support those adults in the City of London community who require care and support.

Supporting Papers and Evidence:

A copy of the full committee report can be found here - http://democracy.cityoflondon.gov.uk/documents/s86921/asc.pdf

Sign-off:

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

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

City & Hackney CCG_____David Maher, Acting Managing Director

Title:	Re-Procurement of London Borough of Hackney Advocacy Service
Date:	5th January 2018
Lead Officer:	Simon Galczynski, Director of Adult Services, London Borough of Hackney
Author:	Christian Markandu, Strategic Commissioner for Learning Disabilities
Committee(s):	• Cabinet Procurement Committee, 6 December 2017 • Transformation Board, 12 January 2018 • Integrated Commissioning Board, 31 January 2018
Public / Non-public	Public

Executive Summary:

The purpose of the report is to inform the Integrated Commissioning of LB Hackney's Cabinet Procurement Committee's (CPC) recent decision to award a contract to 'Bidder A' for the Statutory and Non-statutory Advocacy Service following a competitive tender process.

The service shall deliver the following types of advocacy:

- Independent Mental Health Advocacy (IMHA)
- Independent Mental Capacity Advocacy (IMCA)
- Independent Care Act Advocacy (ICCA)
- Non-statutory Advocacy (including alternative types of advocacy such as peer advocacy, citizen advocacy and self-advocacy)

The new advocacy service will focus on those with the highest level of need, whilst empowering Hackney residents, and supporting local SMEs.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** LB Hackney's Cabinet Procurement Committee (CPC) decision on the 6 December 2017 to award a contract to 'Bidder A' to be the Single Lead Provider to act as a single point of access, delivering both statutory and non-statutory advocacy services in the London Borough of Hackney, for a term of 3 years, with the option to extend for a further 1 year, with the option of an additional 1 year.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board discussed the paper on 12 January and noted the LBH Cabinet's decision to award the contract.

Links to Key Priorities:

The Single Lead Provider will:

- Focus advocacy provision on those with the highest level of need whilst ensuring that they are accessible and responsive to people's needs. The Single Lead Provider will ensure a minimum of 65% of all advocacy cases represent statutory advocacy
- Sign-post inappropriate referrals to other more suitable voluntary and community-based resources within the London Borough of Hackney.
- Develop local SMEs and support them to undertake accredited advocacy training with a contractual obligation for the Single Lead Provider to direct a percentage of statutory referrals to local SMEs – this will be agreed and based on SME capacity.
- Reduce the need for non-statutory advocacy casework over the life of the contract by developing local SMEs to deliver other forms of advocacy (e.g. citizen advocacy, peer advocacy and self-advocacy).
- Continuously raise Advocacy awareness within the London Borough of Hackney and promote appropriate referrals.
- Develop alternative advocacy access points (e.g. online presence, phone line, drop-ins etc.)
- The Single Lead Provider shall sub-contract all 'non-statutory' advocacy casework to local small and medium-sized enterprises (SMEs). This shall support local sustainability and reflect the diversity of Hackney and the needs of its residents and shall leave a legacy that shall last beyond the life of the contract.
- In developing the non-statutory advocacy service the Single Lead Provider shall work in partnership with local SMEs to develop and deliver alternative approaches to advocacy such as peer advocacy, citizen advocacy and self-advocacy.

Specific implications for City

This contract is for the delivery of statutory and non-statutory advocacy service on behalf of the London Borough of Hackney only.

Specific implications for Hackney

- This approach shall empower people in the community whilst being more cost-effective by providing an alternative solution to managing the provision of non-statutory advocacy.
- Reduce the need for non-statutory advocacy casework over the life of the contract by developing local SMEs to deliver other forms of advocacy (e.g. citizen advocacy, peer advocacy and self-advocacy).
- Develop local SMEs and support them to undertake accredited advocacy training with a contractual obligation for the Single Lead Provider to direct a percentage of statutory referrals to local SMEs – this will be agreed and based on SME capacity.
- Ensure strong links with the voluntary and community sector.
- Continuously raise Advocacy awareness within the London Borough of Hackney and promote appropriate referrals.

Patient and Public Involvement and Impact:

Consultation/Stakeholders:

The Commissioning team undertook a consultation exercise between the 9th May and 29th July 2016. The consultation involved users of advocacy services. In addition it involved other stakeholders, such as Adult Social Care Professionals and Health Professionals; and Providers of advocacy services. Health services and the CCG were also included in the consultation.

The purpose of the consultation was to understand what people thought about advocacy services, the type of people who use them, what worked and what didn't and what would make services better.

The main findings of the consultation were:

Advocacy services were highly valued by those who use them, especially non-statutory advocacy:

- Many people were unaware of advocacy services
- There were some accessibility issues around current services.
- Advocacy is important for people from other cultures and people who do not speak English.
- Advocacy should enable and empower users to address specific issues.
- The introduction of Care Act Advocacy will be enable people to access social care

The findings of the consultation have been incorporated into the new advocacy model. The new service will build on the success of existing advocacy services and address the findings of the consultation.

The Commissioning Team met with advocacy providers as a group and individually to discuss the outcome of the consultation and to take them through the model and various delivery options to ensure that there was appetite in the marketplace and that the model could be successfully delivered.

Clinical/practitioner input and engagement:

Health services and the CCG were included in the advocacy consultation.

Impact on / Overlap with Existing Services:

The Single Lead Provider shall establish partnership arrangements with the following:

- London Borough of Hackney (all Council services)
- Mental Health Care for Older People Service
- Hackney Integrated Learning Disabilities Service
- East London Foundation Trust (ELFT)
- Hospital Homerton University Hospital NHS Foundation Trust
- City and Hackney Centre for Mental Health
- John Howard Centre
- Health professionals within the borough.
- Hackney Informed Voices Enterprise (H.I.V.E.)
- Hackney People First
- Deaf Plus
- HCVS (Hackney Council for Voluntary Service)
- Hackney Healthwatch
- Hackney Carers' Centre
- Hackney Autism Board
- City & Hackney CCG
- City and Hackney Safeguarding Board
- Citizens Advice Bureau
- All Housing Support Providers in the London Borough of Hackney

Main Report

Background and Current Position

The current advocacy services in the London Borough of Hackney are designed to provide issue-based advocacy and fall into statutory and non-statutory advocacy services.

In 2015/16 there were approximately 1,375 referrals with 54% of cases focusing on non-statutory advocacy services and 46% of cases focusing on statutory advocacy. There are currently four separate advocacy services in the London Borough of Hackney delivered by two providers that are within the scope of this Business Case and procurement.
A consultation in 2016 evidenced that Advocacy services are well received by services users in the London Borough of Hackney.

The current contracts 'as is' represent no singular strategic vision for advocacy services in the London Borough of Hackney, nor are they future-proofed for an increase in statutory advocacy referrals or upcoming change in legislation that may result in further increases in the number of IMCA referrals.

In addition the use of the term 'Advocacy for All' (Community Advocacy) does not reflect the need for services to target those with the highest need.
The option as set out in this Business Case will ensure a more coherent approach that is responsive and targets those with the highest need.

Commissioners have brought all statutory and non-statutory advocacy services together under a Single Lead Provider model to deliver both efficiencies and a more service-user focused, coherent and flexible service model.

The Single Lead Provider shall be contracted to deliver both statutory and non-statutory advocacy in the London Borough of Hackney.
The Service shall centre on a single referral management and screening Advocacy Hub. The Advocacy Hub shall direct appropriate advocacy referrals to the correct type of advocacy service. This shall result in a seamless and more efficient service.

The Single Lead Provider shall sub-contract all 'non-statutory' advocacy casework to local small and medium-sized enterprises (SMEs). This shall support local sustainability and reflect the diversity of Hackney and the needs of its residents and shall leave a legacy that shall last beyond the life of the contract.

In developing the non-statutory advocacy service the Single Lead Provider shall work in partnership with local SMEs to develop and deliver alternative approaches to advocacy such as peer advocacy, citizen advocacy and self-advocacy. This approach shall empower people in the community whilst being more cost-effective by providing an alternative solution to managing the provision of non-statutory advocacy.
Local SMEs shall receive accredited training to deliver statutory advocacy services

on behalf of the Single Lead Provider. This shall support sustainability within the local market and reduce the number of people waiting for a service.

Inappropriate referrals shall be sign-posted to voluntary and community resources within the London Borough of Hackney. This shall ensure that the service focuses on providing advocacy to those with the highest need, make best use of the overall advocacy budget and achieve efficiencies.

The Single Lead Provider shall be responsible for awareness raising and publicity about advocacy both within the Council as well as across the London Borough of Hackney and its stakeholders.

Options

Option one: Two Lead Providers Model: One provider delivers 'Statutory' advocacy services and another provider delivers 'Non-statutory' advocacy

Advantages	Disadvantages
• Mitigate against one provider having a monopoly on advocacy services in the borough, • Maintain a level of independence, promote competition, whilst spreading any risk.	• Duplication in the screening and referral management process • Lack of consistency for users • Inefficient in terms of service delivery and costs as the London Borough of Hackney would effectively be paying twice for front-end service costs (e.g. two screening and referral management processes). • Takes resources away from delivering actual advocacy casework which is the priority. • Limits the opportunities for joint learning and development between statutory and non-statutory services as there will always be a level of rivalry between the two lead providers

Option two: Separate contracts for Care Act Advocacy, Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Act Advocacy and Non-statutory (Community Advocacy)

This option reflects how advocacy services are currently delivered in the London Borough of Hackney.

Advantages	Disadvantages
• Spreads risk and would prevent a monopoly of the local advocacy market	• Does not provide efficiencies or a joined up service that develops local SMEs and is more challenging to contract manage and monitor.

Option three: Lead 'Contractor' to develop and coordinate advocacy services
This option is a departure from a traditional provider-based model. This option focused on a Lead Contractor coordinating the work of local SMEs and other advocacy organisations to deliver advocacy services in the London Borough of Hackney. Like the Single Lead Provider model, the lead contractor would not deliver any advocacy services directly but would manage the single referral management and screening 'Advocacy Hub' that would direct appropriate advocacy referrals to the correct type of advocacy service.

Advantages	Disadvantages
• Help build specialist advocacy capacity locally • Prevent a monopoly • Ensure that advocacy reflects the diverse population • Retains complete independence	• Lack of provider interest which could have resulted in a failed tender

Elements of this option that have been absorbed into the preferred option, namely a clear outcome for the lead provider to develop specialist advocacy within local SMEs

Equalities and other Implications:
An Equality Impact Assessment (EIA) was undertaken. In summary, the EIA identified that the new advocacy service will impact in a positive way on the most vulnerable and disadvantaged groups.

No significant environmental impacts have been identified. Minor impacts associated with staff travel and office-based work include vehicular emissions, congestion, energy and water usage, procurement and waste generation, all of which should be minimised by the contractor. This will be monitored through contract management.

Bidder A will be working with a network of Hackney SMEs. In addition to the added economic well-being that this will generate for the area, the intention is leave a sustainable advocacy provision. Annual developmental and management costs for SMEs have been frontloaded for the first two years (including the cost for accredited advocacy training for SMEs). The contract requires that London based staff working on the contract receive, as a minimum, the London Living Wage.

Proposals

The preferred option as agreed at CPC on the 6th December 2018 is for a Single Lead Provider will be contracted to deliver both 'statutory' and 'non-statutory' advocacy in the London Borough of Hackney.

The service shall deliver the following types of advocacy:

- Independent Mental Health Advocacy (IMHA)
- Independent mental Capacity Advocacy (IMCA)
- Independent Care Act Advocacy (ICCA)
- Non-statutory Advocacy (including alternative types of advocacy such as peer advocacy, citizen advocacy and self-advocacy)

The Service will centre on a single referral management and screening 'Advocacy Hub'. The Advocacy Hub will direct appropriate advocacy referrals to the correct type of advocacy service. This will result in a seamless and more efficient service.

The Single Lead Provider will sub-contract all 'non-statutory' advocacy casework to local small and medium-sized enterprises (SMEs). This will support local sustainability and reflect the diversity of Hackney and the needs of its residents.

The lead provider will develop local SMEs to deliver alternative types of advocacy such as peer advocacy, citizen advocacy and self-advocacy. This approach will empower people in the community whilst being more cost-effective by providing an alternative solution to managing the provision of non-statutory advocacy.

Local SMEs will receive accredited training to deliver statutory advocacy services. This will support sustainability within the local market and reduce the number of people waiting for a service.

Inappropriate referrals will be sign-posted to voluntary and community resources within the London Borough of Hackney. This will ensure that the Service focuses on providing advocacy to those with the highest need, make best use of the overall advocacy budget and achieve efficiencies.

The Single Lead Provider will be responsible for awareness raising and publicity on advocacy both within the Council as well as across the London Borough of Hackney.

Procuring Advocacy Services is the outcome of the Commissioning Team Review, which was managed through an integrated project board with representatives from Adult Social Care, Finance and Procurement.

The Advocacy contract will be based on an outcomes-based specification aligned to the Marmot outcomes framework and the work of the National Development Team for Inclusion (NDTi).

The four outcomes identified are:

- Person-led decision making e.g. the individual made a decision the user is happy with (NDTi)
- Individuals feel empowered and more able to self-advocate.
- Individuals' quality of life, health and wellbeing improves as a result of advocacy intervention.
- Advocacy services are accessible to disadvantaged groups including people from BAME communities and those with disabilities/impairment. (NDTi)

Conclusion

This new contract for a single lead provider to deliver both statutory and non-statutory advocacy and will empower people in Hackney.

This approach will provide further value by providing alternative advocacy solutions to managing the provision of non-statutory advocacy, and will leave a legacy that will carry on beyond the life of this contract.

Supporting Papers and Evidence:

N/A

Sign-off:

Simon Galczynski, Director of Adult Services - Childrens, Adults, and Community Health Directorate, London Borough of Hackney

Title:	**Proposals for ELFT 2018-19 Recurrent funding**
Date:	8th January 2018
Lead Officer:	Dr Rhiannon England (CCG MH Clinical Lead) Dan Burningham (CCG Director for MH)
Author:	Dan Burningham (Mental Health Programme Director)
Committee(s):	Mental Health Co-ordinating Committee, 20 November 2017 CCG Clinical Executive Committee, 13 December 2017 CYPM Workstream, 18 December 2017 CCG Finance & Performance Committee, 19 December 2017 Transformation Board, 12 January 2018 Integrated Commissioning Boards, 31 January 2018
Public / Non-public	Public

Executive Summary:

These proposals reflect the commissioning intentions issued to ELFT in the September 2017 and the 2018-19 contract variation agreed in December 2017. The investments build on existing pilots or existing services, which have demonstrated effectiveness. They are aligned to the national and local mental health strategy. These investments also support integrative approaches to care across organisational boundaries and a focus on the delivery of care within a community or primary care setting. This investment can be funded from within allocated 2018-19 mental health parity of esteem (PoE) envelope. The following recurrent investments are proposed:

1) **Street Triage.** 136 admissions have been rising in London placing stress on both healthcare and police resources. Admissions from the City are proportionately high making up about 50% of the City and Hackney total. The pilot has demonstrated benefits in terms of improved working relationships with the police and a 46% reduction in 136 admissions. Street Triage forms an important strand of our suicide prevention strategy in line with NHSE's suicide prevention targets. It is proposed that four 10 hour night time shifts per week are funded. Cost per annum: £121,000

2) **Dementia Shared Care Plans**. Co-ordinate my Care (CMC) provide care plans, which can be viewed by service users, carers and organisations involved in the person's care plan including HUH, ELFT, Alzheimer's Society (via ELFT's connection), LBH and London Ambulance. Shared care plans mean care packages are better co-ordinated and that people are more effectively held and monitored across organisational boundaries. In the event of an ambulance call out CMC plans have been found to reduce the likelihood of hospital admission because they provide important information to paramedics. The use of CMC has

already been successfully piloted with frail elderly with dementia. This funding would provide extra administrative resource to ELFT to ensure all people with Dementia are entered on to CMC. The advantages of ELFT undertaking this task are that a) it can be completed at diagnosis as ELFT run the memory clinic b) a single provider is easier to monitor c) ELFT have a major input into the care plans of more complex patients d) there is a considerable backlog of existing patients which GPs will not have time to clear. Cost per annum: £56,000

3) **Adult ADHD Clinic.** Incidences of Attention Deficit Hyperactivity Disorder (ADHD) have been rising. City and Hackney already provides a CYP service but has no counterpart for adults. Whilst ADHD often emerges in childhood, symptoms often persist into adulthood. Funding would therefore support the transition from CYP into adult services as well as newly diagnosed adult cases. The funding is to establish a small NICE compliant adult ADHD clinic staffed with 0.2 WTE psychiatry input and O.5 WTE Band 7 psychologist. ELFT estimate that this will meet current levels of demand. Cost per annum: £65,000

4) **CYP Eating Disorders.** A community eating disorder was created in 2016-17 as part of the CAMHS Transformation Plan. It consists of a hub spanning the boroughs of City and Hackney, Tower Hamlets and Newham and local spokes or teams for each borough. The service has successfully increased ED identification and early intervention but needs further resources in order to provide a full range of therapies and interventions that meet the complexity of the work. Physical health interventions are important in avoiding mortality and CYP Eating Disorders have the highest rates of mortality within CAMHS. It is proposed that nurse with physical health ED specialist expertise is added to the team and there is additional psychiatry time. Cost per annum: £63,476

Total cost of ELFT recurrent new investment: £305,476

Recommendations:

The Hackney Integrated Commissioning Board is asked to:

- **ENDORSE** the proposal for Street Triage (Unplanned Care)
- **ENDORSE** the proposal for Dementia Shared Care Plans (Unplanned Care)
- **ENDORSE** the proposal for Adult ADHD Clinic (Planned Care)
- **ENDORSE** the proposal for CYP Eating Disorders (CYP)

The City Integrated Commissioning Board is asked to:

- **ENDORSE** the proposal for Street Triage (Unplanned Care)
- **ENDORSE** the proposal for Dementia Shared Care Plans (Unplanned Care)
- **ENDORSE** the proposal for Adult ADHD Clinic (Planned Care)
- **ENDORSE** the proposal for CYP Eating Disorders (CYP)

Links to Key Priorities:

1. **Street Triage**
   The proposal aligned to local priorities to reduce unnecessary A&E admissions and the FYFV priority to improve the Crisis Care pathway and reduce suicides.
2. **Dementia Shared Care Plans**
   The proposal fits the overarching priorities for the unplanned care workstream: Enhanced Primary Care, Single point of contact and discharge. It is also aligned to the objective of improving integrated care.
3. **Adult ADHD Clinic**
   Aligned to improving the transition between CYP and adults services and the national objective of providing specialised care closer to home
4. **CYP Eating Disorders**
   Mental Health and Wellbeing is one of the "asks" of the CYP integrated commissioning board. This proposal aligns with Five Year forward view objectives in terms of having NICE compliant Eating Disorders Service meeting all requirements and standards.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board discussed the paper on 12 January and endorsed the proposals.

Specific implications for City

The provision of a City of London street triage will improve the City of London's ability to deal with mental health crisis by supporting early intervention and joint working with the police. It is will also help reduce suicide risks. All services covered in these proposals will be accessible to City patients.

Specific implications for Hackney

All services covered in these proposals will be accessible to Hackney patients.

Patient and Public Involvement and Impact:

Service User Reference Group members reviewed and endorsed these proposals through the Mental Health Coordinating Committee. The Dementia Shared Care Plans were reviewed and endorsed by the Older Person's Reference Group.

Clinical/practitioner input and engagement:

All proposals have been approved by the CCG Clinical Executive Committee in which is clinically chaired and contains mental health CCG clinical leads addition:

1. Street Triage
Developed collaboratively psychiatrists and nurses in ELFT, Local Police and LAs

2. Dementia Shared Care Plans
Developed collaboratively with partners in the C&H Dementia Alliance including psychiatrists and nurses.

3. Adult ADHD Clinic
The proposal was put forward by Dr David Bridle, Psychiatrist and ELFT's clinical lead for City and Hackney

4. CYP Eating Disorders
Developed collaboratively with partners in the C&H CAMHS Alliance including psychiatrists and nurses

Impact on / Overlap with Existing Services:

1. Street Triage

Evidence from the pilot indicates that the service will significantly improve the police capability and capacity to deal with mental health problems. It will also reduce unnecessary A&E admissions, 136 admissions and psychiatric admissions.

2. Dementia Shared Care Plans

The investment will ensure more comprehensive care plans are created for patients with dementia, which bring together a range of inputs from primary care, secondary care, the third sector, social care and other agencies. This will support the integration of the dementia pathway from primary outwards. Furthermore, the memory clinics which create the CMC inputs be embedded in the Primary Care neighbourhood model. Memory clinics will act as a primary care hub for integrated care planning via CMC at the point of diagnosis.

3. Adult ADHD Clinic

This investment will ensure that there is more specialised support for primary care around ADHD diagnosis and on-going management and advice. The consultant and psychologist will be closely linked to the Primary Care Liaison team which offers Primary Care support and will be working within the neighbourhood model. The investment also supports a smooth transition between CYP and adult services.

4. CYP Eating Disorders

By optimising Tier 3 community based specialist services, demands on Tier 4 services should be positively impacted. Patient outcomes for this high risk group will also by improved with significant reductions in risk that would normally be held in primary care otherwise.

