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

City Integrated Commissioning Board

Meeting on Wednesday 18 October 2017, 12.00-14.00 hrs

Tomlinson Centre, Queensbridge Road, E8 3ND

Item no.	Item	Lead and action for boards	Documentation	Page No.	Time
1.	**Apologies / Introductions**				12.00
2.	**Declarations of Interest**	*For noting*	2 – Register of interests	1-4	
	PRIVATE ITEM				
3.	**Local System 2018/19 Financial Planning**	Sunil Thakker Philippa Lowe Ian Williams Mark Jarvis *For discussion*			12.05
	PUBLIC ITEMS				
4.	**Questions from the Public**	Chair	Verbal		12.20
5.	**Minutes of Previous Meeting**	Chair *For approval* *For information* *For noting* *For approval*	5.1 Minutes of City ICB Meeting, 5.2 Minutes of Hackney Meeting, 5.3 ICB Action Log 5.4 Minutes of joint ICB session in August	5-35	12.25
6.	**Framework for Risk sharing 2017/18**	Sunil Thakker *For noting*	6.1 Cover report 6.2 Framework for risk sharing 6.3 ELHCP framework agreement	36-50	12.30
7.	**Workstream Assurance Review Pt. 2 for Planned Care, Unplanned Care and Prevention**	Paul Haigh Tracey Fletcher Neal Hounsell Anne Canning *For approval*	7.1 Cover report 7.2 Workstream Assurance Pt. 2	51-59	12.35
8	**Prioritisation of investment requests**	Anna Garner *For approval*	8. Prioritisation of investments	60-65	12.55

9	**Children and Young People's Obesity and Physical Activity Services**	Angela Scattergood Gareth Wall Jayne Taylor *For endorsement*	9. COPAS report	66-72	13.05
10	**Co-production Charter**	Catherine Mcadam/ Jon Williams *For endorsement*	10. Co-production Charter	73-77	13.15
11	**Investment of PMS Premium: Proactive Care**	Leah Herridge Tracey Fletcher *For endorsement*	11.1 Cover report 11.2 Proactive care proposal	78-95	13.25
12	**Winter Readiness Plan**	Tracey Fletcher Leah Herridge *For noting*	12.1 Cover report 12.2 Winter readiness report	96-149	13.35
13	**Finance Report Month 5**	Philippa Lowe / Mark Jarvis / Ian Williams *For noting*	13.1 Cover report 13.2 Finance report	150-163	13.45
14	**National Ambulance Response Times briefing for CCGs**	Paul Haigh *For noting*	14.1 Cover report 14.2 ARP briefing	164-168	13.50
15	**Reflection on ICB Meetings**	Chairs *For discussion*	Verbal		13.55
16	**Any Other Business**	Chair	Verbal		14.00
	Items for Information: ICB Forward Plan (Paper 17, p.169-170)				

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

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

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

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

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

City Integrated Commissioning Board

Meeting of 20 September 2017

MEMBERS

Members of City Integrated Commissioning Committee

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

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

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

Members of City and Hackney CCG Integrated Commissioning Committee

Paul Haigh – Chief Officer, City & Hackney CCG

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

FORMALLY IN ATTENDANCE

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

Geoffrey Rivett – Representative, City of London Healthwatch

OFFICERS PRESENT

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

Siobhan Harper - Joint Workstream Director – Planned Care

Hackney

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NHS
City and Hackney Clinical Commissioning Group

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

Mark Jarvis, Community and Childrens Services Head of Finance , City of London Corporation

Gareth Wall - Workstream Director - Prevention

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

APOLOGIES

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

1. Apologies and Introductions

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

2. Questions from the Public

2.1. There were none.

3. Declarations of Interest

3.1. The Board **NOTED** the register of members' interest.

3.2. In relation to item 7 the Chair stated that as a GP she referred patients to the service in question. There was no apparent conflict, however, and it was agreed she would take part in discussions as usual, but abstain from involvement in any decision.