Main Report

(Please note, the main report is divided in to four sections for each strand requiring approval)

1) Street Triage

1.1 Background and Current Position

Whilst the vast majority of people with mental disorder never come to the attention of the police, there will be many occasions where the police become involved with persons with mental ill health, who may be victims, witnesses, suspects, missing or a risk to either themselves or others. Street Triage involves ELFT psychiatric nurses working alongside the police on the streets and in response vehicles during shifts at key times where the volume of mental health incidents is likely to be high. This joint working enables a level of mental health clinical expertise and knowledge about appropriate pathways to be brought to mental heath police interventions. It also strengthens working relationships between the police and health services. It can help divert mental health cases away from the criminal justice system and

avoid the unnecessary use of 136 admission (admission to a mental health place of safety).

Police Mental health incidents have been rising steadily since 2011, in the last 3 years alone police incidents relating to mental health have increased by 31%. City of London 136 Figures are as follows:

- 2014/15 102 s136 incidents with a monthly average of 9 per month.
- 2015/16 129 s136 incidents with a monthly average of 11 per month.
- 2016/17 167 s136 incidents with a monthly average of 14 per month

With monthly figures rising largely in relation to attempted suicide in the City of London and across London there is a strong need for joint working over crisis care between the police and health services.

1.2 Results of the Pilot

An interim report on the pilot produced by the City of London Police covered a four month period of operation (June-Sept 2017). The report monitored the number of 136 admissions and also conducted a questionnaire of police staff. The report found the following:

- Total number of 136s issued whilst Mental Health Street Triage (MHST) was on duty: 8
- Total number of 136s issued outside of MHST duty times: 20
- % difference between on duty and off duty times: 60%
- Total 136s for this period: 28
- Total 136s for the same period in 2016-17: 52
- % reduction in 136s as a result of the pilot: 46%

As can be seen the number of 136s is 60% lower when the team are on duty, despite the fact shifts take place during peak incident times. Furthermore, if we compare the total 136s for the period (both on duty and off duty times) with the same period last year the impact on 136s, based on just four shifts a week is a 46% reduction in admissions. This reduction in 136s ensures that a crisis is de-escalated earlier reduces the likelihood of an inpatient admission. It also means that the trauma of being taking into a place of safety in a police vehicle is avoided. A reduction in the use of 136 and inpatient admissions means less pressure on resources and economic benefits. There is pressure at present to increase 136 capacity as part of the Pan London strategy using key sites such as City and Hackney. The likely cost of this is estimated at between £200,000-£500,000 per annum. By using street triage in both the City of London and key spots in Hackney this extra cost could potentially be avoided.

The interim report noted the following other benefits from the pilot:

- Doctors have noticed that there are less patients being brought in on 136's which has made them available to attend to other patients.
- Less pressure on 136 suite and hospital staff required to monitor patients until a doctor is able to assess the patient.
- When patients can be assessed and referred to other services by the Mental Health Support Team (MHST), undertaking street triage, rather than be taken to hospital,

The LAS are not required which impacts their service positively .

- With the proposed admission protocol changes, The MHST will be able to be even more effective in avoiding A&E attendances.
- The relationship between The Police, The NHS and LAS are being improved as MHST either avoid 136's or support patients without the need to attend hospital. MHST manage the patients when we do go to hospital to try and reduce the amount of time that MHST and the police have to stay with the patient.
- The patient is properly handed over to MH professionals at hospital and we can complete initial assessments for the doctor to ease their workload.
- Patient care is improved as they are being assessed by MH professionals at the time of the crisis and not The Police who may be less understanding or aware.
- Joint working with CMHT's, GP's, The City's Homeless Teams and alcohol services that the patient may be under is improving as MHST inform these services with any contact, previously not done so services were unaware of any crisis events with their patients.
- MHST support the mental health of anyone in contact with the police, i.e. victims of crime or an accident, domestic abuse cases. Our immediate intervention may avoid any MH issues that could occur as a result of the incident.
- MHST have greater access to clinical data on patients immediately to hand, which may support any contact between the police and patients
- MHST are highlighting issues between services. MHST are developing new joint working practices and improving communications between services.

1.3 Options / Case for Recurrent Funding

In view of the clinical benefits and cost benefits being generated by the pilot, as detailed above, it is proposed that in 2018-19 the service is recurrently funded. This will also ensure continuity of the service with existing staff. Delaying the move to recurrent funding would mean a break in service and re-recruitment, which will add complexity and cost pressures. Finally the use of Street Triage forms an important strand of our suicide prevention strategy and which supports the achievement of NHSE's targets.

The cost of continuing the pilot on a recurrent basis is £121,000 per annum. This funds nursing input alongside the police on four 10 hour night time shifts a week, 365 days a year. A cost break down is shown in the table below. Higher pay costs for unsociable hours, overtime and for working holidays and bank holidays has been factored in.

Equalities and other Implications:

The street triage service is accessed by some of the most vulnerable people in the City of London, including people who are homeless. Providing the service will therefore improve equity of access to mental health care across income groups. Furthermore, the pilots have evidenced through joint working with the police the police response to mental health has become better informed. This is likely to include improved responses to people from BME backgrounds, who are more likely to be sectioned under the mental health act.

1.4 Proposal Breakdown

Table 1: Street Triage Cost Breakdown

Input	Cost p.a.	Hours

Band 7 nurse	£112,734	Four 10 hour shifts (5p.m. - 3 a.m.) per week, 365 pa year
Supervision	£600	1 hour per month
Total pay costs	£113,334	
Non pay & overheads	£7,666	
Total	**£121,000**	

1.5 Conclusion

Street Triage has been identified as a priority because of its place within the crisis pathway and the impact it makes on people in at risk to themselves and others. This spend is aligned with the CCG's strategy of investing community based in crisis services in order to reduce inpatient admissions and A&E usage. Additional funding beyond this core CCG offer will be sought from the City of London to cover more than one area and/or to extend the hours.

2) Dementia Shared Care Plans

2.1 Background and Current Position

Co-ordinate my Care (CMC) provide care plans, which can be viewed by service users and carers and a range of organisations involved in the person's care plan including HUH, ELFT, Alzheimer's Society (via ELFT's connection), LBH and London Ambulance. Shared care plans means that care packages for people with dementia are better co-ordinated across organisations. It also means that people are more effectively held across organisational boundaries and monitored. In the event of an ambulance call out CMC plans have been found to reduce the likelihood of hospital admission because they provide important information to paramedics.

2.2 The Pilot Project

The use of co-ordinate my care has already been successfully piloted with newly diagnosed frail elderly with dementia. This cohort contains about 40% of the overall dementia cohort. The use of CMC with this group has proved a successful means of updating care plans across organisational boundaries.

2.3. Funding Proposal

This funding would extend this work to cover all people with Dementia, both the existing caseload and at the point of diagnosis. The uploading on to CMC is essentially an administrative task and one best done by ELFT as lead providers of the memory clinic. The advantages of ELFT being responsible for CMC completion are a) it takes place at the earliest point i.e. diagnosis ii) it is easier to hold a single organisation accountable for CMHC coverage than multiple GP practices iii) there is considerable backlog of existing patients and GPs are unlikely to have the time to do this iv) ELFT have a significant input into care plans for more complex patients.

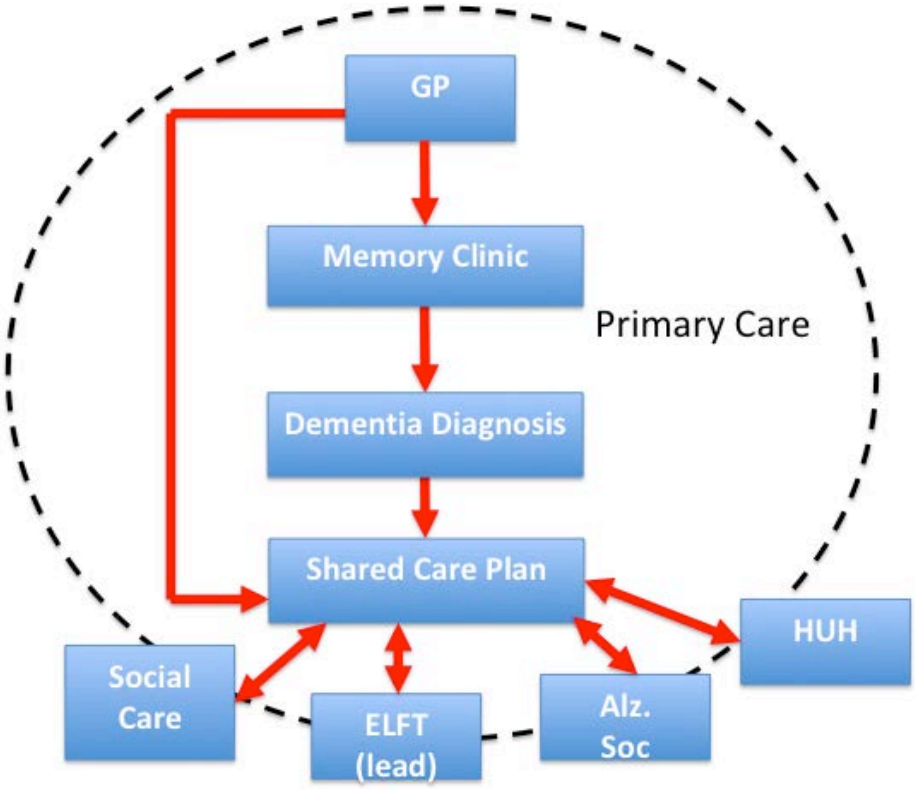
It is estimated that 1 WTE Band 5 administrator would be needed to cover new and existing cases. Once plans are uploaded to CMC other organisations can then update the care plan.

Cost per annum: £56,000

2.4. Primary Care

The investment will ensure more comprehensive care plans are created for patients with dementia, which bring together a range of inputs from primary care, secondary care, the third sector, social care and other agencies. This will support the integration of the dementia pathway from primary care outwards. Furthermore the memory clinics, which create the CMC inputs will be embedded in the Primary Care neighbourhood model. Memory clinics will act as a primary care hub for integrated care planning via CMC at the point of diagnosis. The diagram below shows the care pathway.

Figure 1: Shared Care Plan pathway



3) Adult ADHD Clinic

3.1 Background and Current Position

Incidences of Attention Deficit Hyperactivity Disorder (ADHD) have been rising. There is already a service for CYP in City and Hackney but there is no counterpart for adults. Whilst ADHD often emerges in childhood however symptoms often persist into adulthood. Funding would therefore support the transition from CYP into adult services as well as newly diagnosed adult cases. There is currently an ad hoc service within adult psychiatry but it lack professionals with the relevant training and a consistent dedicated resource.

3.2 The Proposal

The funding to establish a small NICE compliant ADHD clinic staffed with 0.2 WTE psychiatry and a 0.5 WTE psychology input. The psychiatrist would be trained in ADHD, through a brief training in assessment and treatment. The psychiatrist would conduct assessments and offer pharmacological interventions if appropriate. The O.5 WTE Band 7 psychologist would be a specialist in ADHD assessment and treatment, and would be able to offer interventions such as specialist CBT for ADHD. The psychologist would work closely together with the psychiatrist. ELFT estimate that this will meet current levels of demand. The cost per annum reflects staff costs, non-pay and on costs.

0.5 WTE Band 7 Psychologist: £50,000

0.2 WTE Consultant Psychiatrist: £15,000

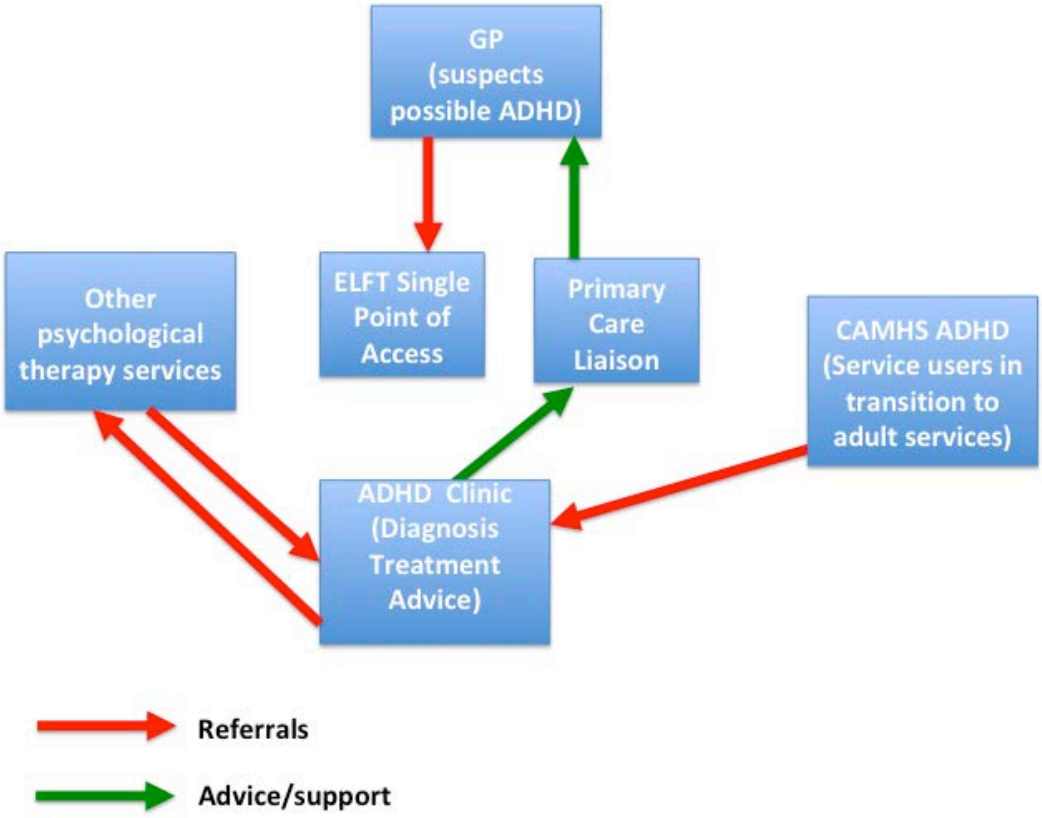
Cost per annum: £65,000

(Please note that the estimate of population need is based on current population need. If demand grows due to population expansion this will need to be reviewed.)

3.3 Primary Care

This investment will ensure that there is more specialised support for primary care around ADHD diagnosis and on-going management and advice. The consultant and psychologist will be closely linked to the Primary Care Liaison team which offers Primary Care support and will be working within the neighbourhood model. The investment also supports a smooth transition between CYP and adult services. The care pathway into and out of primary care is shown below. Other referrals into the clinic will come from existing service users in CAMHS transitioning into adult services and from re-referrals to other psychological therapies.

Figure 2: ADHD Care Pathway



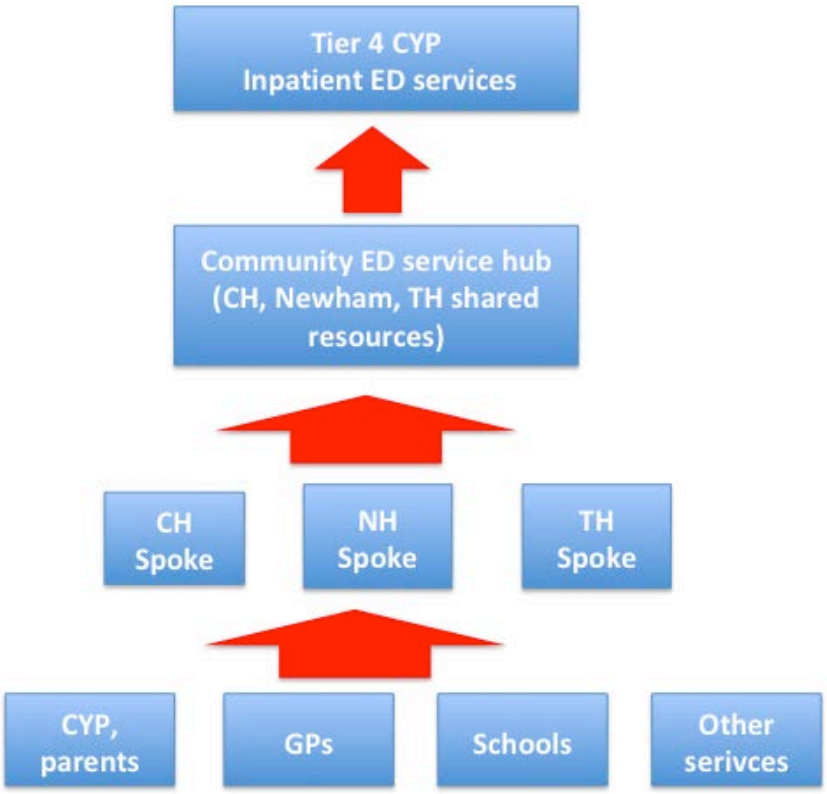
4) CYP Eating Disorders

4.1 Background and Current Position

A community eating disorder was created in 2016-17 as part of the CAMHS Transformation Plan and in line with national guidance. It consists of a hub spanning the boroughs of City and Hackney, Tower Hamlets and Newham and local spokes or teams for each borough. The teams are now successfully established but need further resources in order to provide Children and Young people with a full range of therapies and interventions that meet the complexity of the work which spans physical health issues, diet and psychological and psychiatric interventions.

Eating disorders is the mental health disorder that is linked to the highest physical co-morbidity and death. The majority of these are relating to cardiovascular complications. Hence it is important that there are adequate resources within the service to be able to facilitate the necessary investigations, interpretation of the results and appropriately manage these in relation to eating disorders. At present the team is under resourced in relation to this. The care pathway for Eating Disorder (ED) services is shown below. As can be seen the aim of the community eating disorder service is to provide an early community based intervention to reduce the need for hospital based tier 4 services. The service receives referrals and is closely linked to primary care and schools.

Figure 3: The Eating Disorder Care pathway:



4.2 Proposed Investment

4.2.1 Physical health nursing

To ensure cardiovascular complications are other physical health risks properly addressed it is proposed that Band 7 physical healthcare nurse is appointed to work in combination with a fulltime eating disorder child and adolescent psychiatrist. Both will provide the necessary investigations and interpretation of the results in a safe and effective way from the young person and their family. The nurse will offer physical monitoring, phlebotomy and ECG tracing. This will allow for the centralisation of these aspects of patient care to be held within the Community Eating Disorder Service team rather than across three agencies (i.e. CEDS, GPs and general hospital), making the process more streamlined for the patient by avoiding the to/fro from one facility to another. Furthermore process will be safer as the post-holder will be trained up to know what specific eating disorder health aspects to look for. The nurse can also link up with the relevant GPs and paediatricians to update them and ensure adequate communication across services. The post holder would also be skilled up to support meals in the general hospitals when young people are admitted for physical stabilisation/when at high risk of re-feeding.

4.2.2 Increased psychiatry time

The team currently has too little consultant psychiatry time. The current consultant psychiatry post is only for 3 days a week across all the three boroughs and this includes clinical work, liaison with GPs/paediatricians/radiologists/CAMHS, consultation slots to CEDS staff, supervision to CEDS professionals, as well as leadership, service development and management. The only other medical input in this service is four hours of general consultant paediatric time.

From a clinical perspective the consultant psychiatrist is getting calls outside of the 3 working days from the CEDS team asking for work in a number of important clinical areas including the following:

- consultation about local urgent assessments (e.g. advice around need for paediatric admission/out of range physical parameters or blood Investigations)
- consultation on follow up appointments (e.g. for physical or psychiatric co-morbid management advice or on the management of cases which are not progressing as expected)
- Requests for clinical advice from the paediatric consultants/wards around the management of young people admitted to the paediatric wards (e.g. re-feeding supplementation, correction of electrolyte imbalance, nasogastric tube feeding or the use of the mental health act).

It is therefore proposed that the consultant psychiatrist time is increased from 3 days a week to 5 days a week.

4.3 Costs

The costs below reflect the costs City and Hackney. They can be provided as an addition to the City and Hackney spoke or as part of a jointly provided hub with Newham and Tower Hamlets.
Discussions with Newham and Tower Hamlets CCG will determine which of these routes is followed.

- 0.5 WTE Band 7 Physical Health nurse: £34,148
- Increase of 0.2 WTE Band Consultant Psychiatrist: £29,328

Total: £63,476

Supporting Papers and Evidence:

Irvine A, Allen L, Webber M (2015) Evaluation of Scarborough, Whitby and Ryedale Street Triage Service, University of York

Sign-off:

The following officers have been cited and had an opportunity to input into the proposals:
David Maher, Acting Managing Director, City & Hackney CCG
Chris Pelham, Assistant Director of People, Department of Community and Children's Services, and Planned Care Senior Responsible Officer, City of London Corporation
Angela Scattergood, Senior Responsible Officer, CYPM Workstream
Amy Wilkinson, CYPM Workstream Director
Nina Griffith Unplanned Care Workstream Director
Gareth Wall, Prevention Workstream Director
Siobhan Harper, Planned Care Workstream Director
Dr Mark Ricketts, Governing Body GP, City and Hackney CCG
City and Hackney CCG: Dr Rhiannon England, Mental Health Clinical Lead
Dr David Bridle, City & Hackney Clinical Director, East London NHS Foundation Trust
Nicole Klynman, Consultant in Public Health, London Borough of Hackney
Lesley Hill, Strategic Commissioning Lead for MH, Homelessness, Advocacy, London Borough of Hackney

Title:	**Proposals for HUH 2018-19 recurrent funding for Mental Health Services** 1) Psychosexual (Planned Care) and 2) Complex Chronic Conditions Service (Planned Care)
Date:	8th January 2018
Lead Officer:	Dr Rhiannon England (MH Clinical Lead) Dan Burningham (Mental Health Programme Director)
Author(s):	Dan Burningham, Mental Health Programme Director Greg Condon, Mental Health Programme Manager
Committee(s):	Mental Health Co-ordinating Committee, 20 November 2017 CCG Clinical Executive Committee, 13 December 2017 CYPM Workstream, 18 December 2017 CCG Finance & Performance Committee, 19 December 2017 Transformation Board, 12 January 2018 Integrated Commissioning Boards, 31 January 2018
Public / Non-public	Public

Executive Summary:

This proposal reflects the commissioning intentions issued to the HUH in September 2017 and the 2018-19 contract variation agreed in December 2017. Both services involve integrating mental health and physical health and as such they are in line with national mental health strategy embodied in documents such as the FYFV and local mental health strategy. This investment proposal also supports the provision of locally based community healthcare interventions, which are closely aligned to primary care. The proposal can be funded from within the 2018-19 mental health Parity of Esteem (PoE) envelope.