4. Minutes of the Previous Meetings

4.1. The Board **APPROVED** the minutes of the meetings held on 2 August 2017 as an accurate record.

4.2. The Board **NOTED** the minutes of the Hackney ICB meeting on 2 August 2017.

4.3. The Board **NOTED** progress on actions recorded at the previous meeting.

5. Updates on Integrated Commissioning Governance

5.1. Paul Haigh presented the report on amending the Terms of Reference of the Integrated Commissioning Boards to allow the 3 statutory committees to meet concurrently. More work needed to be done with the legal teams on getting this right. In addition the need for two further changes had emerged namely provision for appointment of Deputies and the appointment of a new Member on the CCG Committee following the expected appointment in November of single Accountable Officer for the 7 north east London CCGs. Currently the three CCG Members are the Chair of the Governing Body, A Lay Member of the Governing Body and the Chief Officer whose place would now be taken by the new single AO and there was an issue as to whether they would have the time to attend meetings. One proposal being considered was to replace the AO with a Lay Member or another GP Member of the Governing Body. He undertook to secure legal advice and report back and asked if Members were in agreement with the principles in the report whether the final draft of the single Terms of Reference could be agreed by Chair's Action and submitted to the 3 statutory organisations, who would agree the revised terms of reference which would then come back to the Board for noting.

5.2. Neal Hounsell and Randall Anderson asked for reassurance on the timeline here as the changes would need formal approval by City. Neal Hounsell added that the issue of ensuring sufficient deputies would need to be addressed and Andrew Carter suggested that deputies should perhaps be encouraged to attend regularly as observers in order to better familiarise themselves with the work of the Board and improve their understanding of the issues.

5.3. The Integrated Commissioning Board:

- **APPROVED** the approach set out in the report;
- **AGREED** that the final wording of the recommended revision of the Terms of Reference be agreed by **Chair's Action** for submission to the three statutory organisations
- **NOTED** that after the three statutory organisations had agreed the Terms of Reference that it would return to the ICBs for noting
- **NOTED** that once the revised Terms of Reference were approved, the three integrated commissioning committees would be able to sit concurrently in a single meeting

- **NOTED** that where meeting timings would require revision these would be agreed with Members but it was hoped that the dates should remain as is.

6. 2016/17 Clinical Priority Area Ratings (Cancer) Action Plans

6.1. Siobhan Harper introduced the IAF Cancer Improvement Plan. It was noted that City and Hackney was not performing well on the four measures and was below the national average. Much work was going on at STP and local level to improve screening uptake. On 1-year survival rates there were some good measures particularly for breast cancer, however colorectal cancer rates were not good.

6.2. SH added that there was a Cancer Vanguard project in North Central London and North East London and locally the focus was to support early detection and diagnosis. It was difficult to segregate the data for City and that cancer pathways for City residents were quite different with most using Barts Health rather than the Homerton. The numbers in the Homerton were small and it represented only the diagnostic part of the pathway. There had been a vast improvement at Barts Health led by the co-chair of the NEL Cancer Board.

6.3. There was a discussion on the age at which patients no longer qualify for screening for colorectal cancer, currently was set at 74. SH stated that screening programmes were nationally set and she was not aware of any deviations at local level. Penny Bevan stated that the policy here was not about ageism but rather the evidence base. The issue was about striking a balance in terms of when the risk of false positives would subject too many patients to lots of unnecessary tests, procedures and operations which would not be helpful to them in the long run. Being in a particular screening programme might not be in the best interest of the population she added. If someone is over 74 years and has symptoms then of course they would be tested. She noted also that a much better screening test for bowel cancer had now been launched.

6.4. Dhruv Patel expressed a concern that unless more City specific data could be provided to City Members it was difficult for them to make decisions. There were issues for example relating to the number of City residents registered with GPs in Tower Hamlets. The Chair responded that screening data on cancer should be provided at Practice level however this would be difficult to extract from Providers. There were issues about Barts data for Neaman Practice and delays

on cancer pathway data from UCLH. Neal Hounsell and Andrew Carter commented that there was a need for more resources to be put in to mining this data in order to get a better understanding of the health of City residents and workers.

6.5. **ACTION: CICB 1709-1**: To examine securing more City level data on cancer (Neal Hounsell and Siobhan Harper).

6.6. Randall Anderson asked why there was such variance between CCG areas. SH replied that national targets for the different screening programmes were carefully set and much time was spent questioning why variances appeared. The Chair stated that there were equalities issues here and levels of deprivation were crucial. The correlation between screening programmes and cancer mortality rates was troubling she added.

6.7. Andrew Carter asked about whether there was enough challenge to the data. SH replied that the focus of the work was at STP level now. The 2012 Act had meant that cancer screening decisions were now made across a much broader footprint than previously, when the focus had been local. The Chair added that the funding needed to be in Primary Care with greater emphasis put on increasing exercise and reducing alcohol intake and obesity and a focus on early diagnosis to avoid morbidity.

6.8. Paul Haigh added that once all the Clinical Priority Area Rating Action Plans were completed there needed to be a quarterly reporting on performance against the trajectories.

6.9. The Integrated Commissioning Board:

- **NOTED** the report and asked the Transformation Board to finalise an action plan across the partner organisations outlining the trajectory for improved performance during 18/19

7. Social Prescribing Contract Extension

Note: Clare Highton abstained from the recommendation on this item, making the Board inquorate, however the Board was being asked here merely to endorse a formal decision of the CCG's Chief Financial Officer, which he had taken under delegated authority.

7.1 Gareth Wall introduced this report on endorsing the approval of this existing contract with the existing provider for a further 2 years. Social Prescribing was central to the delivery of the Prevention Workstream's 'big ticket' item on increasing self-management and access to self-care/advice, he added. There had been significant patient and public involvement in the design of this and more time was now required to get the scheme embedded.

7.2 Andrew Carter asked if City specific information could be secured here. GW replied that they could come back with a business case on developing that. Neal Hounsell welcomed the proposal stating that it was an opportunity for the City and they could look at making this new service available particularly for City workers who were not covered by occupational health schemes.

7.3 The Chair stated that under the new Neighbourhoods Model which was being developed City would be covered in the South West quadrant and there was an opportunity there to link in with the occupational health schemes of City firms. NH undertook to explore this further. Penny Bevan commented that it was very mixed health economy in the City and mental health problems for City workers needed attention. Noted that activities such as City employers supporting staff Mindfulness programmes related to this and that it was in the interests of employers to improve the health of their workforce and reduce illness absence.

7.5 The Integrated Commissioning Board:

- **ENDORSED** the approval of the Chief Financial Officer of City and Hackney CCG that the Social Prescribing contract is awarded to the current provider (Family Action) from 1 October 2017, for a further 2 year period (with the option of a one year extension) as set out in the report, noting this would give the Prevention Workstream time to develop a more aligned offer

8. Service (and budget) transfer between Workstreams

8.1 Philippa Lowe introduced the paper. It was noted that this was a refinement of a previous system and that it was being updated to ensure there was a more robust and transparent mechanism in place to manage the transfer of service budgets from one Workstream to another. Members approved this effort to streamline processes.

8.2 The Integrated Commissioning Board:

- **APPROVED** the process for service transfer between workstreams.

9. Consolidated Finance (income and expenditure) reports as at July 2017 – Month 4

9.1 Philippa Lowe and Mark Jarvis introduced the Consolidated Finance report for month 04. Some historical finance pressures that needed to build into baseline budgets for next year were flagged. PL added that once priorities were settled upon the Workstreams would be asked to find efficiencies for next year. MJ added that ameliorating actions were being taken on Adult Social Care and Homelessness budgets to relieve pressures and a paper would come to the next ICB on priority setting.