Please note the Complex Conditions Service proposal may present conflicts of interest to the Transformation Board. ELFT (as the outgoing provider) and CCG (as commissioner) are still in discussion about the exit terms of the Chronic Fatigue Service. It is therefore important that this does not influence the discussion in relation to the incoming service model.

The two services covered are:

1) **The psychosexual mental health service (Planned Care),** which successfully ran for 1 year as a pilot with positive patient outcomes. **Cost: £90,940.** The cost per treatment is less expensive than the cost of an out of borough placement with a specialist provider. Prior to the local pilot most referrals were send to the SLAM Psychosexual service. Treatment costs are significantly higher than a local service: £3,540 compared to £909, locally. However, if the service was not provided, not all

of the current service costs would be transferred to SLAM and in the long run more cost effective alternatives might be found particularly for less complex patients. Nevertheless, if we assume that just 25% the 2017-18 activity completed by the local pilot (180 assessments and 80 treatments) would be transferred to SLAM, this would cost £90,735 making the service effectively cost neutral. The advantages or providing a local service are: care closer to home, better links to local care pathways and alignment with our local strategy of integrating mental and physical health.

2) **Complex Chronic Conditions Service (Planned Care)**. ELFT will no longer provide a Chronic Fatigue Service from 1st April 2018 onwards for the boroughs of Newham, Tower Hamlets, the City and Hackney. The proposed service model is for a local City and Hackney only service rather than a tri-borough service. The other boroughs will be making their own arrangements. It will also combine chronic pain and chronic fatigue within a Complex Chronic Conditions Service. Recommended treatments for chronic fatigue and chronic pain share important similarities such as the use of physiotherapy, psychology and occupational therapy with required medical input. The new combined service will therefore allow expertise to be shared between chronic pain and chronic fatigue. The service will comply with NICE Chronic Fatigue guidelines (NICE, 2107)

Providing a commissioned service is significantly less expensive than spot purchase with an average cost per treatment of £2,327 compared to £4,258 for a spot purchase. Furthermore, Chronic Fatigue patients tend to find travelling problematic particularly in the initial phases of treatment and hence there are strong advantages to providing a local service. The Homerton University Hospital are the only local provider of a chronic pain service and are a provider that is fully integrated into the Hackney and City integrated commissioning arrangements. As a provider, they also have locally accessible clinical space that can be used to deliver the services. The CCG has completed a single tender waiver for sign off by the Chief Officer. There will be a gap between the ending of the ELFT's service and a local service becoming operational. This will be filled by the use of spot purchase.

Total recurrent cost: £186,142. There is also a non-recurrent start-up cost of £24,800 to cover clinical consultancy to finalise the service model design and management backfill to create operational policies, systems and structures.

Recommendations:

The Hackney Integrated Commissioning Board is asked to:

- **ENDORSE** the proposal for Psychosexual mental health service (Planned Care)
- **ENDORSE** the proposal for Complex Chronic Conditions Service (Planned Care)

The City Integrated Commissioning Board is asked to:

- **ENDORSE** the proposal for Psychosexual mental health service (Planned Care)
- **ENDORSE** the proposal for Complex Chronic Conditions Service (Planned Care)

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board discussed the paper on 12 January and endorsed the proposals.

Links to Key Priorities:

1. Psychosexual mental health service
   Aligns to the following priorities of the Planned Care Workstream: 1) Outpatient Transformation, 2) Community Health Services
2. Complex Chronic Conditions Service
   Aligns to the following priorities of the Planned Care Workstream: 1) Outpatient Transformation, 2) Community Health Services with future scope to 3) IAPT

Specific implications for City

Psychosexual mental health service
This service will be based at Homerton Hospital. Patients will have the option to access services closer to home if required. The CCG will pay under "who pays guidance" in these instances. Otherwise implications for City residents are the same as for Hackney.

Complex Chronic Conditions Service
This service will be based at St Leonards Hospital and easily accessible for City Patients. Patients will have the option to access services closer to home if required. The CCG will pay under "who pays guidance" in these instances.
Otherwise implications for City residents are the same as for Hackney.

Specific implications for Hackney

Both services will be based in Hackney providing optimised accessibility for Hackney patients. Otherwise implications for Hackney residents are the same as for the City.

Patient and Public Involvement and Impact:

Service User Reference Group members reviewed and endorsed these proposals through the Mental Health Coordinating Committee in November 2017 and the Patient Public Involvement Committee in December 2017.

Clinical/practitioner input and engagement:

1. **Psychosexual mental health service**
   Dr Rhiannon England, Clinical Lead MH (CCG)
   Dr David Bridle, Clinical Director, City and Hackney (ELFT)
   Dr Sarah Zetler, Clinical Psychologist (HUH)
   Dr Sarah Creighton, Lead Consultant Sexual Health (HUH),

2. **Complex Chronic Conditions Service**
   Dr Rhiannon England, Clinical Lead MH (CCG)
   Dr David Bridle, Clinical Director, City and Hackney (ELFT)
   Hilda Walsh, Operational Lead Locomotor Services (HUH)
   Dr Melanie Rendall, Principal Clinical Psychologist (HUH)

Impact on / Overlap with Existing Services:

1. **Psychosexual mental health service**
   The service will offload primary care management of these conditions as well as providing appropriate services locally for primary care to refer to. The service could reduce inappropriate referrals to Gynaecological and Urology acute care services.
2. **Complex Chronic Conditions Service**
   The new service model will require GPs to manage the pre-referral diagnostics including blood tests. The service will be integrated in to the exiting locomotors service with joined governance structures to ensure high quality of care.

Main Report

(Please note, the main report is divided in to two sections for each strand requiring approval)

1. Psychosexual mental health service

1.1 Key Issues

1.1.1 Costs

- The CCG receives a significant numbers of funding requests for Psychosexual Health referrals mainly to the Royal London and SLAM, which were funded via the CCGs Non-Contracted Activity Budget.
- Primary care representatives are reporting a significant overburden through having to manage Psychosexual Health problems internally without specialist local support
- Where no appropriate local specialist service was available it was hypothesised that support from secondary care is being sought:
  - Gynaecology referrals for Females
  - Urology referrals for males
  - Pain services

1.1.2 Patient Care

- Patients having to access care out of area / Access issues
- Patients being referred to services that could not meet their needs
- Patients outcomes negatively impacted

1.1 Background and Current Position

In 2017/18 The Sexual Health Service at Homerton University Hospital NHS Foundation Trust was commissioned to pilot a Psychosexual Health Service. The key clinical pathways focused on were:

Females:

- Vulval Pain
- Anorgasmia
- Loss of Desire
- FGM related difficulties

Males:

- Erection Difficulties
- Premature / Delayed Ejaculation
- Loss of Desire
- Painful sex

The pilot was developed to test viability as a solution to a system pathway issues that result in subsequent significant cost pressures:

- Referrals to out of area Psychosexual Health Services from primary care covered by the CCG's Non-Costed Activity (NCA) Budget
- Significant demand managed in primary care with repeat attendance
- Inappropriate referrals to secondary care, e.g. Gynaecology and Urology.

The aim of the work was: to improve clinical outcomes for City and Hackney patients, who are experiencing Psychosexual mental health issues by better meeting their needs locally and to improve access to appropriate healthcare interventions at the right time and right place. The pilot began in April 2017 and will run to March 2018 (4 more months from date of this paper). This business proposal details a strong case for recurrent funding of the service beyond March 2018 and recommends approval. Without approval by end of January 2018, the service will stop accepting new referrals and wind down its existing caseload for termination of service on 31st March 2018. There is also likely to be a loss of staff, as staff seek to make other arrangements in relation to an uncertainty around continuity.

1.2 Results of the Pilot

A stepped care model was established in 2017 based on the following steps:

Level 1

Level 1 interventions provide psycho-education and guided self-help exercises to people with psychosexual difficulties who present at a variety of healthcare settings. A resource pack, consisting of self-help material has been developed to assist healthcare professionals

in talking with patients around sexual difficulties.

Level 2

Level 2 services provide joint medical and psychological assessment within HSHS. Following assessment, patients can be offered medical follow-up and/or short term psychological interventions. If treatment within HSHS is not considered appropriate onward referral to the most appropriate mental or physical health service is recommended.

The table below shows the staffing for the service:

Table 1: Staffing

Staff group	Time taken per week	WTE	WTE including absences (+23%) where needed
Consultant Doctor (resourced outside of this contract)	Development, dissemination and evaluation of resource pack for level 1 service	0.5	Resourced outside of this contract
Consultant Doctor 1WTE = 40hr/week	5 new patient consultations x 30 min 1 follow-up patient consultation x 30 min Letter writing 6 x 10 min Onward referrals 1 x 30 min	4.5/40 = 0.11 WTE	0.14 WTE
Band 7 psychologist 1WTE = 37.5hr/week	5 new patient consultations x 60 mins 20 follow-up patient consultations (assuming that patients are offered up to 6 sessions and arrange an average of 4) x 60 mins Letter writing (after assessment and end of treatment) 10 x 20 mins Onward referrals 2 x 30 min Clinical supervision 1 x 60 min Total	30 hours/37.5 = 0.8 WTE	1.2 WTE
Band 8c psychologist 1WTE = 37.5hr/week	Clinical supervision x 60 mins	1/37.5 = 0.027 WTE	0.027 WTE
Band 2 secretary 1WTE = 37.5hr/week	Typing letters 16 x 15 min	4/37.5 = 0.11 WTE	0.13 WTE
Band 2 receptionist 1WTE = 37.5hr/week	Registering new patients 5 x 12 mins Booking appts/FU patients 20 x 3 mins	0.53 WTE	0.07 WTE

The performance of the service was as follows;

Table 2: Service Key Performance Measures

	Q1	Q2	End of pilot Trajectory
KPI1: No of referrals	152	86	410
KPI2: No. assessed	49	42	180
KPI3: No. suitable for treatment	38	35	146
KPI4: No. completing treatment	1	14	80
KPI5: Improvement in symptoms	100%	93%	95%
KPI6: % assessed within 13 weeks / 18 weeks	100%	71% / 100%	100% / 75%
KPI7: No. diverted from other services	80	48	224
KPI8: Onward referrals	14	6	32

Consultations diverted were measured using our standard referral form. A question was included asking referrers to indicate where they would have sent patients had our service not been available to them. Where this was not completed on receipt of referral, the referrer was contacted for a response. A diversion has been classified as a referral that would otherwise have been sent to Urology, Gynaecology, Fertility or Psychosexual Services out of area (with the national service in SLAM being the most common).

Table 3: Further KPIs

Diversion Source	**Q1**	**Q2**	**End of Pilot trajectory**
Urology	10	7	22
Gynaecology	15	10	31
Fertility	1	0.5	2
Psychosexual Services (out of area)	39	26.5	110
Other (i.e., Endocrinology; Diabetes; Primary or Secondary Care Psychology	15	10	26

1.3 Equalities and other Implications:

The provision of a local service is likely to increase access to psychosexual interventions for local residents. The service will also provide equality of access to people regardless of gender, age, ethnicity, disability or sexual orientation and will adhere to a strict equality and diversity policy.

1.4 Proposal Breakdown

The service is functioning well and able to meet its targets. It reported a slight under capacity to meet demand resulting in a backlog. This will be resolved by an additional 0.2WTE Band 5 to the existing capacity. Clinical outcomes were very strong as were patient experience measures. There are strong cost benefits from providing a local service as out of borough placements are considerably more expensive. The pilot is due to end in April 1st 2018 and if the service is not commissioned on a recurrent basis at this point there will be a loss of continuity and likely loss of current staff. The costs of the service, based on the staffing

identified in table 1 is **£90,940 per annum**.

The cost of a local service is significantly less expensive than the cost of an out of borough placement with a specialist provider. Prior to the local pilot most referrals were send to the SLAM Psychosexual service. Costs per assessment are £443 and £3,540 per treatment. This compares to an estimated local cost of £100 per assessment and £909 per treatment. However, if the service was not provided, not all of the current service costs would be transferred to SLAM and in the long run more cost effective alternatives might be found for less complex patients. Nevertheless, if we assume that just 25% the 2017-18 activity completed by the local pilot (180 assessments and 80 treatments) would be transferred to SLAM. This would cost £90,735 making the service effectively cost neutral. The advantages or providing a local service are: care closer to home, better links to local care pathways and alignment with our local strategy of integrating mental and physical health.

1.5 Conclusion

The pilot has demonstrated that a locally commissioned psychosexual service will provide care closer to home, improved links to care pathways and better value for money than using existing out of borough provision. It is therefore recommended that recurrent funding for the service is approved.

2. Replacement of the Chronic Fatigue Service

2.1 Background and Current Position

Having given the CCG notice to terminate delivering the service, on 31st March 2018 ELFT will cease to operate its Chronic Fatigue Service for ELC CCG's (Newham, Tower Hamlets and City & Hackney). As of December 2017, ELFT is no longer accepting referrals for City and Hackney Patients and the CCG will be spot purchasing from its Non-Costed Activity Budget.

The new service model will replace the tri-borough model with a City and Hackney only service. It will also combine chronic pain and chronic fatigue within a Complex Chronic Condition Services. Recommended treatments for chronic fatigue and chronic pain share important similarities such as the use of physiotherapy, psychology and occupational therapy with required medical input. The new combined service will therefore allow expertise to be shared between chronic pain and chronic fatigue. It is also essential that the service is commissioned locally as this patient group find it hard to travel. Combining fatigue and pain services will also lead to economies of scale meaning the service offers better value for money than if it was procured.

The Homerton University Hospital are the only local provider of a chronic pain service and are a provider that is fully integrated into the Hackney and City integrated commissioning arrangements. As a provider they also have locally accessible clinical space that can be used to deliver the services.

2.2 Key issues

Spot purchasing is 82% more expensive compared to a locally commissioned services. City and Hackney receive approximately 70 patients per year for Chronic Fatigue Assessment and Treatment. The average cost of a full treatment from a spot purchase arrangement is

£4,258 compared to an estimated cost of £2,327 for a locally commissioned service. Although it is possible a local service could lead to a higher volume of demand, nevertheless it seems likely that a local service would be less costly than spot purchase arrangement. Service level agreements are only marginally less expensive. Furthermore, Chronic Fatigue patients tend to find travelling problematic particularly in the initial phases of treatment and hence there are strong advantages to providing a local service.

Therefore providing a replacement service will be significantly less expensive than the alternative of spot purchasing arrangement and better for patients. Economies of scale can be realised by aligning the new service to HUH's pain clinic.

2.3 Service Objectives

- To provide an equitable specialist CFS/ME service across City and Hackney
- To provide specialist input based on need in proportion to the population profile
- To implement NICE guidance
- To improve Health and wellbeing promoting social inclusion and improving economic productivity
- To ensure, that appropriate targets are met
- To ensure people with CFS/ME have improved health and wellbeing outcomes including social inclusion, and access to mainstream health and social care systems
- To ensure sufficient capacity, utilised productively to:
    - Provide timely response
    - Promote Patient Choice
    - Avoid Waiting lists
    - Provide specialist therapy skills where required

2.4. Service Model

2.4.1 Provider: The replacement service will managed by Homerton University Hospital NHS Foundation Trust

2.4.2 Location: Chronic Fatigue Service, 'A' Block, St Leonard's, Nuttall Street, London,N1 5LZ

2.4.3 Days/ hours of operation
Monday – Friday 9am-5pm

2.4.4 Referral processes
GP or other medical practitioner (Medical test conducted and included in referrals)

The therapies and treatments offered are consistent with the NICE guidelines (http://guidance.nice.org.uk/)

2.4.5 The Model of Care
The NICE (2007) guidelines describe a specialist CFS/ME service as:
'A service providing expertise in assessing, diagnosing and advising on the Clinical management of CFS/ME, including symptom control and specific interventions. Ideally this is provided by a multidisciplinary team, which will have appropriate access to clinicians with a special interest in the condition'

The service will offer a stepped approach dependent on need and based on the levels of

severity as defined in the NICE guidance. Providing a person-centred programme that aims to:

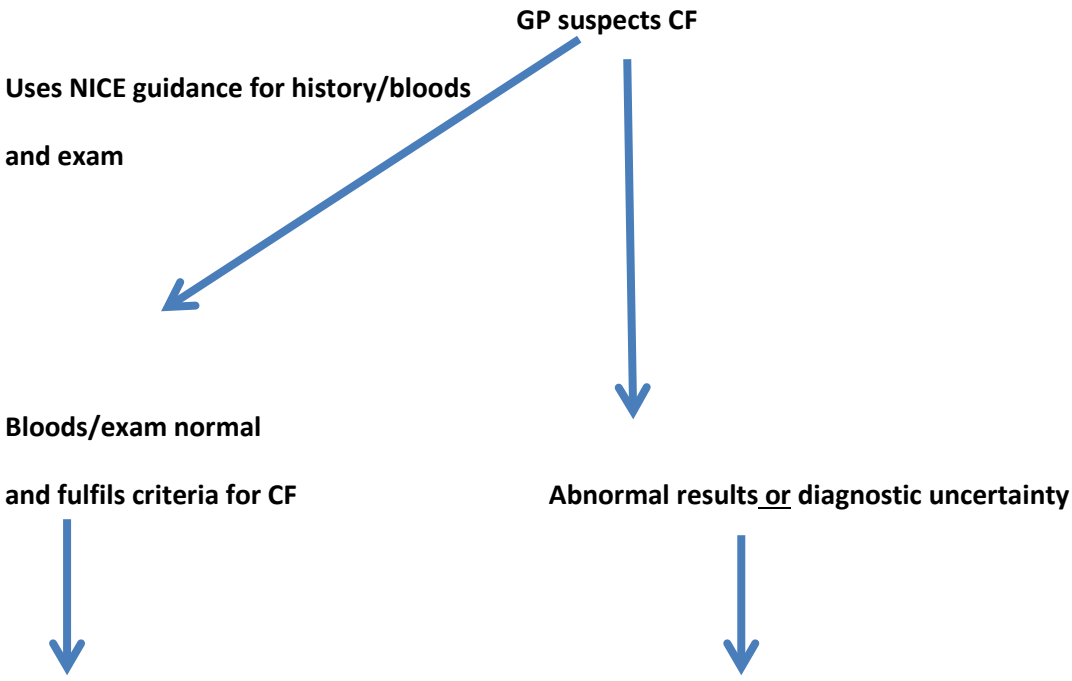
- Sustain or extend the physical, emotional and cognitive capacity based on their needs, the type , duration, complexity and severity of their symptoms and the presence of co-morbidities
- Manage and treat the physical and emotional impact of symptoms and their underlying cause.
- Signpost to appropriate local support networks, health, social care, employment and voluntary organisations dependent on need.
- Facilitate effective management which includes engagement with family and carers
- Meet the identified needs of adults (18+) in the City & Hackney and be equitable across this area.
- Liaise with children's services regarding transitions to adult services and the development of children's services

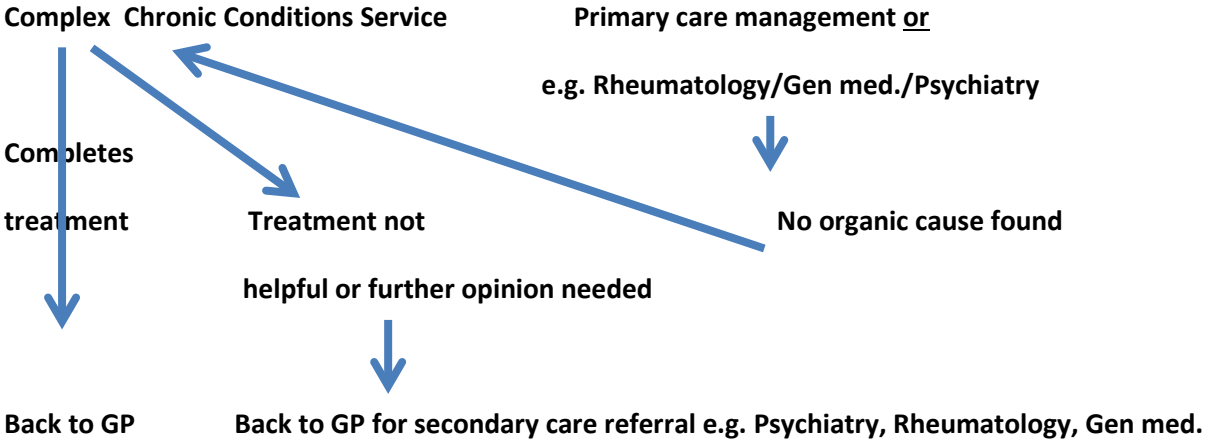
3.3.6 The Care Pathway

The care pathway is shown in the diagram below. As can be seen the first stage of the diagnostics involving bloods and a general assessment is conducted by the GP. This avoids unnecessary referrals into secondary care and keeps the first stage accessible and close to the patient's home. If there is diagnostic uncertainty the GP can refer to a secondary care. If there is physical health diagnostic uncertainty this might be to HUH rheumatology or general medicine. On the mental health side this might be to psychiatry within ELFT's Primary Care Liaison Service or CHAMRAS assessment service.