9.2 Dhruv Patel queried the sustainability of the current budget situation. Penny Bevan commented that the cost of some services would reduce as a result of re-procurement. She also explained how some open access services such as sexual health created added pressures, as residents using services elsewhere were billed to their home borough and it was not possible to compel people to give full contact information in order to engage them with local services.

9.3 Clare Highton added that the life chances and health outcomes for children and families in hostels would need to be addressed. Currently there were 10,000 in temporary accommodation in Hackney and this was storing up health problems for the future. Noted that for the City homelessness numbers were not growing but they did fluctuate. PL added that in relation to City residents, they used the Homerton less and other providers more.

9.4 In response to a question on finance modelling PL explained that they modelled 2-3 years ahead and much work was on going on achieving system wide modelling. Paul Haigh proposed that a workshop be held in November between ICB members and TB members to share financial scenarios and work through them because everyone across the system needed to understand the whole-system pressures. NH added that each commissioner and provider was making savings in their individual organisations and there was still silo thinking taking place. There was a need for a whole-system approach. Members agreed that the Chief Financial Officers would bring a paper on assumptions to the next

Board and this would be followed in Nov by a financial scenarios workshop between the ICBs and TB.

9.7 The Integrated Commissioning Board

- **NOTED** the report
- **AGREED** that the assumptions to inform future financial plans should come to the ICBs and then a joint workshop be held between the ICBs and TB to debate these and agree the timing and next steps

10. Minutes of the Transformation Board

10.1 The Integrated Commissioning Board

- **NOTED** the minutes of the Transformation Board on 11 August 2017.

11. Joint Community Grants Scheme (City and Hackney Innovation Fund and Healthier Hackney Fund)

11.1 Gareth Wall introduced the report on the combining of the two grant funds. It was noted that the joint funding pot was available to bid for by organisations from the City. Neal Hounsell welcomed this and stated that in principle the City would want to put money into this fund in future but the timing had not made it possible this year. He stated that City's Community and Children's Services Committee would be asked to contribute to this joint fund in the future. It was noted that the City had its own Stronger Communities Grant. The Chair asked whether the targeting of the fund was similar enough to make this work and it was noted that it was.

11.2 Andrew Carter welcomed the initiative and stated that making it sustainable was the key and therefore it needed to run for two years at least to assess impact. PL cautioned that if the CCG and LBHs budgets got tighter here the contributions to this fund would of course be impacted.

11.3 It was noted that City's Stronger Community Grants was funded through endowments funding came via the City's Endowment not from core budgets so contributions to the fund could be maintained.

11.4 The Integrated Commissioning Board

- **NOTED** that the proposal had already been formally approved in the three statutory organisations and was coming to the Board for information.
- **AGREED** to bring together the two funding streams by pooling the budgets and aligning the fund themes to the priorities of the Integrated Commissioning Workstreams.
- **AGREED** to establish a joint working group with representation from the CCG, LBH and City of London as well as VCS reps, patients and members of the public to oversee the planning and delivery of the work
- **AGREED** to launch the joint fund in October 2018 with successful projects commencing delivery in May 2019 for the period of 12-24 months
- **AGREED** to provide non-financial support to successful grantees alongside the budget, to build organisational capacity and ensure high quality project delivery.

12. Reflection on ICB meetings

12.1 Members reflected on the operation of the Integrated Commissioning process and the TB and ICB meetings.

12.2 Dhruv Patel welcomed the 3 committees meeting as 1 format and urged that the move to this format is expedited because hearing a range of viewpoints from a larger group improved the discussions. Members agreed.

12.3 Joyce Nash and Geoffrey Rivett raised concerns about the difficulty of securing GP appointments at the Neaman Practice. Geoffrey Rivett asked whether the CCG had a Plan B if GP Practices were no longer able to cope with workloads to the extent that they were not serving the needs of their patients. The Chair commented that there were issues about recruitment and retention and diversity of workforce here. Neal Hounsell commented that he could feed in information on the consultation plan for the southern Hackney Hub.