If there are clear diagnostic indicators for Chronic Fatigue a referral is made to the Complex Chronic Condition Service where a further assessment will be done. Again if there is diagnostic uncertainty a referral to psychiatry, general medicine or rheumatology will be made. Once the diagnosis is clear the service will complete NICE recommended chronic fatigue treatments.

Figure 1: Chronic Fatigue Care Pathway




Complex Chronic Conditions Service
Primary care management or
e.g. Rheumatology/Gen med./Psychiatry
Completes
treatment
Treatment not
helpful or further opinion needed
No organic cause found
Back to GP
Back to GP for secondary care referral e.g. Psychiatry, Rheumatology, Gen med.

Supporting Papers and Evidence:

NICE 22 Aug 2007: Chronic Fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management.

Sign-off:

The following officers have been cited and had an opportunity to input into the proposals:
Chris Pelham, Assistant Director of People, Department of Community and Children's Services, City of London Corporation
David Maher, Acting Managing Director, City & Hackney CCG
Chris Pelham, Assistant Director of People, Department of Community and Children's Services, and Planned Care Senior Responsible Officer, City of London Corporation
Nina Griffith Unplanned Care Workstream Director
Gareth Wall, Prevention Workstream Director
Siobhan Harper, Planned Care Workstream Director
Dr Mark Ricketts, Governing Body GP, City and Hackney CCG
City and Hackney CCG: Dr Rhiannon England, Mental Health Clinical Lead
Dr David Bridle, City & Hackney Clinical Director, East London NHS Foundation Trust
Nicole Klynman, Consultant in Public Health, London Borough of Hackney
Lesley Hill, Strategic Commissioning Lead for MH, Homelessness, Advocacy, London Borough of Hackney
Mark Davidson, Senior Commissioning Manager, City of London Corporation

Title:	How to Monitor Financial and Performance Risks across the System
Date:	31 January 2018
Lead Officer:	Anna Garner, Head of Performance, CCG
Author:	Anna Garner, Head of Performance, CCG
Committee(s):	Integrated Commissioning Board – 31 January 2018
Public / Non-public	Public

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the progress on aligning systems to monitor performance and financial risks

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the progress on aligning systems to monitor performance and financial risks

Executive Summary:

Update on revising systems to identify and monitor performance and financial risks across City and Hackney system, managed via the Integrated Commissioning governance.

Questions for the Integrated Commissioning Board

N/A

Issues from Transformation Board for the Integrated Commissioning Boards

N/A

Links to Key Priorities:

N/A

Specific implications for City and Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

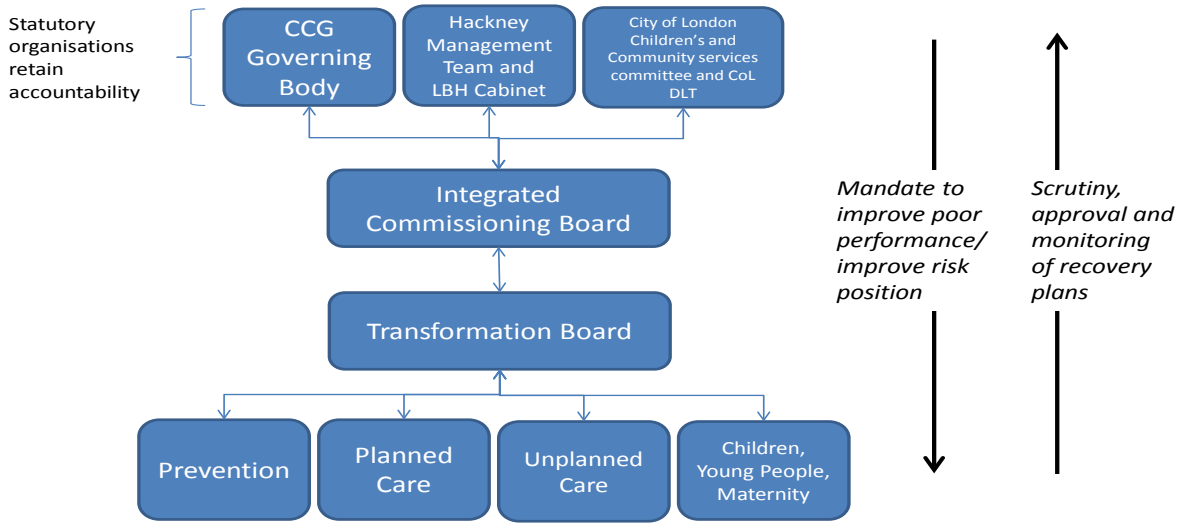
Impact on / Overlap with Existing Services:

N/A

How to monitor financial and performance risks across the City and Hackney system – UPDATE paper

Theoretical framework: what we are aiming for performance monitoring across the system

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



Pilot areas identified

a. Learning Disabilities (pooled budgets in place already; financial risk and LA overspend; under Planned Care workstream)
b. Continuing Healthcare/Residential Care/Nursing Care (pooled budgets proposal being drawn up; financial risk and CCG overspend; under Planned Care workstream)

c. Delayed Transfers of Care (strong impact on LBH budget, opportunities for joint working, strong external pressure on LBH; under Unplanned Care workstream). Recovery plan going to Transformation Board in December
d. Emergency Admissions (financial risk and CCG overspend, opportunities for joint working, under Unplanned Care workstream)
e. Smoking prevalence/substance misuse (strong health gain argument, large impact on future financial health: would enable test of commitment to focus on Prevention [compared with more immediate financial risks]; under Prevention workstream).
f. Immunisations (strong health gain argument, barriers to changing NHSE commissioned service; under CYPM workstream).

Progress against development of more aligned systems

1. Reconstituting CCG Finance and Performance Committee: TOR revised, potential for FPC to have a role in:
   - Support to ICBs in having greater capacity to review detail of finance and performance information
   - Review overall financials against budget for particular workstream and any significant variances, including QIPP performance
   - Review assurance/quality measures, contractual performance etc where relevant
   - To understand the drivers behind any variances against plans and ensure that the relevant workstreams have identified any risks and have mitigating actions in place to address these, and to monitor progress and performance against these plans

2. Start work on aligning performance reports to prompt thinking on what information needed, by whom, when:
   - Started regular meetings between performance teams
   - Development of workstream dashboards – development of format and content of these with workstreams (e.g. Unplanned care dashboard as work in progress attached)
   - Ongoing work on aligning work of current performance teams (including sharing of policies, report formats, monitoring systems)

3. Reflect on process already been through for some of the pilot areas: recovery plans for DTOCs and Learning Disabilities already produced via workstreams, and presented via Transformation Board and ICB. Need more time to look at added value of that process, and how to streamline any future recommendations about more aligned system reporting (including use of reconstituted FPC as above).

Indicator	Latest data period	City and Hackney	Hackney	City of London	England	London Cosmopolitan group	Trend	Achieving target
A&E attendances – number (SUS)	Q1 17/18	31764			5,996,455			
A&E attendances – rate per 1000 popn (SUS)	Q4 16/17	30.3				30.8		
A&E performance – 4 hr target (IAF)	Q1 17/18	92.7%			90.3%	90.4%		95%
Patients treated in AEC - number								
% patients with AEC HRG who are treated in AEC								
% all A&E attendances who are managed in PUCC								
A&E conversion rate - all ages	Q4 16/17	19.0%				19.0%		
A&E conversion rate - over 65s								
Non-elective admissions - number (SUS)	Q1 17/18	6607				221080		
Non-elective admissions – all ages, rate per 1000 popn (BCF)	Mar-17	6.5				6.8		
Non-elective admissions – over 75s, per 1000	Mar-17	46.45				37.84		
Number of patients admitted more than 10/20 times in last year								
Emergency bed day rate per 100,000 popn (IAF)	Q3 16/17	505.8			502			
Excess bed days	Q1 17/18	1380						
% eligible patients receiving discharge to assess								
% patients receiving discharge to assess where 'hospital to destination' occurred within 48hrs								
DTOCs Delayed Days - NHS blame (BCF)	Q1 17/18	37%	35%	100%	56%			
DTOCs Delayed Days - SC blame (BCF)	Q1 17/18	62%	64%	0%	38%			
Rate of DTOCs per 100,000 popn (IAF)	Mar-17	12.9			15.0			
% of patients classified at DTOC								
% of patients who are admitted in their last year of life								
Average number of bed days for patients in their last year of life								
% of deaths in hospital (IAF)	Q2 16/17	50%			47.1%			
Permanent admissions to nursing homes and residential care - aged 18-64 (per 100,000 popn; ASCOF)								
Permanent admissions to nursing homes and residential care - aged 65+ (per 100,000 popn; ASCOF)								
Proportion of older people (65 and over) who were offered reablement services following discharge from hospital (ASCOF)	2015/16		9.2	5.8	2.9	3.9		
Proportion of people still at home 91 days after discharge into reablement services (ASCOF)	2015/16		93%	88%	83%	85%		
% eligible patients requiring no social care following reablement								
% eligible patients requiring a lower level of care following reablement								
Social care mental health clients aged 18-64 years receiving home care during the year: rate per 100,000 popn	2013/14		44.4	0	42.2	46.1		
Proportion of those that received short-term service during the year where sequel was either no ongoing support or support of a lower level (ASCOF)	2015/16		71.0%	64.7%	75.8%	71.4%		
Long-term support needs of younger adults/older adults met by admission to residential and nursing care homes, per 100,000 population (ASCOF)	2015/16		10.6	0	13.3	10.2		
Emergency admissions for urgent care sensitive conditions (IAF)	Q3 16/17	548			2405			
Inequality in avoidable admissions for urgent care sensitive conditions (IAF)	Q3 16/17	-397			1758			
Inequality in avoidable admissions for chronic ambulatory care sensitive conditions (IAF)	Q3 16/17	-149			904			
Ambulance target: RED1	Q1 17/18	72%						75%
Ambulance target: RED2	Q1 17/18	72%						75%
Ambulance target: 19 mins	Q1 17/18	94%						95%
% of 999 calls conveyed to acute trust								
Number of 999 calls from care homes								
% of 999 calls from care homes that are conveyed to an acute trust								
% of 999 calls from care homes that result in an admission								
% of 999 calls referred to Paradoc								
% of 999 calls from care homes referred to Paradoc that are conveyed to an acute trust								
IUC service activity for agreed urgent care conditions - number								
A&E attendances for IUC urgent care conditions - number								
IAF mental health clinical priority area overall rating	2016/17	Good						
IAF mental health out of area placements for acute inpatient care	Q4 16/17	100%						
People eligible for standard NHS Continuing healthcare per 50,000 population (IAF)	Q3 16/17	33.4			45.0			
1st episode psychosis accessing package of care within 2 weeks (IAF)	Mar-17	96.0%			74.4%			50%
IAF mental health crisis care transformation indicator	Q4 16/17	95%						
% of IAPT patients being seen within 6 weeks								
Patients not being seen within 6 weeks - number waiting								
Bed occupancy - inpatient MH units								
Mental health DTOCs								
IAF Dementia clinical priority area rating	2016/17	Outstanding						
% dementia patients with care plan reviewed in last 12 months (IAF)	2015/16	86%				80.1%		
Estimated diagnosis rate for people with dementia (IAF/PHOF)	Mar-17	75.7%			68%			
Achievement of milestones in the delivery of an integrated urgent care service (IAF)	Jan-17	5						
Injuries from falls in those aged 65+ (PHOF)	Q3 16/17	422			1946			
Patient experience measure (TBC)								
Staffing measures (primary care, community nursing, social work): TBC								

Sign-off:

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

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

City & Hackney CCG_____David Maher, Acting Managing Director

Title:	Hackney Stop Smoking Service Procurement
Date:	Wednesday 31 January 208
Lead Officer:	Anne Canning, Prevention Workstream Senior Responsible Officer Gareth Wall – Prevention Workstream Lead
Author:	Timothy Lee – Transformation Support Officer
Committee(s):	Proposals for the service where considered by the Prevention Core Leadership Group on 6th September 2017. The Business Case Report authorising this procurement was agreed by Hackney Procurement Committee on 10th October 2017 This report will be submitted to: Transformation Board – for discussion and noting – 12th January 2018 Integrated Commissioning Board – for discussion and noting – 31st January 2018 LB Hackney Cabinet Procurement Committee is scheduled to agree the award of contract on 13th March 2018
Public / Non-public	Public

Executive Summary:

In October 2017 LB Hackney Procurement Board (HPB) authorised the procurement of a Stop Smoking Service for Hackney at a maximum budget of £4.1M over up to five years, commencing on 1 July 2018.

The procurement of the new Stop Smoking Service will build on the successes of the previous contract, to deliver further improvements and savings. It will replace a number of stand-alone services with a single integrated system, resulting in a more efficient and streamlined service that is based on the needs and preferences of service users and that targets high risk groups more effectively.

Recommendations:

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the report;
- To **CONSIDER** the options for partners across the health and care system to support the delivery of an effective Stop Smoking Service following the anticipated award of contract in March 2018.

Issues from Transformation Board for the Integrated Commissioning Boards

The Transformation Board discussed the paper on 12 January and endorsed the paper, noting the progress being made on improving rates of smoking cessation.

Links to Key Priorities:

The new Stop Smoking Service supports the priority of Hackney's Joint Health and Wellbeing Strategy of:

Controlling the use of tobacco, with a renewed emphasis on stopping people from starting smoking as well as helping them to quit

In addition, it supports a specific priority in Hackney Council's Corporate Plan (to 2018), as follows:

We will work with our colleagues in the NHS and use our new public health duties to tackle health inequalities, including child obesity, smoking levels and mental health problems.

It also supports the Integrated Commissioning Prevention Workstream 'Ask' to deliver the Quality Premium Target on Smoking Quitters.

Specific implications for City

The Hackney Stop Smoking Service will have a limited impact on the City. There is a separate Stop Smoking Service commissioned by the City of London Corporation which City of London residents can access.

Specific implications for Hackney

The Hackney Stop Smoking Service is commissioned by the LB Hackney and targets those that live, work or study within the borough.

Patient and Public Involvement and Impact:

A review of the existing stop smoking service was completed, that involved focus group discussions with service users from key priority groups, interviews with key stakeholders and a stakeholder consultation meeting.

Clinical/practitioner input and engagement:

The project team developing the service included a Consultant in Public Health. Stakeholder interviews and the consultation meeting included representatives from primary care, pharmacies and hospital based services. Health Commissioners and Clinicians were also consulted via the Prevention Core Leadership Group.

Impact on / Overlap with Existing Services:

The new service will replace the existing provision from June 2018. The service will support the delivery of stop smoking CQUIN targets for the Homerton Hospital (and East London Foundation Trust (ELFT) from 2018). The service will work with the City of London Stop Smoking Service delivered by Westminster Drugs Project.

Main Report

Background and Current Position

Significant progress has been made in tackling smoking in recent years, however it remains a leading cause of preventable disease and death and is one of the most significant factors contributing to health inequalities. It is estimated that every year in Hackney, smoking costs society just under £67 million. These costs are spread across health services, businesses, local government and the fire service. Smoking related ill health also leads to increased costs for the adult social care system due to the demand on home care services

The main components of the Stop Smoking Service delivered in Hackney since 2014 consisted of four lots, broken down as follows:

- A GP Hub Service, with specialist advisors operating stop smoking clinics in nine practices geographically spread across the borough
- A community outreach and hospital in-reach services delivered by Shoreditch Trust
- Training in smoking cessation delivered by Whittington Health
- Management of a triage hub also provided by Whittington Health

In addition there are individual contracts with 23 community pharmacies to offer one to one behavioural support and mediation and contracts with a further 12 pharmacies to supply medication for those accessing the local Stop Smoking Service.

A review of the existing Stop Smoking Service was completed in August 2017, involving focus group discussions with service users from priority groups, interviews with key stakeholders (including service providers) and a stakeholder consultation meeting. Pharmacy providers were also consulted, in collaboration with the Local Pharmaceutical Committee. The latest best practice guidance and relevant national standards were reviewed and a gap analysis of current provision completed.

This review highlighted the need to redesign the new service in the following ways:

- To integrate all elements of the service, with a single organisation providing overall coordination, accountability and direction. This approach would help to overcome the challenges of multiple providers competing for users and deliver additional efficiencies by removing duplication.
- To continue to prioritise high risk groups and high prevalence communities with renewed emphasis on people with mental illness and other long term conditions.
- To continue to deliver services from a range of community venues including locations accessible to high risk/hard to engage smokers and high prevalence communities and to offer out of hours service such as early mornings, evenings and weekends.
- Retain as a minimum the benefits of the existing GP hub service i.e. at least 80% of the GP practices to be referring into one of nine hub practices geographically spread across the borough. The hubs would provide conveniently located venues for specialist stop smoking advisors to run weekly appointment based sessions in clinics for patients from all parts of the borough.
- Have clear and well-advertised points of access (including digital) into the service and offer online and new media support through a dedicated platform and/or in partnership with the pan London portal (depending on the outcome of the pilot).
- The offer of support would cover a range of different options and ensure people wanting to quit can access appropriate support tailored to their needs and preferences.
- Strong partnership needed with local acute and mental health trusts (Homerton hospital and ELFT) to support delivery of their own in-house stop smoking services in line with NICE guidelines.
- To ensure all types of smoking cessation training (Level 1, Level 2 and Refresher) can be adapted to suit those working with specific target audiences including people with mental ill health, pregnant women, children and young people, and people in substance misuse services.
- To align payments to pharmacies for delivering stop smoking services with other local authority areas with similar demographics.

Options

LB Hackney Procurement Board agreed the preferred option set out in the Business Case Report to award the contract to deliver the Hackney Stop Smoking Service to a single organisation via a competitive procurement process (in line with local

government procurement Standing Orders). This may include the sub-contracting of various elements to specialist providers (e.g. GP hub service). The main contractor will be responsible for all elements of the service from point of access, marketing and promotion, training, behavioural support and medication, performance management and data submission. It will operate a tiered approach which will give people who would like to quit smoking the opportunity to access different levels of support depending on their individual preferences and needs

Equalities and other Implications:

Smoking has a negative impact on the health of all people regardless of their age, disability, ethnicity, gender, religion/belief or sexual orientation. Whilst the service will target specific groups, no groups will be excluded and a universal service will be available to all residents, workers and students in Hackney.

Proposals

The preferred option of a single, integrated service has a wide range of benefits including:

- Having one accountable organisation coordinating all aspects of the service with Key Performance Indicators (KPI) set for the service as a whole, helps to address the issue of competition between providers and facilitates the principles of partnership working.
- Integrating the various elements of the service, which have overlapping staffing needs increases flexibility and efficiencies compared to procuring and managing separate Lots for each service area.
- The risk of managing activity based pharmacy contracts will be transferred to the main contractor. This will allow the provider to use their experience and expertise to effectively manage the pharmacies.
- Having a single organisation responsible to commissioners frees up the time of the authorised officer to work on other complementary areas of tobacco control, which is key to reducing smoking prevalence and preventing uptake, as reflected in the Hackney Health and Wellbeing Strategy priority.

Providers will be required to deliver a service that includes triage, training provision, assessment and referral, community outreach, a pharmacy based service and a GP hub service. The GP hub will retain the benefits delivered by the existing service. The provider will also be required to offer a pharmacy service that meets certain minimum requirements (e.g. minimum activity, quality and geographical spread). However, bidders will have greater freedom to determine the balance between community and pharmacy based services. This will facilitate innovation and support the delivery of a more integrated and efficient service. The scope of the service will be comprehensively detailed in the Specification. This will include challenging but realistic KPIs to monitor the effectiveness of the service.

Under the preferred option, a ring-fenced budget will be allocated to the delivery of a

GP hub service. As a minimum, the existing service of nine hubs working with 80% of practices will be reproduced. Bidders will have the option of working with the existing provider or proposing an alternative that delivers the same or better level of service. Costings will be specified to prevent price inflation.

Whole life costings

The table below details the costs of the existing service. This includes the variable annual Nicotine Replacement Therapy costs and the activity costs of the pharmacy service.

Service description	Oct 14- Sept 15	Oct 15 – Sept 16	Oct 15 – Sept 17
Total annual cost of the service	£865,173	£951,982	£929,991

The new service will deliver savings without reducing the level of service provision. This is considered achievable because of the potential for:

- Process efficiencies achieved by having a single provider, removing the existing duplication of services
- The restructuring of pharmacy payments in line with other local authorities
- Aligning cost per quit for all service elements
- Predicted continuing downward trend in medication costs due in part to the increase in popularity of electronic cigarettes

The table below details the budget for the proposed service from 2018- 2021

Service description	**Year 1** (Jul 18 – Jun 19)	**Year 2** (Jul 19 – Jun 20)	**Year 3** (Jul 20 – Jun 21	**Year 4** (Jul 20 – Jun 21	**Year 5** (Jul 20 – Jun 21	**Whole Life Budget**
Whole service total (of which £211,582 is for the GP hub)	£820,000	£820,000	£820,000	£820,000	£820,000	£4,100,000

Key Performance Indicators

The table below details the Key Performance Indictors (KPI) for the service. These will be reported on a quarterly and annual basis and used to measure the quality of service delivery and to support continuous service improvement.

	Description of indicator	Target
Minimum activity levels and validation		
1	Number of people setting a quit date	Minimum 3000 people per year
2.	Number of 4 week quits	1300
3.	Number of 12 week quits	Year one to establish baseline with annual increases
4.	Quit success rate	Minimum 35%
5.	Follow up at 6 months with quit status established	60%
6.	Follow up at 12 months with quit status established	45%
7.	a) CO validation at 4 weeks	85%
	b) CO validation at 12 weeks	Year 1 to establish baseline with annual increases
8.	% of clients with occupational status recorded	95%
Target groups		
9.	Routine and manual/ unemployed/carers	50% of all 4 week quitters
10.	BME groups	50% of all 4 week quitters
11.	Mental health conditions	Year one to establish baseline with annual increases
12.	Other long-term conditions	7%

13.	Pregnant women	4%

Key Milestones/Next Steps

Following agreement of the Business Case Report by LB Hackney Procurement Board the contract was advertised following an OJEU compliant process. The tender evaluation process is currently underway and contract award is scheduled to be authorised by Hackney Cabinet Procurement Committee in March 2018. A three month implementation period has been built into the timetable and the new service will be delivered from 1st July 2018.

Conclusion

The procurement of the Hackney Stop Smoking Service will build on the successes of the previous contract, to deliver further improvements and savings. It will replace a number of stand-alone services with a single integrated system, resulting in a more efficient and streamlined service that is based on the needs and preferences of service users and that targets high risk groups more effectively.

Supporting Papers and Evidence:

Appendix 1 - Hackney Stop Smoking Service Business Case Report to Hackney Procurement Board

Sign-off:

Workstream SRO _____Anne Canning, Group Director Children, Adults and Community Health, LB Hackney
London Borough of Hackney _____Anne Canning, Group Director Children, Adults and Community Health,
City of London Corporation _____Simon Cribbens, Assistant Director Commissioning and Partnership
City & Hackney CCG _____David Maher, Deputy Chief Officer

Hackney

HACKNEY STOP SMOKING SERVICE **HPB and LOW RISK BUSINESS CASE** **Key Decision No**	
HPB MEETING DATE **10 October 2017**	**CLASSIFICATION:** **Open** **If exempt, the reason will be listed in the main body of this report.**
WARD(S) AFFECTED **All Wards**	
CABINET MEMBER **Cllr Jonathan McShane** **Health, Social Care and Devolution**	
CORPORATE DIRECTOR **Anne Canning, Group Director of Children, Adults and Community Services**	

1. GROUP DIRECTOR'S INTRODUCTION

1.1 Hackney Council has been providing a stop smoking service since 2013 after it was transferred from the former Primary Care Trust along with other Public Health services.

1.2 Smoking causes around 79,000 preventable deaths in England and is estimated to cost our economy in excess of £11 billion per year, including £2.5 billion to the NHS and £1.4bn to Adult Social Care.

1.3 The estimated costs in Hackney are just under £67 million. These costs are spread across health services, businesses, local government and the fire service.

1.4 Providing support to help smokers quit is highly cost effective and local stop smoking services continue to offer smokers the best chance of quitting.

1.5 The procurement for the new stop smoking service will build on the successes of the previous contract, to deliver further improvements and savings. It will replace a number of stand alone services with a single integrated system, resulting in a more efficient and streamlined service that is based on the needs and preferences of service users and that targets high risk groups more effectively.

2. RECOMMENDATION(S)

2.1 To authorise the progression of the procurement of the Stop Smoking Service (SSS) for Hackney as set out in this report at a maximum budget of £4,100,000 over up to five years (3+1+1) years. Commencing on 1 July 2018, the contract will be for an initial three years with an option for annual extensions up to a further two years.

3. RELATED DECISIONS

None

4. COMMENTS OF THE GROUP DIRECTOR OF FINANCE AND RESOURCES

4.1 This reports seeks approval to commence the procurement of the Public Health Stop Smoking Service to award a three year contract with the option to extend for a further two years (1+1). The contract will commence on 1 July 2018 and will have a budget of £4.1m over the maximum five year life of the contract.

4.2 The existing Stop Smoking service was commissioned under four lots at a cost of £965,000. This new procurement is estimated to cost £820,000 annually under a single service contract and deliver savings

through the proposed service configuration which will focus on efficiency improvement plans set out in section 7.5.5.

4.3 The procurement will align the service to support the delivery of strategic objectives, and will deliver efficiencies to ensure that the department can manage its expenditure within the Public Health budget. The Council's Public Health expenditure must be contained entirely within the grant funded cash limit. If any additional pressures are incurred management actions need to be identified to mitigate them.

5. COMMENTS OF THE INTERIM DIRECTOR OF LEGAL

5.1 Hackney Procurement Board is asked to agree the recommendations in paragraph 2 regarding the procurement of the Stop Smoking Service.

5.2 The services to be procured in this Report are classified as Social and other Specific Services under Schedule 3 of the Public Contracts Regulations 2015 and are of a value above the threshold of £589,148 for such services. Therefore it will be necessary to publish an OJEU notice in respect of the procurement of the services. However the Council is free to determine the procedures to be applied in the award of the contract, although such procedures will need to comply with the principles of transparency and equal treatment of bidders.

5.3 Legal Services will assist with the procurement procedure, including the drafting of a suitable services contract, as requested in due course.

6. COMMENTS OF THE DIRECTORATE PROCUREMENT MANAGER

6.1 The reports seeks permission from the Chair of HPB to go out to market for the procurement of Stop Smoking Services, for total of 5 years on 3+1+1 basis, with a combined contract value of no more than £4.1m, commencing from 1st July 2018 to a maximum of 30th June 2023.

6.2 The Service comes under the social services charter of the public contracts regulations 2015 and will be subject to a light touch regime, it shall be advertised with OJEU and will be conducted as an open procurement process.

6.3 The Category lead would like to remind the service team of the possible risk of TUPE as the services changes its model from multiple to single provider.

6.4 The Category lead is satisfied with the approach to the procurement and will support the service team moving forward

7. OPTIONS APPRAISAL AND BUSINESS CASE (REASONS FOR DECISION)

7.1 The Evidence Base

7.1.1 Significant progress has been made in tackling smoking in recent years, with prevalence in England now at the lowest level for 50 years, at just under 16%. Despite this, smoking remains a leading cause of preventable disease and death and is one of the most significant factors contributing to health inequalities. Each year approximately 200 people die each year locally from smoking related disease.

7.1.2 According to the Annual Population Survey (2015), around 20% (roughly 43,000) of Hackney adult residents smoke. Smoking causes lung cancer, respiratory disease and heart disease as well as numerous cancers in other organs including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

7.1.3 As well as dying prematurely, smokers also suffer many years in poor health. For every death caused by smoking, approximately 20 smokers are living with a smoking-related disease such as Alzheimer, asthma, gastric and duodenal ulcers, gum and tooth disease, osteoporosis, cataracts, macular degeneration, impotence, sight loss, hearing loss, multiple sclerosis and diabetes.

7.1.4 Tobacco smoking harms others too through second hand smoke, while smoking in pregnancy impairs foetal growth and development and increases the risk of stillbirth and infant mortality.

7.1.5 Not all groups are affected by smoking in the same way. Some are at greater risk of harm (such as pregnant women) and others find it harder to give up (such as people living with a mental illness). In some communities, smoking appears to be promoted through cultural norms.

7.1.6 Risk of smoking is strongly linked to socio-economic status and all measures of deprivation. People in routine and manual occupations are more than twice as likely to smoke as people in managerial and professional occupations. Among unemployed people, almost 40% smoke as do around 40% of people with longstanding mental health problems and more than 70% of people who are homeless or in prison.

7.1.7 It is estimated that every year in Hackney, smoking costs society just under £67 million. These costs are spread across health services, businesses, local government and the fire service. Smoking related ill health also leads to increased costs for the adult social care system due to the demand on home care services.

7.1.8 Tobacco dependence is one of the hardest addictions to break. A smoker will typically have many failed attempts before they manage to

successfully quit smoking. Providing support to help smokers quit is highly cost-effective and local stop smoking services continue to offer the best chance of quitting. Smokers who use them are up to four times as likely to quit successfully as those who choose to quit without help or with over the counter nicotine replacement therapy products.

7.1.9 The National Institute for Health and Care Excellence (NICE) as well as the National Centre for Smoking Cessation and Training (NCSCT) have produced various guidelines on effective models for delivering smoking cessation support, which have been used in the design of the proposed service (see 7.2.3 for list of guidance)**.**

Current Service Provision

7.1.10 The main components of the SSS delivered in Hackney since 2014 (commissioned by Hackney Council's Public Health Service) consist of four lots, broken down as follows:

- A GP hub service, with specialist advisors operating stop smoking clinics in nine practices geographically spread across the borough, provided by City and Hackney GP Confederation.
- A community outreach and hospital in-reach service that offers support for priority groups who are the most likely to smoke and/or at increased risk of the harms from smoking - including certain minority ethnic groups, routine and manual workers, pregnant and post-partum women, as well as staff and patients at the East London Foundation Trust (ELFT). This is provided by the Shoreditch Trust.
- Training in smoking cessation (Level 1, Level 2 and Level 2 Refresher) provided by Whittington Health
- Management of triage hub (involving telephone, website and email service) and distributing training materials. This is also provided by Whittington Health.

7.1.11 In addition to the main SSS, 23 community pharmacies offer one to one behavioural support and medication, via individual payment by activity contracts with Public Health. A further 12 pharmacies supply medication for those accessing local SSS but do not provide behavioural support.

7.1.12 In May 2017, a new pan London stop smoking helpline service was launched by the Association of Directors of Public Health London (ADPH) as part of the London Smoking Cessation Transformation Programme (LSCTP). The Programme aims to support boroughs to transform and improve the way their residents access stop smoking support. Funded by 31 participating boroughs (including Hackney), the pan-London service involves enhanced telephone support, a Stop Smoking web Portal and a targeted communications programme to direct Londoners to self-support solutions where appropriate. While

separate to the procurement of the SSS, this service will complement it through self-help support and provision of a telephone helpline for those who do not want to access a specialist face-to-face service. Through its communication programme, it will also help drive those who need specialist support to the local SSS. However, this is a pilot and the future continuation of this service is not yet confirmed.

Review and Findings

7.1.13 A review of the existing SSS was completed in August 2017, involving focus group discussions with service users from priority groups, interviews with key stakeholders (including service providers) and a stakeholder consultation meeting. Pharmacy providers were also consulted, in collaboration with the Local Pharmaceutical Committee. The latest best practice guidance and relevant national standards were reviewed and a gap analysis of current provision completed. The review identified the following:

- A perception that the different providers compete for clients which undermines partnership working, a key element of delivering a joined up service with strong referral pathways between and within organisations
- Individual providers marketing their own service which can cause confusion among service users and risks undermining one of the service's key strengths – that of choice and providing a wide range of clinics and settings all over the borough.
- Costs per quitter vary widely between different providers with the community outreach service being the most expensive.
- Results of a pan London survey on payments to pharmacies for stop smoking services revealed costs in Hackney to be among the highest in London.
- Community outreach/hospital in-reach service are underperforming (relative to other local SSS providers) in terms of reaching high risk groups – one of the key metrics for this service component. Wide variation in performance and activity in pharmacy settings with substantial Council resource required to monitor contracts and provide appropriate support to individual providers.
- A need for improved targeting of smokers with mental health conditions and with people experiencing other long term conditions given the substantial inequalities that exist with people from these groups, and the relatively low numbers accessing the service.
- Lack of awareness amongst some Black and Minority Ethnic priority groups on what smoking cessation support is available and where
- The need to offer a less intensive service for those who are unwilling to attend much face to face support.
- Weak referral pathways between East London Foundation Trust and the Stop Smoking Service.

- Disjointed referral pathways between Homerton Hospital (inpatients and outpatients service) and the community outreach provider
- A successful 'hub' service working within GP practices which has seen quit rates almost triple from 19% to 52%
- Improved referral rates and an increase in the number of quitters among pregnant women following the implementation of a new referral pathway between Homerton Hospital and the Hackney SSS.

New Proposals

7.1.14 The service review and pharmacy consultation highlighted the need to redesign the new service in the following ways:

- To integrate all elements of the service, with a single organisation providing overall coordination, accountability and direction. This approach would help to overcome the challenges of multiple providers competing for users and deliver additional efficiencies by removing duplication.
- To continue to prioritise high risk groups and high prevalence communities with renewed emphasis on people with mental illness and other long term conditions.
- To continue to deliver services from a range of community venues including locations accessible to high risk/hard to engage smokers and high prevalence communities and to offer out of hours service such as early mornings, evenings and weekends.
- Retain as a minimum the benefits of the existing GP hub service i.e. at least 80% of the GP practices to be referring into one of nine hub practices geographically spread across the borough. The hubs would provide conveniently located venues for specialist stop smoking advisors to run weekly appointment based sessions in clinics for patients from all parts of the borough.
- Have clear and well-advertised points of access (including digital) into the service and offer online and new media support through a dedicated platform and/or in partnership with the pan London portal (depending on the outcome of the pilot).
- The offer of support would cover a range of different options and ensure people wanting to quit can access appropriate support tailored to their needs and preferences.
- Strong partnership needed with local acute and mental health trusts (Homerton hospital and ELFT) to support delivery of their own in-house stop smoking services in line with NICE guidelines.
- To ensure all types of smoking cessation training (Level 1, Level 2 and Refresher) can be adapted to suit those working with specific target audiences including people with mental ill health, pregnant women, children and young people, and people in substance misuse services.

- To align payments to pharmacies for delivering stop smoking services with other local authority areas with similar demographics.

7.2 Strategic Context:

7.2.1 This procurement supports the Council to meet its new duties and obligations as set out by the Health and Social Care Act 2012 and the Children and Families Act 2014, to protect and improve the health and well-being of residents (including families, children, vulnerable adults, and older people).

7.2.2 The Council is developing and implementing an Accountable Care System in partnership with The City of London Corporation, the City and Hackney Clinical Commissioning Group and local provider organisations. The model for this Accountable Care System comprises four workstreams, each of which are required to focus on prevention as a priority. This proposed procurement is aligned to the Prevention Workstream which is specifically being tasked with implementing a system-wide plan to tackle smoking.

7.2.3 The service design applies the strategic and operational guidance set out by the national bodies responsible for the direction and quality of health services in England, including but not limited to:

- Towards a smoke-free generation: tobacco control plan for England, Department of Health (2017)
- Stop Smoking Services, NICE PH10
- Stopping smoking in pregnancy and after childbirth, NICE PH26
- Smoking: acute, maternity and mental health services, NICE PH48
- Smoking harm reduction, NICE PH45
- Smoking: supporting people to stop, NICE QS 43
- Stop Smoking Services – Needs Analysis: A Toolkit for Commissioners, NCSCT
- Standard Treatment Programme: A guide to providing behavioural support for smoking cessation, NCSCT
- Electronic cigarettes: A briefing for stop smoking services, NCSCT
- Training Standard, NCSCT

7.3 Preferred Option:

7.3.1 The preferred option is to award the contract to deliver Hackney SSS to a single organisation. This may include the sub-contracting of various elements to specialist providers (e.g. GP hub service). The main contractor will be responsible for all elements of the service from point of access, marketing and promotion, training, behavioural support and medication, performance management and data submission. It will operate a tiered approach which will give people who would like to quit smoking the opportunity to access different levels of support depending

on their individual preferences and needs. This option has a wide range of benefits including:

- Having one accountable organisation coordinating all aspects of the service with Key Performance Indicators (KPI) set for the service as a whole, helps to address the issue of competition between providers and facilitates the principles of partnership working.
- Integrating the various elements of the service, which have overlapping staffing needs increases flexibility and efficiencies compared to procuring and managing separate Lots for each service area.
- The risk of managing activity based pharmacy contracts will be transferred to the main contractor. This will allow the provider to use their experience and expertise to effectively manage the pharmacies.
- Having a single organisation responsible to commissioners frees up the time of the authorised officer to work on other complementary areas of tobacco control, which is key to reducing smoking prevalence and preventing uptake, as reflected in the Hackney Health and Wellbeing Strategy priority.

7.3.2 Providers will be required to deliver a service that includes triage, training provision, assessment and referral, community outreach, a pharmacy based service and a GP hub service. The GP hub will retain the benefits delivered by the existing service. (see 7.3.3 below). The provider will also be required to offer a pharmacy stop smoking service that meets certain minimum requirements (e.g. minimum activity, quality and geographical spread). However, bidders will have greater freedom to determine the balance between community and pharmacy based services. This will facilitate innovation and support the delivery of a more integrated and efficient service. The scope of the service will be comprehensively detailed in the Specification. This will include challenging but realistic KPIs to monitor the effectiveness of the service.

7.3.3 Under the preferred option, a ring-fenced budget will be allocated to the delivery of a GP hub service. As a minimum, the existing service of nine hubs working with 80% of practices will be reproduced. Bidders will have the option of working with the existing provider or proposing an alternative that delivers the same or better level of service. Costings will be specified to prevent price inflation.

7.4 ALTERNATIVE OPTIONS (CONSIDERED AND REJECTED)

7.4.1 Do Nothing (let the current contracts end and don't replace them)
There is a significant need for the Council to continue offering a stop smoking service as highlighted by the large numbers of adults who still

smoke in the borough, the subsequent costs to society and the impact smoking has on driving inequalities in health. In 2016/17, more than 3,100 people accessed the service, illustrating the level of local demand. Smoking is the leading cause of preventable illness and death and requires action across the different elements of tobacco control which includes a high-quality and effective cessation service for those most at risk. Failure to offer a SSS risks widening health inequalities and contributing to increased future costs to society.

7.4.2 Re-buy (run another procurement using the current specification)

This option would be unable to deliver the required level of savings and would fail to maximise the potential for efficiency savings and service improvements. A review of the current service highlighted weaknesses and gaps in the SSS and the service delivered by community pharmacies. For example, the cost of a 'quit' in the community outreach service is more than three times the GP hub service and the pharmacy SSS, and does not manage to achieve its target of supporting clients from priority groups. In addition, the price paid for pharmacy stop smoking services is significantly higher than most of the rest of London, including areas with similar populations and smoking rates. Integrating all elements of the service will improve coordination and help to address the issue of competition between providers and at the same time make it more efficient, flexible and streamlined.

7.5 Success Criteria/Key Drivers/Indicators:

The new SSS will contribute to improving the follow indicators for Hackney in the Public Health Outcomes Framework for England 2016-19:

Domain 2: Health Improvement:

- 2.03 Smoking status at time of delivery
- 2.09 Smoking prevalence at age of 15
- 2.14 Smoking prevalence – adults (over 18s)

Domain 4: Healthcare public health and preventing premature mortality

- 4.03 Mortality rate from causes considered preventable
- 4.04 Under 75 mortality rate from cardiovascular disease (including heart disease and stroke)
- 4.05 Under 75 mortality rate from cancer
- 4.07 Under 75 mortality rate from respiratory diseases

It will also contribute to the government's new Tobacco Control Plan for England 'Towards a Smokefree Generation' which includes the following four national ambitions:

- The first smokefree generation
- A smokefree pregnancy for all
- Parity of esteem for those with mental health conditions
- Backing evidence based innovations to support quitting

7.5 Whole Life Costing/Budgets:

7.5.1 The table below (Existing Community Stop Smoking Service 2014-17) details the existing service, currently delivered as four separate lots at fixed costs. Also included in the table are the annual Nicotine Replacement Therapy (NRT) costs and the activity costs of the pharmacy service from which is currently delivered via individual contracts with community pharmacies.

7.5.2 In total, 34 pharmacies have activity based contracts to deliver stop smoking services. Pharmacies are only paid for the activity they deliver so the exact expenditure will vary year to year. Average yearly costs over the contract period comes to £926,367 with a total cost over three years amounting to £2,747,146.

Existing Community Stop Smoking Service (2014-17)

Service description	Time period			Total
	Oct 14 – Sep 15	Oct 15 – Sep 16	Oct 16 – Sep 17	
Lot 1: Community outreach service	£286,500	£286,500	£286,500	
Lot 2: GP hub service	£211,582	£211,582	£211,582	
Lot 3: Training	£48,758	£48,758	£48,758	
Lot 4: Triage	£59,979	£59,979	£59,979	
Total SSS costs	**£606,819**	**£606,819**	**£606,819**	
NRT spend	£169,000	£251,364	£235,297	
Pharmacy SSS	£89,354	£93,799	£87,875	
TOTAL	**£865,173**	**£951,982**	**£929,991**	**£2,747,146**

7.5.3 The table below (Proposed Community Stop Smoking Service 2018-2022) shows the budget for the new service which will bring all elements into a single service.

7.5.4 In 2014 responsibility for stop smoking services had only recently been transferred to the local authority and no historical data was available on the cost of NRT or pharmacy activity levels. The new service will include the cost of NRT and pharmacy services based on costings over the past three years and our understanding of activity levels going forward.

7.5.5 The new services will deliver savings without reducing the level of service provision. This is considered achievable because of the potential for:

- Process efficiencies achieved by having a single provider, removing the existing duplication of services
- The restructuring of pharmacy payments in line with other local authorities
- Aligning cost per quit for all service elements
- Predicted continuing downward trend in medication costs due in part to the increase in popularity of electronic cigarettes

Proposed community Stop Smoking Service 2018 – 2021

Service contract description	**Year 1** (Jul 18 – Jun 19)	**Year 2** (Jul 19 – Jun 20)	**Year 3** (Jul 20 – Jun 21	**Year 4** (Jul 20 – Jun 21	**Year 5** (Jul 20 – Jun 21	**Whole Life Budget**
Whole service total (of which £211,582 is for the GP hub)	£820,000	£820,000	£820,000	£820,000	£820,000	£4,100,000

7.5.6 The budget for this service is contained within the Public Health allocation. Public Health is currently funded via a ring fenced grant, however in the near future, the source of that funding is expected to change from a national grant to local business rates. We currently anticipate that there will no longer be a nationally imposed ring-fence from 2019/20. Therefore it is important to note that funding for this service is dependent on local choices that will need to be made in light of the significant pressure on universal local authority budgets.

7.5.7 This service will deliver annual savings of approximately £100,000 and continue to provide evidence-based support to address the significant burden of disease and early death caused by smoking in Hackney. To achieve these savings, we have redesigned the service by integrating different elements into a single contract to create efficiencies, while also retaining access to a high quality SSS.

7.5.8 In recognition of the fact that in-year cuts have previously been applied to the Public Health Grant by Central Government and may be applied again, the contract terms and conditions allow us to give six months' notice to terminate the contract if required. As is standard in Public Health tenders, providers are questioned about their ability to deliver best value and how they can offer a high quality service whilst working to reduce costs.

7.5.9 Reducing smoking prevalence has been identified as a key area in the Prevention Workstream in the new Accountable Care System in partnership with The City of London Corporation, the City and Hackney Clinical Commissioning Group and local provider organisations. In this

context we consider the savings in the new service to be sufficient to provide a sustainable level of funding to support the duration of the contract.

7.6 Policy Context

7.6.1 This procurement set within a strategic framework that supports the Mayor's Priorities and other Council objectives including but not limited to:

- City and Hackney Health and Wellbeing Profile (2016)
- Hackney Joint Health and Wellbeing Strategy (2015-18)

7.6.2 The new service will support the following priorities of Hackney's Joint Health and Wellbeing Board:

- Controlling the use of tobacco, with a renewed emphasis on stopping people from starting smoking as well as helping them to quit

7.6.3 In addition, it supports a specific priority in the Council's Corporate Plan (to 2018), as follows:

We will work with our colleagues in the NHS and use our new public health duties to tackle health inequalities, including child obesity, smoking levels and mental health problems

7.6.4 It is also linked to Priority Three in the Sustainable Community Strategy, specifically:

Promote health and wellbeing for all, and support independent living.

7.7 Consultation/Stakeholders

7.7.1 A review of the existing stop smoking service was completed that involved focus group discussions with service users from key priority groups, interviews with key stakeholders and a stakeholder consultation meeting.

7.7.2 The project team responsible for designing the new service included:

- Public Health Consultant, London Borough of Hackney
- Head of Public Health (Adults), LBH
- Public Health Commissioning Officer, LBH
- Public Health Strategist, LBH
- Public Health Practitioner, LBH
- Graduate Trainee, LBH

7.7.3 Discussion also took place with the Homerton and ELFT regarding their responsibilities in treating tobacco addiction with their patients and the

need to ensure strong referral pathways between hospital and local stop smoking services.

7.8 Risk Assessment/Management:

Risk	Likelihood	Impact	Overall	Action to avoid or mitigate risk
	L – Low; M – Medium; H - High			
Not enough bidders	**L**	**M**	**M**	A number of potential providers were identified through the stakeholder consultation event. The tender will be advertised widely through relevant networks and via other local authorities.
Hard to reach priority groups are not effectively engaged	**M**	**M**	**M**	The Service Specification will have a strong emphasis on the importance of partnership working, such as with local hospitals and the community and voluntary sector. This will help to ensure priority groups are accessing the service. Also KPIs/PbR to incentive engagement with hard to reach groups.
Perception that the GP Confederation (GPC) has a monopoly over GP practices and exploits this in negotiations with bidders in relation to the proposed continuation of the GP hub model	**L**	**M**	**L**	A ring fenced budget will be allocated to the GP hub and the Specification will be specific about price and activity levels to prevent a bidding war between providers. Providers will not be required to work with the GPC and may propose alternative models.
Quitter KPIs unrealistic	**L**	**M**	**L**	The KPIs have been developed based on current uptake and taking into consideration the increased emphasis

				on engaging with hard to engage/more addicted clients (including people with mental health conditions).
Level of funding committed to the service cannot be maintained for the duration of the contract (ring-fencing of the Public Health Grant is currently due to end in 2019/20)	**L**	**H**	**M**	The new service will deliver annual savings of approximately £100k. Smoking cessation is integral to delivery of the local Integrated Commissioning plans, and is strongly supported by the Integrated Commissioning Board as a priority within a wider strategy to address significant tobacco related harm. The contract terms and conditions allow us to give six months' notice to terminate the contract if required.
Providers don't bid or pull out of contract due to perceived or actual risk of managing activity based elements in contracts (i.e. pharmacies and NRT).	**L**	**L**	**L**	Costs have been modelled over the last three years and have been shown to be relatively stable. We've laid the groundwork by restructuring pharmacy payments from October 2017 and enforcing minimum activity levels through contract management.

7.9 **Market Testing (Lessons Learnt/Bench Marking):** The stop smoking services market is well established. As well as the current providers, there are a number of other organisations delivering similar services in London which are known to Public Health. A stakeholder consultation event was held in June 2017 which was attended by a number of potential providers. This provided an opportunity for them to network with possible delivery partners, input to the design of the

preferred service delivery model and generated interest in the upcoming procurement.

7.10 Savings: The service will deliver annual savings of approximately £100,000 (see section 7.5 above). Activity levels will be maintained and efficiency savings will be achieved through a more effective, streamlined and integrated service delivery model*.*

8. SUSTAINABILITY ISSUES

8.1 Equality Impact Assessment and Equality Issues Smoking has a negative impact on the health of all people regardless of their age, disability, ethnicity, gender, religion/belief or sexual orientation. Whilst the service will target specific groups, no groups will be excluded and a universal service will be available to all residents, workers and students in Hackney.

8.2 Environmental Issues: The service will have a minimal environmental impact. No capital works will be required and staff will be encouraged to either walk, cycle or use public transport when travelling across the borough to deliver services.

8.3 Economic Issues: Stopping people from smoking will have a positive economic impact on the local community. By getting smokers to quit, the service will reduce the financial burden of smoking both at an individual level, community level and societal level, and consequently free up much needed resources to be spent on other areas.

9. PROPOSED PROCUREMENT ARRANGEMENTS

9.1 Procurement Route and EU Implications:

9.1.1 The Public Contract Regulations list Health and Social Care services as being 'light touch' – which means that the procurement of these services is not fully regulated under the 2015 procurement regulations. The procurement procedure is not prescribed but is left to the contracting authority to decide the procurement format.

9.1.2. An OJEU notice will be published and we will follow the 2015 Procurement Regulations during this process to ensure that this is transparent and fair to all bidders.

9.1.3. An open procurement process will be followed. Tender documentation will be issued and evaluated using the Council's eProcurement system ProContract.

9.2 Resources, Project Management and Key Milestones:

9.2.1 The project will be led by a Public Health Strategist and overseen by the Senior Management Team (Public Health Consultant and Head of Public Health). The Public Health Commissioning Team will provide support and manage the procurement process.

Key Milestones	
Business Case Report to HPB	10 October 2017
OJEU Advert placed	11 October 2017
Closing date for EoI	10 November 2017
Tender returns	17 November 2017
Tender Evaluation	1 December 2017 – 22 December 2017
Contract Approval Report considered at CPC	13 February 2018
Alcatel Period	14-28 February 2018
Mobilisation period	March – June 2018
Start on site / Contract start	1 July 2018

9.3 Contract Documents: Anticipated contract type

9.3.1 A comprehensive Specification has been drafted and will be available to potential bidders alongside the method statements, Public health terms and conditions and other documents within the Invitation to Tender.

9.3.2 It is anticipated that following the completion of a successful tender process a contract to deliver the Stop Smoking Service will be awarded to single organisation.

9.4 Contract Management: The contract will be managed by the Public Health Strategist through quarterly review meetings, which will be used to review service delivery and performance data. These will be measured against KPIs, as explained below*.*

9.5 Key Performance Indicators: The main KPIs for this service (in Appendix One) match up to the proposed interventions in the service giving SMART targets that will be reported on a quarterly and annual basis and used to measure the quality of service delivery, and to support continuous service improvement. Some of the targets are based on a Payment by Results formula which is explained in more detail in Appendix One.

EXEMPT

None

APPENDICES

Open Appendix One - KPIs and Payment by Results

BACKGROUND PAPERS

None

Report Author	Miranda Eeles, Public Health Strategist Miranda.eeles@hackney.gov.uk 020 8356 2717
Comments of the Corporate Director of Finance and Resources	Bunmi Fuwa, Group Accountant Bunmi.fuwa@hackney.gov.uk 020 8356 8287
Comments of the Interim Director of Legal	Patrick Rodger, Senior Lawyer Patrick.Rodger@Hackney.gov.uk 020 8356 6187
Comments of Departmental Procurement manager	Rizwan Khalid, Directorate Procurement Manager Rizwan.khalid@hackney.gov.uk 020 8356 7782

Appendix One – KPIs and Payment by Results

Payment by Results

There will be eight Payment by Results (PbR) performance measures covering a total value of 10% of the annual budget (7% in the first year). The relevant performance measures and values are detailed in the table.

Calculating PbR

Payments made when targets are not achieved will be calculated based on the following formula.

% of total possible PbR payment to be made = (target achieved/target required*100)

Key Performance Indicators

	Description of indicator	Target	PbR allocation (% total contract value)
Minimum activity levels and validation			
1	Number of people setting a quit date	Minimum 3000 people per year	1%
2.	Number of 4 week quits	1300	2%
3.	Number of 12 week quits	Year one to establish baseline with annual increases	2%
4.	Quit success rate	Minimum 35%	
5.	Follow up at 6 months with quit status established	60%	
6.	Follow up at 12 months with quit status established	45%	
7.	a) CO validation at 4 weeks	85%	
	b) CO validation at 12 weeks	Year 1 to establish baseline with annual increases	
8.	% of clients with occupational status recorded	95%	
Target groups			
9.	Routine and manual/ unemployed/carers	50% of all 4 week quitters	1%
10.	BME groups	50% of all 4 week quitters	1%
11.	Mental health conditions	Year one to establish baseline with annual increases	
12.	Other long-term conditions	7%	1%
13.	Pregnant women	4%	1%

Title:	Consolidated Finance (income & expenditure) report as at November 2017 - Month 8
Date:	31 January 2018
Lead Officer:	Anne Canning, London Borough of Hackney (LBH) Paul Haigh, City & Hackney Clinical Commissioning Group (CCG) Simon Cribbens, City of London Corporation (CoLC)
Author:	Integrated Finance Task & Finish Group CCG: Dilani Russell, Deputy Chief Finance Officer CoLC: Mark Jarvis, Head of Finance, Citizens' Services LBH: Jackie Moylan, Director – Children's, Adults' and Community Health Finance
Committee(s):	Transformation Board – 12 January City Integrated Commissioning Board – 31 January 2018 Hackney Integrated Commissioning Board – 31 January 2018
Public / Non-public	Public

Executive Summary:

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

The forecast variance for the Integrated Commissioning Fund as at Month 08 (November) is £3.8m adverse. This no change from the reported forecast variance at month 7. Driving the overall adverse forecast outturn is the Learning Disabilities commissioned care packages position at London Borough of Hackney (outlined within the report). The risks to the position have been flagged in the risk schedule which will be updated and reported on monthly basis.

Issues from Transformation Board for the Integrated Commissioning Boards

Comments from Transformation Board to be provided verbally at meeting.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the report.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the report.

Links to Key Priorities:

N/A

Specific implications for City and Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Impact on / Overlap with Existing Services:

N/A

Supporting Papers and Evidence:

N/A

Sign-off:

London Borough of Hackney _____Ian Williams, Group Director, Finance and Corporate Resources

City of London Corporation _____Mark Jarvis, Head of Finance, Citizens Services

City & Hackney CCG ____Sunil Thakker, Joint Chief Finance Officer

City and Hackney Clinical Commissioning Group

Hackney

City of London

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

Integrated Commissioning Fund
Financial Performance Report

Month 08 (November) Year to date cumulative position

Table of Contents

Consolidated summary of Integrated Commissioning Budgets

	Organisation	Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend	Forecast Fcast Variance £000's	Forecast Prior Mth Variance £000's
Pooled Budgets	City and Hackney CCG	24,947	16,631	16,631	-	24,947	-	-
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	283	105	136	(31)	277	6	6
Total		25,230	16,736	16,767	(31)	25,224	6	6
Aligned	City and Hackney CCG	367,066	241,402	240,322	1,080	365,632	1,434	1,435
	London Borough of Hackney Council	LBH split between pooled and aligned not available.						
	City of London Corporation	6,068	3,425	4,162	(737)	6,352	(284)	(314)
Total		373,134	244,827	244,484	343	371,984	1,150	1,121
ICF	City and Hackney CCG	392,013	258,033	256,953	1,080	390,579	1,434	1,435
	London Borough of Hackney Council	102,127	68,085	76,696	(8,612)	107,095	(4,968)	(5,006)
	City of London Corporation	6,351	3,530	4,297	(768)	6,629	(278)	(308)
Total		**500,491**	**329,647**	**337,947**	**(8,299)**	**504,303**	**(3,812)**	**(3,880)**
CCG Primary Care co-commissioning		44,183	28,129	28,129	(0)	44,183	-	-
Total		44,183	28,129	28,129	(0)	44,183	-	-

Notes:

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

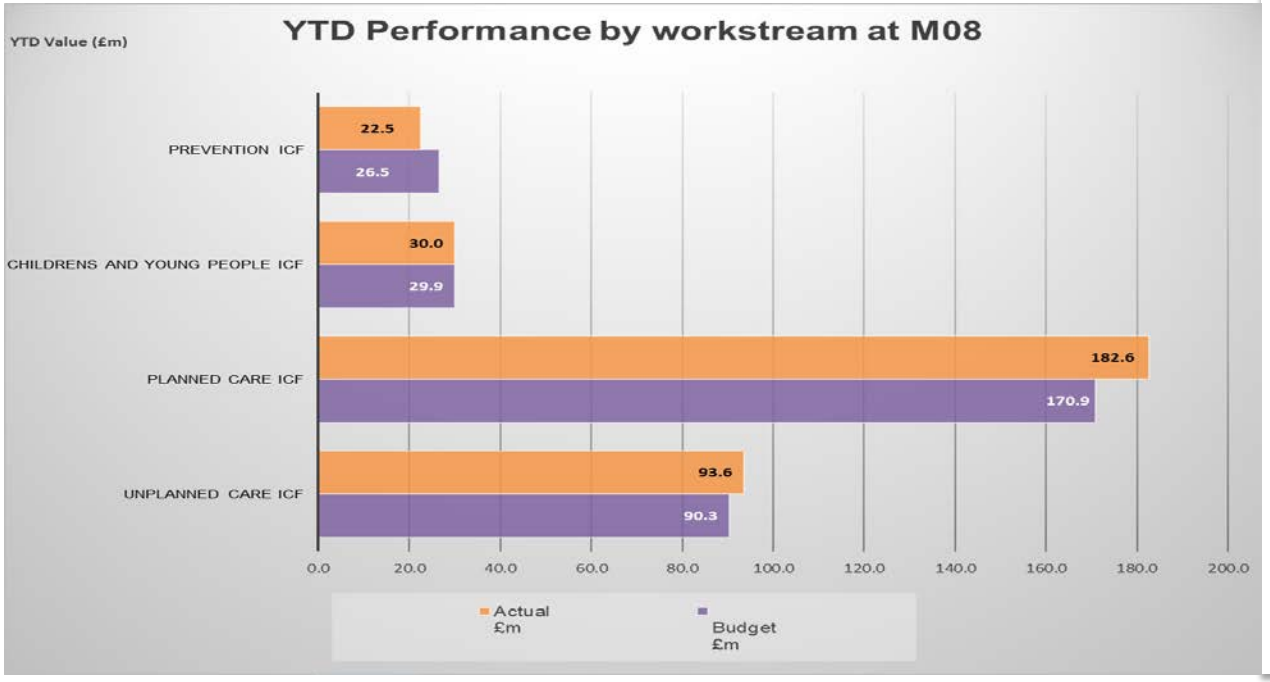
Summary Position at Month 08

- The forecast variance for the Integrated Commissioning Fund as at Month 08 (November) is £3.8m adverse. This a favourable movement of £68k from the reported forecast variance at month 7.
- Driving the overall adverse forecast outturn (FOT) position is the London Borough of Hackney, which is forecasting a £4.9m over spend for the year, a £40k improvement on last month's reported FOT. The adverse position relates to Learning Disabilities commissioned care packages.
- The City of London forecasts over spend of £0.3m against the annual plan. The over spend is expected to be met by a request for additional Adult Social Care funding and Public Health reserves.
- The CCG is forecasting a favourable position of £1.4m driven by underspends and reserve funding.
- The **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (BCF) including the Integrated Independence Team (IIT) and Learning Disabilities.
- At present London Borough of Hackney budgets are not split between pooled and aligned due to the fact that pooled funds are contributing to towards the services in aligned funds.
- The CCG took on Primary Care Co- commissioning on 1 April 2017. At M08 these budgets are break even with a forecast break even position at year end.

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

Integrated Commissioning Budgets – Performance by workstream

WORKSTREAM	Annual Budget £m	YTD Performance Budget £m	YTD Performance Actual £m	YTD Performance Variance £m	Forecast Fcast Spend £000's	Forecast Fcast Variance £m	Forecast Prior Mth Variance £000's
Unplanned Care ICF	135.8	90.3	93.6	(3.2)	135.9	(0.2)	0.7
Planned Care ICF	257.3	170.9	182.6	(11.7)	263.8	(6.4)	(6.4)
Childrens and Young People ICF	44.8	29.9	30.0	(0.1)	45.0	(0.1)	(0.3)
Prevention ICF	40.5	26.5	22.5	4.0	40.8	(0.3)	(0.2)
All workstreams	**478.5**	**317.6**	**328.6**	**(11.0)**	**485.5**	**(7.0)**	**(6.2)**
Corporate services	20.7	11.1	8.3	2.8	17.5	3.2	2.5
L ocal Authorities (DFG Capital and CoL income)	1.3	0.9	1.0	(0.1)	1.3	0.0	(0.1)
Not attributed to Workstreams	**22.0**	**12.0**	**9.3**	**2.7**	**18.8**	**3.2**	**2.4**
Grand Total	**500.5**	**329.6**	**337.9**	**(8.3)**	**504.3**	**(3.8)**	**(3.9)**



Performance by Workstream.

- The report by workstream combines 'Pooled' and 'Aligned' services but excludes chargeable income. CCG corporate services are also excluded and are shown separately as they are not within work streams.
- The workstream position reflects the Integrated Commissioning Fund without the application of mitigating reserve and non recurrent funding. These lines are £2.7m underspent in the year to date with a FOT variance of £2.4m.
- The Month 8 combined workstream position highlights a forecast over spend of £7m for the year – a deterioration of £0.8m on the Month 07 position.
- Across the CCG, LBH and CoL,
  - The Planned care workstream is driving the adverse position with a reported adverse forecast variance of £6.4m. This position reflects LBH Learning disabilities overspend of £5.9m which represents undelivered savings from previous years (£3m) and increases in complexity of clients resulting in higher cost packages. Within the CCG over spends on Continuing Health Care of £0.8m are being mitigated by underspends against the Homerton contract line resulting in an overall over spend of £0.5m.. This reflects anticipated savings achievements of targets for escalation ward and PUCC via contract variation.
  - Unplanned care workstream forecasts £0.2m over spend against the annual budget. A £0.9m deterioration against the month 7 forecast of £0.7m favourable. This underspend includes: LBH underspend of £1.0m relating to interim care and substance misuse which is partially offset by CCG overspend of £1.2m relating to over performance (primarily UCLH non elective).

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

City and Hackney CCG – Position Summary at Month 8

	ORG	WORKSTREAM	Annual Budget	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend	Forecast Variance £000's	Forecast Prior Mth Variance £000's
Pooled Budgets	Commissioned	Unplanned Care	18,735	12,490	12,490	0	18,735	0	0
		Planned Care	6,202	4,135	4,135	0	6,202	0	0
		Prevention	10	7	7	0	10	0	0
		Childrens and Young People	0	0	0	0	0	0	0
	Pooled Budgets Grand total		24,947	16,631	16,631	0	24,947	0	0

	ORG	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Aligned	Commissioned	Unplanned Care	111,324	74,216	75,221	(1,005)	112,484	(1,160)	(304)
		Planned Care	186,457	123,644	124,256	(612)	186,935	(478)	(382)
		Prevention	3,761	2,508	2,508	(0)	3,762	(0)	(0)
		Childrens and Young People	44,849	29,899	30,016	(117)	44,983	(135)	(332)
		Corporate and Reserves	20,676	11,136	8,322	2,814	17,469	3,207	2,453
	Aligned Budgets Grand total		367,066	241,402	240,322	1,080	365,632	1,434	1,435
Subtotal of Pooled and Aligned			**392,013**	**258,033**	**256,953**	**1,080**	**390,579**	**1,434**	**1,435**

In Collab	Primary Care Co-commissioning	44,183	28,129	28,129	(0)	44,183	0	0
Grand Total of including Primary Care Co-commissioning		**436,196**	**286,162**	**285,082**	**1,080**	**434,762**	**1,434**	**1,435**
CCG Total Resource Limit		466,394						
SURPLUS		30,198						

- Corporate (Running Cost Allowance - RCA) underspends and reserve funding are off setting overspends at an organisational level. However, workstream YTD budgets and FOT are adverse.
- Primary Care Co-Commissioning : At month 8, the Primary Medical Service budget is reporting a year to date and forecast position to plan. Whilst there is some pressure in the budget this is being actively managed and is expected to be fully mitigated through reserves.
- *Continuing Health Care , FNC = Funded Nursing Care
- London Ambulance Service (LAS)

- At Month 08 the CCG reports a surplus of £1.1m with a forecast £1.43m full year forecast outturn. This represents the release of additional in-year savings previously held as contingency, released in M8 as directed by NHSE.
- **Pooled budgets** reflect pre-existing integrated and are break even.
- **Aligned budgets**: The **Unplanned Care** workstream is over spent by £1.0m YTD with a £1.1m forecast over spend which represents a deterioration of £0.8m on the previous month's forecast. The FOT reflects:
  - Acute over spends within UCLH - £0.8m driven by Adult A&E +NEL activity. LAS and North Middlesex service are also over spent against budget by £0.2m and £0.1m respectively related to activity. Whittington Hospital is also overspend of acute lines by £0.1m. This is being slightly mitigated by under spends in Non Contracted Activity lines.
- The **Planned Care** workstream reports a YTD over spend of £0.5m with a FOT of £0.4m adverse. The FOT position reflects:
  - CHC* overspends (including FNC) of £0.9m, a deterioration of £0.2m on Month 07 due to physical disabilities pipeline cases increasing. Challenges are being made to the adverse FOT through the workstream CHC Improvement Group.
  - Acute overspends (mainly UCLH & Moorfield's) of £0.8m. These are being mitigated by the impact of £0.6m under spend against HUHFT planned care line which reflects anticipated savings achievement of targets for escalation ward and PUCC via a contract variation.
- Children's and Young people adverse position relates to over spends across almost all acute providers including in UCLH, North Middlesex and Whittington Hospital as well as CHC spot purchase complex care packages.

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

Risks and Mitigations Month 8 - City and Hackney CCG

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

Ref:		Description	Risks/ (Opps) £'000	Prob. %	Adj. Recurrent £'000	Adj. Non Recurrent £'000	Narrative
1	Risk	Homerton Acute performance	1,500	22%	326	0	Gross position based on historic trend. Net risk based on the trend inclusive of claims and challenges.
2		Bart's Acute performance	800	37%	294	0	Gross position reflects over-performance risk and possible NHSE disputed misattribution.
3		Outer sector - Acute performance	2,450	70%	1,715	0	Increased NCL provider over-performance risk contained by reserves in the mitigations section.
4		Non-Contracted Activity (NCA) performance	400	0%	0	0	Gross risk reflects uncertainty of costs including mental health choice. Currently this stands at 0% probability.
5		Continuing Healthcare, LD & EOL	1,600	46%	737	0	Risk relating to activity increase above plan, high cost patients packages and service provision. Gross risk high given worsening trends and FNC tariff pressure.
6		Non Acute performance	700	46%	322	0	Non acute cost pressure across the portfolio.
7		Programme Costs	300	0%	0	0	In-year non-recurrent costs in support of the integrated commissioning programme and other non-recurrent schemes.
8		Property Costs	300	0%	0	0	Property services cost pressure.
9		Non Recurrent Investment Cost Pressure	3,000	30%	0	900	Underwriting NR investment programme, dispute resolution and other pressures.
10		Primary Care - Rent Revaluation	750	0%	0	0	Retrospective rent increases.
11		Primary Care - Rates	250	0%	0	0	Increased rateable value on properties.
12		QIPP Under Delivery	400	0%	0	0	Under-delivery for schemes within the Operating Plan.
Total Risks			**12,450**	**34%**	**3,394**	**900**	
1	Opps	Acute contract Claims and Challenges	(2,100)	56%	(1,167)	0	Gross position based on historic trend, revised to reflect current probability.
2		Outer sector - Acute performance	(500)	70%	(350)	0	Projected forecast underspend.
3		Acute Reserves	(599)	100%	(599)	0	Release of reserve to contain pressures.
4		Programme Costs	(400)	50%	(200)	0	Underspend across portfolio.
5		Contingency (0.5%)	(1,867)	46%	(856)	0	Release of contingency.
6		Prescribing	(300)	30%	(90)	0	Underspend across portfolio.
7		Property Costs	(600)	79%	(476)	0	Benefits recognised following negotiated settlement.
8		Running Costs	(1,400)	78%	(1,090)	0	Headroom declared to contain non acute pressures and savings delivery.
9		Prior year Items	(4,000)	23%	0	(900)	Opportunities arising from settlement of disputed items, accruals etc. invoices provided for in prior year resulting in an in-year benefit.
10		Non Recurrent Investment slippage	(500)	0%	0	0	Reviewed and risk assessed and position contained at month 8.
11		QIPP Over Delivery	(200)	0%	0	0	Expectation is on-plan delivery of £5.0m QIPP declared in the Operating Plan.
Total Opportunities			**(12,466)**	**46%**	**(4,828)**	**(900)**	
					(1,434)	**0**	

Net Underlying Forecast Outturn	**(1,434)**
Net Cumulative Brought Forward surplus	**(30,198)**
Headline Forecast Outturn Cumulative	**(31,632)**

City of London Corporation – Position Summary at Month 8

				YTD Performance			Forecast		
	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Comm'ned & *DD	Unplanned Care	65	2	21	(20)	65	-	-
		Planned Care	208	101	114	(14)	202	6	6
		Prevention	10	3	-	3	10	-	-
Pooled Budgets Grand total			283	105	136	(31)	277	6	6

	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Aligned Budgets	Comm'ned & *DD	Unplanned Care	208	-	-	-	208	-	-
		Planned Care	3,959	2,691	2,595	96	3,953	6	(77)
		Prevention	2,172	891	1,678	(787)	2,358	(186)	(164)
		Non - exercisable social care services (income)	(271)	(158)	(111)	(47)	(167)	(104)	(74)
Aligned Budgets Grand total			6,068	3,425	4,162	(737)	6,352	(284)	(314)
Grand total			**6,351**	**3,530**	**4,297**	**(768)**	**6,629**	**(278)**	**(308)**

- At Month 08 City of London forecasts over spend of £0.3m against the annual plan.
- **Pooled budgets** are under spent by £6k attributable to BCF services within Planned care work stream - Care Navigator Service.
- **Aligned budgets** are over spent by £0.7m in the year to date with a forecast variance of £0.3m for the full year. The forecast is being driven by the Prevention workstream which is £0.2m adverse as a result of pressures on the adult social care budget (largely driven by the cost of home care), along with increased contract costs for the public health service. Additional pressures have been caused by the broadening of the substance misuse and healthy weight / exercise services that are being offered and taken up by City residents including services provided by Square Mile Health (smoking, alcohol and substance misuse).
- The adverse forecast position also includes an adverse variance of £0.1m on CoL income which represent a includes a 38% shortfall against the chargeable income projections.
- A request for additional funding to cover the forecast over spends will be made. The position does not reflect the anticipated application of any such reserve funding.

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

London Borough of Hackney – Position Summary at Month 8

						YTD Performance			Forecast		
	ORG Split	WORKSTREAM	Total Annual Budget £000's	Pooled Annual Budget £000's	Aligned Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Variance £000's	Prior Mth Variance £000's
Pooled and Aligned Budgets	Commissioned & Directly Delivered	LBH Capital BCF (Disabled Facilities Grant)	1,299	1,299	-	866	979	(113)	1,299	-	-
		LBH Capital subtotal	1,299	1,299	-	866	979	(113)	1,299	-	-
		Unplanned Care (including income)	5,452	1,593	3,859	3,635	5,856	(2,221)	4,446	1,006	968
		Planned Care (including income)	60,509	22,640	37,869	40,339	51,484	(11,145)	66,483	(5,974)	(5,974)
		Prevention	34,867	-	34,867	23,245	18,377	4,868	34,867	-	-
		LBH Revenue subtotal	100,828	24,233	76,595	67,219	75,717	(8,499)	105,796	(4,968)	(5,006)
Grand total			**102,127**	**25,532**	**76,595**	**68,085**	**76,696**	**(8,612)**	107,095	(4,968)	(5,006)

102,127

- At Month 08 LBH reports a forecast over spend of £5m
- **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (including the Integrated Independence Team IIT) and Learning Disabilities.
- **Planned Care:** The Pooled Planned Care workstream is driving the LBH over spend. Learning Disabilities Commissioned care packages within this work stream is the main driver of the over spend, with a £5.7m pressure. There is nil change from the October position
- The overall budget pressure within LD represents undelivered savings from previous years (£3m) and increases in complexity of clients resulting in higher cost packages.
- Management actions through the Care Funding Calculator (CFC) will seek to mitigate some of this pressure this financial year. The LD Budget Review meetings will continue to look at the service in further detail to attempt to manage these pressures.

- **Unplanned Care:** The Unplanned Care workstream has not had any significant movement from the previous months position.
  - The overall Unplanned care forecast under spend relates to Interim Care (£0.6m) and is offset by linked over spends on care packages expenditure which sits in the Planned Care workstream.
  - The favourable forecast also reflects underspends in Substance Misuse (£0.3m) due to declining activity levels.
  - The delay in implementation of Telecare charging coupled with the undelivered savings to date in Housing Related Support are being partially offset by one off additional income.
  - The Planned Care overspend is partially offset by one off forecast underspends in the Unplanned Care reducing the overall overspend to £4.9m
- **Prevention Budgets:** Public Health (constitutes 100% of LBH Prevention budgets) forecasts a breakeven position.

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

Risks and Mitigations - London Borough of Hackney

London Borough of Hackney

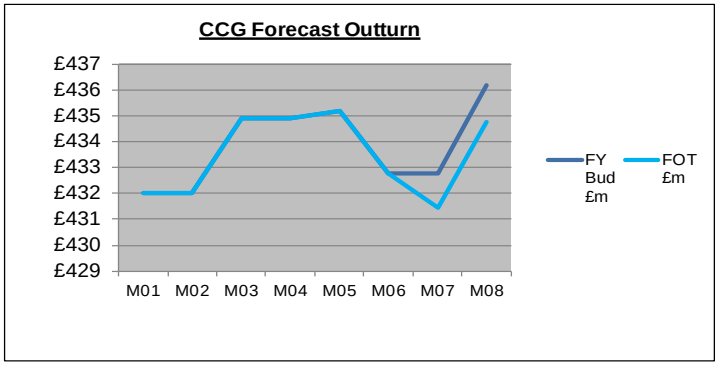
Risks	Full Risk Value £'000	Probability of risk being realised %	Potential Risk Value £'000	Proportion of Total %
Pressures remain within Planned Care (mainly Learning Disabilities Commissioned care packages) as mitigating actions are unlikely to have significant impact in this financial year	4,968	100%	4,968	100%
TOTAL RISKS	**4,968**	**100%**	**4,968**	**100%**

Mitigations	Full Mitigation Value £'000	Probability of success of mitigating action %	Expected Mitigation Value £'000	Proportion of Total %
Management actions through the implementation of initiatives such as the Care Funding Calculator (CFC) will seek to mitigate some of this pressure this financial year.	TBC	TBC	TBC	TBC
Review one off funding	4,968	100%	4,968	100%
Uncommitted Funds Sub-Total	**4,968**	**100%**	**4,968**	**100%**
Actions to Implement				
Actions to Implement Sub-Total	**0**	**0**	**0**	**0**
TOTAL MITIGATION	**0**	**0**	**0**	**0**

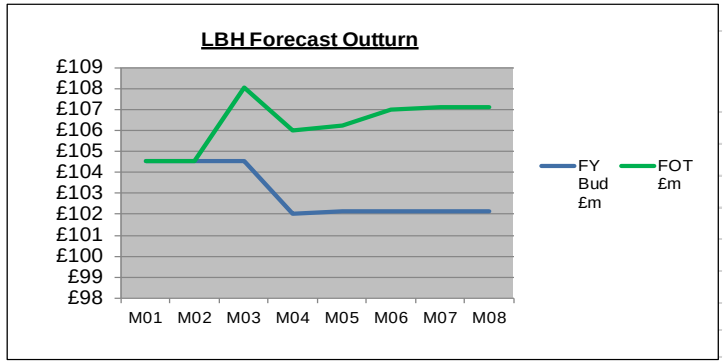
Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Forecast Run Rate at Month 08

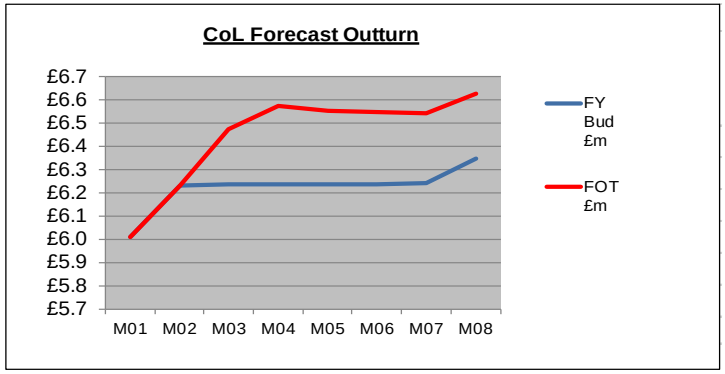
City and Hackney CCG Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	432.0	432.0	-
M02	432.0	432.0	-
M03	434.9	434.9	-
M04	434.9	434.9	-
M05	435.2	435.2	-
M06	432.8	432.8	-
M07	432.8	431.5	1.3
M08	436.2	434.8	1.4



London Borough of Hackney Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	104.5	104.5	0.0
M02	104.5	104.5	0.0
M03	104.5	108.1	(3.5)
M04	102.0	106.0	(4.0)
M05	102.1	106.2	(4.1)
M06	102.1	107.0	(4.9)
M07	102.1	107.1	(5.0)
M08	102.1	107.1	(5.0)



City of London Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	6.0	6.0	0.0
M02	6.2	6.2	0.0
M03	6.2	6.5	(0.2)
M04	6.2	6.6	(0.3)
M05	6.2	6.6	(0.3)
M06	6.2	6.5	(0.3)
M07	6.2	6.5	(0.3)
M08	6.4	6.6	(0.3)



- At Month 08 the CCG is forecasting an underspend of £1.43m against the full year budget.
- At Month 08 LBH is forecasting a £5.0m adverse position at year end. This is being driven by Learning Disabilities commissioned care packages. Mitigating actions are being undertaken by management to reduce the overspend, which is largely underpinned by unmet savings targets in previous years. The budgets are reported net of savings.
- At Month 08 the CoLC is forecasting an adverse position of £0.3m for year end due to increasing cost of homecare. This will be mitigated by the application of reserve funding which is not currently reflected in the position.

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

Integrated Commissioning Fund – Savings Performance Month 8

City and Hackney CCG

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

- The CCG has identified an additional saving of £1.4m which is over and above the £5m target is not reflected in the position as advised by NHSE.
- Savings reported at Month 8 are reported to plan.
- The full year forecast has been reported achieve the target of £5m. Weekly savings delivery meetings are the platform to address any slippage and identify mitigations.
- There is some risk around the achievement of the additional £5m stretch target (see mitigations table).

London Borough of Hackney

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

The shortfall in savings relates to:

- Housing Related Support (£1,062k savings agreed) - the savings achieved to date is £955k, leaving a shortfall of £107k which is offset by one off additional income.
- Telecare (£362k savings) charging agreed as part of the 2016/17 savings, has been delayed due to issues with the previous provider. The service is now working with a new provider and it is anticipated that the charging will not be implemented until the 2018/19 financial year.

City of London Corporation

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

Title:	Integrated Commissioning Risk Management
Date:	31 January 2018
Lead Officer:	Devora Wolfson, Integrated Commissioning Programme Director
Author:	Matt Hopkinson, Integrated Commissioning Governance Manager
Committee(s):	Integrated Commissioning Board, 31 January 2018
Public / Non-public	Public

Executive Summary:

Good risk management is part of robust governance, supports effective decision-making and is an essential part of CCG and local authority activity.

This report proposes a risk management structure and process to be adopted within the Integrated Commissioning programme. It covers the protocol for risk identification and scoring, and the flow of reporting from the care workstreams to the Transformation Board and the Integrated Commissioning Board.

The protocol has been written to be in line with the risk management policies of the London Borough of Hackney, the City of London Corporation and the City & Hackney CCG.

The ICB is asked to note the register of programme-level risks associated with Integrated Commissioning.

Each of the four Care Workstreams has responsibility for the identification and management of risks within its remit. The workstream risk registers are currently being finalised. Starting from February 2018, it is proposed that the workstreams will escalate key risks to the Transformation Board and the Integrated Commissioning Board for scrutiny. The threshold for escalation will be for the inherent risk score (before mitigating action) to be 15 or higher (and therefore RAG-rated as red). Such risks will continue to be reported to the ICB regardless of the residual risk score, until the ICB is satisfied that further reporting is not necessary.

All risks identified will be associated with a particular area of work, be it a care workstream, a cross-cutting area such as mental health, or the overall programme. The ICBs are asked to consider whether it would be useful to see the risks aligned to a set of ambitions/objectives, similarly to how the CCG currently aligns each risk identified to one of six overall corporate objectives. If the ICB wishes to take such an approach, objectives could be drawn from the strategic priorities of Integrated Commissioning, and could be identified as part of the review taking place over the next 2-3 months.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **APPROVE** the draft Integrated Commissioning Risk Management Protocol;
- To **NOTE** and **COMMENT** on the Integrated Commissioning Programme Risk register; and
- To **CONSIDER** whether future risk reports should be aligned to strategic priorities and objectives.

The Hackney Integrated Commissioning Board is asked:

- To **APPROVE** the draft Integrated Commissioning Risk Management Protocol;
- To **NOTE** and **COMMENT** on the Integrated Commissioning Programme Risk register; and
- To **CONSIDER** whether future risk reports should be aligned to strategic priorities and objectives.

Links to Key Priorities:

This report is aligned to the delivery of priorities in the City Joint Health & Wellbeing Strategy including:

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

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

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

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Impact on / Overlap with Existing Services:

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

Supporting Papers and Evidence:

Appendix 1.1 - Integrated Commissioning Risk Management Protocol
Appendix 1.2 - Criteria for Risk Scoring
Appendix 1.3 - Risk Register Template
Appendix 2 - Integrated Commissioning Programme Risk Register

Sign-off:

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

NHS CITY & HACKNEY CLINICAL COMMISSIONING GROUP, LONDON BOROUGH OF HACKNEY AND CITY OF LONDON CORPORATION

INTEGRATED COMMISSIONING ARRANGEMENTS

RISK MANAGEMENT PROTOCOL

1. INTRODUCTION

1.1 Risk Management is the proactive identification, assessment and control of risks that might affect the delivery of objectives or outcomes. It covers clinial, corporate, financial and reputational aspects. Good risk management is part of good governance, supports effective decision-making and is an essential part of CCG and local authority activity.

1.2 This document outlines the risk management structure and processes adopted by the partners involved in the integrated health and social care commissioning arrangements established by NHS City & Hackney Clinical Commissioning Group (the CCG), London Borough of Hackney (LBH) and City of London Corporation (CoLC).

1.3 This protocol applies only to the integrated commissioning arrangements. It is consistent with the policies and procedures established by the CCG, LBH and CoLC for the purposes of their activities generally, and it takes account of the statutory duties that apply to individuals involved in the integrated commissioning arrangements. However, in the event of any inconsistency between this protocol and the arrangements established by the CCG, LBH or CoLC, those other arrangements and duties shall take precedence.

1.4 This document refers to officer and organisational responsibility for risk. It should be noted that the statutory bodies remain accountable for the management of risks within integrated commissioning.

2. PROTOCOL FOR RISK MANAGEMENT

2.1 Risk Identification

2.1.1 The Terms of Reference for the Care Workstreams state that workstream boards must "Ensure that risks associated with the workstream are identified and managed, and that risks identified are included on a risk register, to be reported and escalated through the integrated commissioning governance structure in accordance with the processes established by the Integrated Commissioning team."

2.1.2 Workstream Boards are responsible in the first instance for the identification of risks and actions to mitigate and control those risks associated with all areas for which they are responsible. Risk Management will be a standing item of business on the workstream board agendas.

2.1.3 Any risks associated with the work of the workstream enabler groups will be identified and included in the workstream risk registers.

2.1.4 Where a 'cross-cutting' risk is identified (affecting more than one workstream), the Transformation Support Officers will coordinate efforts to ensure that the risk is consistently reported.

2.1.5 The Integrated Commissioning Team is responsible for the identification and management of risks associated with the programme as a whole. Any such risks will be recorded in a separate programme risk register.

2.1.6 Risks identified will be scored and reported to the Transformation Board and Integrated Commissioning Boards as set out in Sections 2.2 and 2.4, below.

2.2 Risk Scoring / Rating

2.2.1 In order to decide on the best option for action and to prioritise the management of risks identified, risks must be scored. This is done by identifying the likelihood of the event occurring and multiplying this by a factor representing the impact or consequences of the event if it did occur.

2.2.2 Likelihood and impact scores are plotted into a five-by-five matrix (see Table 1, below) to generate an overall risk score, which is RAG-rated. Scores are used to inform the appropriate response of management in prioritising and mitigating risks.

Table 1 - Scoring Matrix

LIKELIHOOD (PROBABILITY)							
	5	Almost certain: > 80%	Low (5)	Medium (10)	High (15)	High (20)	High (25)
	4	Likely: 51% – 80%	Low (4)	Medium (8)	Medium (12)	High (16)	High (20)
	3	Possible: 21% – 50%	Low (3)	Low (6)	Medium (9)	Medium (12)	High (15)
	2	Unlikely: 6 – 20%	Low (2)	Low (4)	Low (6)	Medium (8)	Medium (10)

	1	Rare: < 6%	Low (1)	Low (2)	Low (3)	Low (4)	Low (5)
SCORING SCALES (each score for likelihood and impact is multiplied to attain overall score)			1: Insignificant	2: Minor	3: Moderate	4: Major	5: Severe
			IMPACT (CONSEQUENCES)				

2.2.3 The criteria for scoring are included as **Appendix 1.2**, below. There are some variations between the statutory organisations in terms of how risk scores are defined and weighted. The policy of the CoLC expresses a slightly greater tolerance for non-extreme-impact risk than either the CCG or LBH, while weighting extreme-impact risks higher than the other organisations. By adopting a five-by-five matrix and definitions in line with the CCG and LBH policy, the Integrated Commissioning Programme will take a marginally more risk-averse position that CoLC, supporting an appropriate level of assurance for all parties.

2.3 **Risk Registers**

2.3.1 Each workstream will maintain a register of risks identified, which may be strategic or operational. The register will record the following:

- Risk Reference Number
- Workstream / Project
- Lead Officer
- Risk Description (including consequences of risk and indicators of risk developing)
- Inherent Risk Score (Impact and likelihood before mitigating action)
- Mitigation Plan - Scoped plan of work to mitigate this risk (including timescales and performance metrics where available & appropriate); and monthly account of actions taken
- Residual Risk Score (Impact and Likelihood after mitigating actions have taken place) - *Note - the residual risk score takes account only of actions actually taken*.
- Direction of Travel - Indication of whether a risk is improving or getting worse.

2.3.2 The Integrated Commissioning Programme team will also maintain a separate register which identifies risks associated with the programme as a whole.

2.3.3 The Risk template is included as **Appendix 1.3**, below.

Hackney

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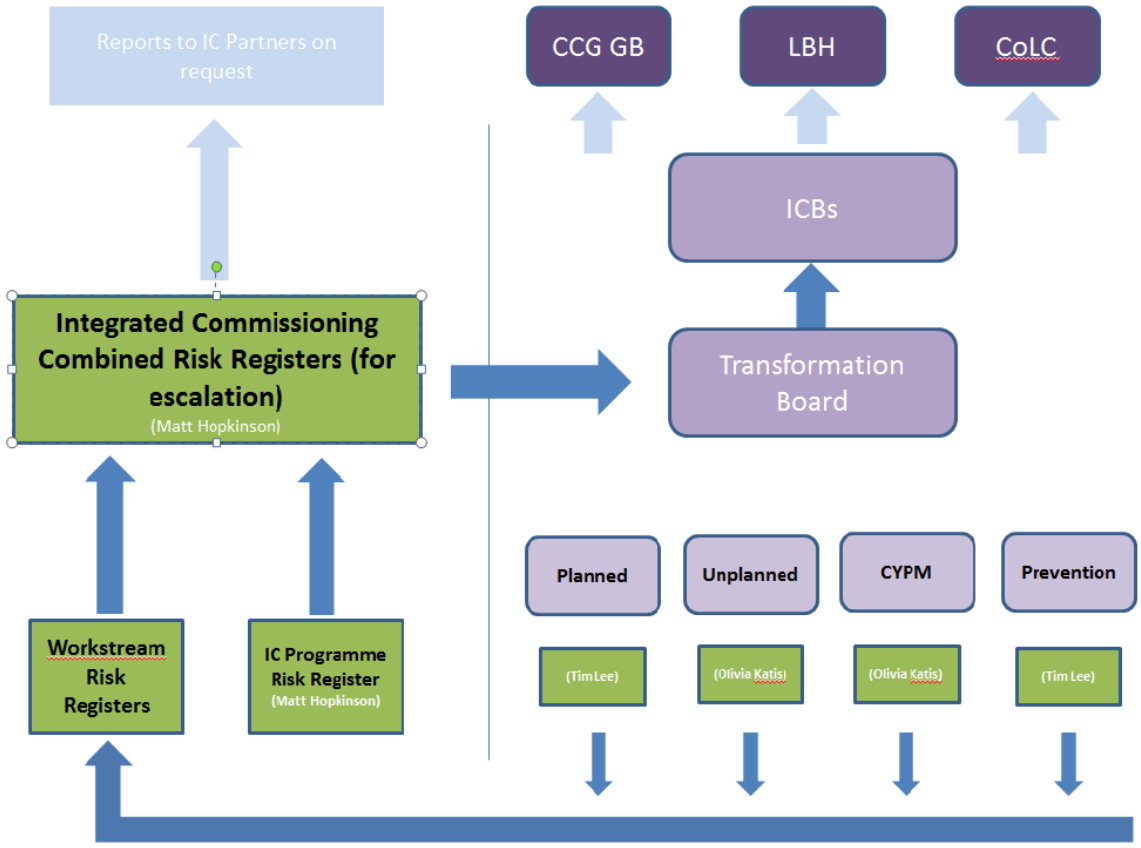
NHS
City and Hackney
Clinical Commissioning Group

2.4 Reporting and Escalation

2.4.1 Table 2 shows the flow of reporting on Integrated Commissioning risks.

Table 2 - Risk Reporting Flow



2.4.2 The Transformation Board and Integrated Commissioning Boards will consider a report on risk management on a quarterly basis. Additional reports may be requested by the TB and ICBs or submitted by the workstreams to address increasing or persistent risks, as required.

2.4.3 Any risks with an inherent, pre-mitigation score of 15 or above (Red) will be reported to the Transformation Board and the Integrated Commissioning Board. These risks will be collated into a single document. Additional commentary to inform discussion and highlight key considerations will be included in a cover report.

2.4.4 The ICBs will report on Integrated Commissioning risk management to the statutory bodies when requested.

2.4.5 If, after mitigating action has taken place, a risk is given a green residual risk score, this should be reported to the ICB. If appropriate, the ICB may decide to remove the risk from future board reports. The risk will continue to be monitored by the

workstream, etc.

2.5 Transfer of Risks from Commissioner Programmes

2.5.1 When Care Workstreams take on the responsibility for the delivery of pre-existing projects and programmes within the CCG or the Local Authorities, the workstream boards automatically take on responsibility for the ongoing management of any existing risks associated with those projects. The Transformation Support Officers will facilitate this process and the workstream board must assure that any risks are effectively transferred.

2.6 Duties and Responsibilities

2.6.1 Integrated Commissioning Board

- Oversee the identification and management of all risks associated with Integrated Commissioning.
- Provide assurance to statutory bodies that risk in the programme is appropriately managed.

2.6.2 Transformation Board

- Oversee the identification and management of all risks associated with Integrated Commissioning Programme areas.
- Provide assurance to the Integrated Commissioning Boards that risk in the programme is appropriately managed.

2.6.3 Workstream Boards

- Oversee the identification and management of all risks associated with the workstream
- Ensure pre-existing risks inherited from CCG and Local Authorities are properly managed

2.6.4 Transformation Support Officers

- Ensure the maintenance of the workstream risk registers
- Coordinate the handover of pre-existing risks from areas outside of the workstream
- Coordinate the management and reporting of cross-cutting risks

2.6.5 IC Governance Manager

- Ensure the maintenance the IC Programme Risk Register

- Produce reports on IC Risk Management to the Transformation Board and Integrated Commissioning Board
- Manage timetable of reporting to TB and ICB

This matrix is for guidance and is not intended to be prescriptive. It should usually be the worst-case scenario that is used to rate the risk.

APPENDIX 1- RISK SCORING MATRIX

Impact ➡	1 Negligible	2 Minor	3 Moderate	4 Major	5 Extreme
Finance	Negligible organisational or personal financial loss (<£1k) Costs managed within the delegated authority of individuals as stated in the partners' schemes of delegation	Minor organisational or personal financial loss (£1k-£10k) Major impact on individual project or budget holders financial position	Significant Organisational or personal loss (£10k-£100k) Major impact on care workstream budget	Major organisational or personal financial loss (£100k-£1m) Significant impact on the financial position of partner organisation	Severe organsiational or personal financial loss (>£1m) Serious impact on financial position of partner organisation
Compliance/ Legislation	No or minimal threat to breech of statutory duty	Reduced provider performance rating Single failure to meet internal standards Minor breach of contract / short term failure to achieve KPI Minor threat to breech of statutory duty	Reduced provider rating following CQC improvement notice. Single breech of statutory duty, regulation or standing order Minor breech of standard NHS contract Sustained failure to achieve a single KPI Failure to deliver NHS constitutional standard (e.g. Acknowledging complaints within 32 working days)	Critical independent report Provider performance rating resulting in enforcement notice. NHSE Assurance process failure Non-compliance with national standards carrying a risk to patients Significant failure of a vital KPI Sustained failure to achieve multiple KPIs	CCG placed under special measures by NHSE Prosecution as a result of mismanagement Gross sustained failure to meet national standards Gross failure to deliver against contract resulting in poor outcomes or care
Safety	None or minimal chance of harm to patients No/minimal intervention required	CCG Minor safety incident (eg. Small IG data sharing breech) Minor injury or illness requiring minimal intervention Impact on length of stay by 1-3 days	Injury requiring professional intervention Increased length of stay by 4-14 days Increased waiting times by up to 3 weeks (excluding RTT) Infection control threshold breech Reportable incident (RIDDOR) An event impacting on a small number of patients (1-10)	Clinical Serious Incident as defined by national guidance Major injury leading to long term condition/disability Increased length of stay >15 days Mismanagement of patient care with long term effects	Incident leading to death NHS never event Multiple permanent injury or irreversible health effect An event significantly impacting on a large number of patients (>10)
Partnership Working	Difficulties communicating with partners	Lack of information sharing	Temporary closure of small service Targets and plans not alligned Partners intending to cut services that impact on services	Significant disagreement with partners on plans and priorities Overview and scrutiny committee publicly critical of partner organisations	Legal action from Partner Financial mismanagement of partner
Service Quality	Locally resolved complaint No/minimal chance of claim No impact on outcome	Small claims <£10k Clinical / practitioner outcome not affected Minor risk to quality (eg. Delayed discharge) Complaint peripheral to clinical care	Justified complaint involving substandard service provision Formal complaint (ombudsmen) Service has significantly reduced effectiveness	Significant increase in SIs at provider the partners hold substantial contracts with Failure to meet a number of nationally mandated targets Multiple complaints/independent review multiple claims exceeding £10k Significant impact on clinical / practitioner outcome	Failure to meet RTT /Cancer/A&E target (more than 6 months) Inquest/ombudsmen inquiry Gross failure of patient care Multiple or single claim exceeding £1m

This matrix is for guidance and is not intended to be prescriptive. It should usually be the worst-case scenario that is used to rate the risk.

Reputation	Minor adverse publicity	Negative local media report Localised media campaign against provider for which we hold substantial contracts	Poor patient reported outcomes Poor patient audit report Local Media front page report National media report critical of provider services for which we hold substantial contracts with or are mentioned in the report.	Sustained local media campaign against partner organisation short national media article critical in nature	National media focus for more than 3 days MP concerned (questions raised in the house of commons) Complete loss of public confidence

Likelihood	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
	Should not occur and probably never will. May occur only in exceptional circumstances	Not expected to occur but there is a slight possiblity it could at some point.	Could occur at some point There is a history of occurrence within the organisation	The is a strong possibility the event will occur There is a recent and frequent history of the occurrence within the organisation or across the NHS	The event is expected to occur in most circumstances There is a history of regular occurrence at the organisation or across the NHS
Timeframe	A one off event at most less than once a year	Frequency of less than once a quarter	Likely occurrence of less than once a month	Likely to occur within a week but not a persisting issue	Expected to occur at any point possible daily May occur on multiple occasions

Integrated Commissioning Programme Risks

Risk / Event Details				Inherent Scores [pre mitigation]			Mitigation Plan	Action Taken	Residual Scores [post mitigation]			Risk Direction since last report
Reference Number	Workstream / Project	Lead Officer	Risk Description	Likelihood	Severity	Inherent Risk Score	**Scoped programme of work to mitigate this risk** [bullet action plan including timescales and performance metrics where available & appropriate]	**Monthly update on actions taken to mitigate risk and impact of actions**	Likelihood	Significance	Inherent Risk Score	
IC1	IC Programme	David Maher / Anne Canning / Simon Cribbens	Risk that staff are unclear on how roles and responsibilities will fit into the new integrated commissioning arrangements/ACS, timescale, etc., and that partners encounter issues in integrating due to organisational and cultural differences, leading to negative impact on service delivery.	3	3	9	Workstream Directors and SROs to act as link between partner organisations. Continued development of Workstream activity into business as usual.	Workstream Directors working between partner organisations; organisational leads working with SROs and WDs to facilitate integration, with regular meetings in place between organisations.	3	2	6	↓
IC2	IC Programme	ICB Chairs	Failure to agree on material matters resulting in disputes between partner organisations.	4	3	12	Governance documents for Integrated Commissioning to set out clear approach to decision making. All governance documents to be approved by partners with appropriate inout from legal counsel.	Clear processes are now in place. The Terms of Reference for the Transformation Board and ICBs (as well as for the CWDG and ICSG) have been agreed by all parties, and the Commissioners have agreed to adopt a consensus approach to decision making. In terms of financial matters there is a dispute resolution process set out in the terms of the s75 agreement. Functional architecture is now also in place for all workstreams. Regular staff briefings have taken place and two internal working groups; the Care Workstream Directors Group and the Integrated Commissioning Steering Group, have been established, and meet monthly.	4	2	8	↓
IC3	IC Programme	Ian Williams / Philippa Lowe / Mark Jarvis	Failure to deliver financial control total with impact on organisations' finances and service delivery	4	3	12	A range of actions have been identified to mitigate this risk. These actions have now been taken.	Pooling of budgets in 2017/18 limited to existing s75 agreements, allowing time for workstreams to bed-in. Contract for 3 Year Evaluation of Integrated Care awarded to Cordis Bright in December 2017. Assurance Review point 1 & 2 successfully achieved for Planned Care, Unplanned Care and Prevention workstreams. Assurance Review point 1 successfully acieved for CYPM workstream. As at Month 8, the combined financial forecast position across all three commissioning partners for 2017/8 shows an adverse variance of £3.8m, relating to ongoing pressures in Learning Disabilities. This position is being monitored. There are no indicators at month 8 of loss of sound financial control or impact on services. Chief Finance Officers of each of the commissioning	4	2	8	↓

IC4	IC Programme	David Maher / Anne Canning / Simon Cribbens	Reputational damage to the statutory bodies in terms of their standing with partner organisations and the wider STP in the event of Integrated Commissioning arrangements failing.	3	3	9	Rigorous process for development of workstreams; Clear governance systems to manage IC processes and provide rigorous oversight.	Work is ongoing on system and process design. Piloting workstreams and taking a phased approach to implementation, while existing governance structures continue to provide oversight, direction and performance management mitigates the risk. Partner organisations are in close communication and are jointly responsible for (and in agreement on) system design.	3	2	6	↓
IC5	IC Programme	David Maher / Anne Canning / Simon Cribbens	Poor performance or failure of commissioned services within the scope of s75 agreements due to inadequate management at workstream level	4	4	16	Rigorous process for development of workstreams; Clear governance systems to manage IC processes and provide rigorous oversight.	Ongoing work on system and process design. Phased approach and piloting will limit the risk to delivery and allow time for lessons learned to be embedded across all workstreams. Transformation Board and ICBs provide oversight to ensure levels of performance are maintained.	4	3	12	↓
IC6	IC Programme	TB/ICB Chairs	Failure to appropriately manage conflicts of interest causing reputational damage to the partner organisations and open them to legal challenge on contracting arrangements, with impact of finances and service delivery	4	3	12	Agree clear policy on Conflicts of Interest. Ensure Register of Interests up to date; Ensure all IC Governance meeting agendas include Conflicts of Interest.	The partners have agreed a clear policy on management of conflicts of interest, and procedures for managing potential conflicts are detailed in the Terms of Reference for the Transformation Board and the Integrated Commissioning Boards. All members and attendees of both groups have made declarations and potential conflicts are being managed in meetings.	3	2	6	↓
IC7	IC Programme	David Maher / Anne Canning / Simon Cribbens	Insufficiently robust framework of assurance provided by the ICBs to statutory bodies delegating authority whilst retaining responsibility could result in them not delivering their legal duties.	4	3	12	Governance documents for Integrated Commissioning to set out clear approach to decision making and reporting. Care Workstreams to undergo rigorous assurance process before assuming full responsibility for delivery.	Governance documents (drafted and reviewed by legal advisors)were approved by the statutory bodies in February 2017. Clear reporting and assurance frameworks / dashboards have been produced to ensure that statutory bodies retain oversight and control over delivery of services under s75 agreements. Workstream Assurance Review Points 1 and 2 have been passed by Planned Care Unplanned Care and Prevention, and CYPM has passed Assurance point 1. At present the ICB only has delegated authority over the pre-existing s75 agreements.	4	2	8	↓
IC8	IC Programme	David Maher / Anne Canning / Simon Cribbens	ICB Members do not feel adequately equipped or informed to make the decisions which are required of them.	3	3	9	Ensure ICBs receive and discuss a full range of business items; Provide seminars and one-to-one support to ICB Members.	The ICBs have been meeting since May 2017, managing a wide range of business decisions and strategic issues. Members have been offered individual coaching information gathering sessions with senior officers, and seminars on key areas such as finance were held in summer/autumn 2017.	3	2	6	↓
IC9	IC Programme	David Maher / Anne Canning / Simon Cribbens	Failure to agree on a collaborative model for the Accountable Care System (e.g. payment system, risk share model, organisational form) resulting in impact on delivery of services and financial viability of partner organisations	4	4	16	Develop appropriate model in collaboration with full range of stakeholders; Use current phase of Integrated Commissioning to develop partnerships in City & Hackney health and social care networks;	A series of workshops to collaboratively discuss models is underway with engagement from all commissioners and providers. Providers are also meeting together to discuss options and there will be further system-wide discussions. Work done to build relationships between partners in health and social care organisations and commitment of partners to collaboration and integrated service delivery. Further guidance has been issued by NHS England and the four Care Workstreams are making good progress on developing collaborative, integrated approaches to service delviery.	4	3	12	↓

IC10	IC Programme	David Maher / Anne Canning / Simon Cribbens	Risk of key members of staff leaving the programme, given the high number of interim appointments and the pace of change. This would have an impact of the timelines for delivery of integrated commissioning programme.	3	3	9		As the programme grows in scope and maturity the impact of individual members of staff moving on is lessened. Recruitment of Workstream Directors has been completed reduces the programme's dependence on interim staff.	2	3	6	

Integrated Commissioning Boards Forward Plan, 2017/18					
Title	**Summary of Decision**	**IC Decision Pathway**	**Care Workstream**	**Reporting Lead**	**Notes**
28-Feb-18					
Hackney Health Fund	To discuss and make recommendations	Transformation Board - 9 March CCG GB 23 February	Prevention	Gareth Wall/Jayne Taylor	
External Engagement & Communications	To discuss and make recommendations		All	Jon Williams / Catherine Macadam / Devora Wolfson	
Integrated Commissioning Governance - 6 Month Review	Review and discuss outcomes of governance review and agree next steps	n/a	All	Devora Wolfson	
Business Case for Pooling - Prevention	To approve the business cases for further pooling of budgets	Transformation Board 12 January	Prevention	Anne Canning / Gareth Wall / Jayne Taylor	
Business Case for Pooling - Residential and Continuing Care	To approve the business cases for further pooling of budgets	Transformation Board 12 January	Planned Care	Siobhan Harper / Simon Cribbens	
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 9 February	Planned Care	Simon Galczynski/ Siobhan Harper	
Finance Report	Discuss and note	Transformation Board 9 February	n/a	Philippa Lowe / Ian Williams / Mark Jarvis	
Analysis of impact of Universal Credit	Discussion and to note		All	Ian Williams	
Integrated Commissioning Risk Management Procedures and Risk Register	Discuss and approve	Transformation Board 9 February	All	Devora Wolfson / Matt Hopkinson	
Transformation of Outpatients	Approve transformation proposals and business case		Planned Care	Simon Cribbens	
21-Mar-18					
Reprocurement of Carers Services			Prevention	Anne Canning	
Finance Report	Discuss and note	Transformation Board 12 January	n/a	Philippa Lowe / Ian Williams / Mark Jarvis	
Workstream Assurance Review Point 2 & 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	
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	
Unscheduled Items					
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	

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