12.4 **ACTION: CICB 1709-2:** That the issue of increased pressure for GP appointments and in particular concerns relating to Neaman Practice be referred to the CCG's Local GP Provider Contracts Committee (Paul Haigh).

12.4 The Integrated Commissioning Board

- **AGREED** that officers work towards establishing the format of the three integrated commissioning committees sitting concurrently as one as the standard from now on (item 5.3 also refers)

13. Any Other Business

13.1 There was none.

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

Hackney Integrated Commissioning Board

Meeting of 20 September 2017

MEMBERS

Hackney Integrated Commissioning Committee

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

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

City and Hackney CCG Integrated Commissioning Committee

Paul Haigh – Chief Officer, City & Hackney CCG

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

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

FORMALLY IN ATTENDANCE

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

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

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

Ian Williams – Group Director, Finance and Resources, London Borough of Hackney

STANDING INVITEES

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

Jake Ferguson – Chief Executive, Hackney Council for Voluntary Services

Jon Williams – Director, Hackney Healthwatch

Hackney

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OFFICERS PRESENT

Siobhan Harper - Joint Workstream Director – Planned Care

Gareth Wall - Workstream Director - Prevention

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

(*Minutes*)

APOLOGIES

Members

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

1. Apologies and Introductions

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

2. Questions from the Public

2.1. There were none.

3. Declarations of Interest

3.1. The Board **NOTED** the register of members' interest.

3.2. In relation to item 7, Honor Rhodes stated that she used to be employed by Family Action and will receive a pension from them. Clare Highton and Haren Patel stated that as GPs they referred patients to this service. There was no apparent conflict, however, and it was agreed that both should take part in discussions as usual, but abstain from involvement in decision-making.

4. Minutes of the Previous Meetings

4.1. The Board **APPROVED** the minutes of the meetings held on 2 August 2017 as an accurate record.

4.2. The Board **NOTED** the minutes of the City ICB meeting on 2 August 2017.

4.3. The Board **NOTED** progress on actions recorded at the previous meeting. On the action 1706-1 regarding the masterclass for ICB members on Finance reports, Ian Williams stated that he was working on arranging a suitable date for this.

5. Updates on Integrated Commissioning Governance

5.1. Paul Haigh presented the report on amending the Terms of Reference of the Integrated Commissioning Boards to allow the 3 statutory committees to meet concurrently. More work needed to be done with the legal teams on getting this right. In addition the need for two further changes had emerged namely provision for appointment of Deputies and the appointment of a new Member on the CCG Committee following the expected appointment in November of single Accountable Officer for the 7 north east London CCGs. Currently the three CCG Members are the Chair of the Governing Body, A Lay Member of the Governing Body and the Chief Officer whose place would now be taken by the new single AO and there was an issue as to whether they would have the time. One proposal being considered was to replace the AO with a Lay Member or another GP Member of the Governing Body. He undertook to secure legal advice and report back and asked if Members were in agreement with the principles in the report whether the final draft of the single Terms of Reference could be agreed by Chair's Action and submitted to the 3 statutory organisations, who would agree the revised terms of reference which would then come back to the Board for noting.

5.2. Clare Highton asked whether one option might be to make the third CCG rep "any voting member of the CCG Governing Body". She commented that she would expect that the local "Managing Director" of City and Hackney (whatever their title would be) would be required to be formally in attendance at the ICB, although they could not be a voting member of the CCG GB and so couldn't be a formal CCG committee member It was noted that the new single Accountable Officer for north east London was expected to be in post from 1 November.

5.3. The Integrated Commissioning Board:

- **APPROVED** the approach set out in the report;

- **AGREED** that the final wording of the recommended revision of the Terms of Reference be agreed by **Chair's Action** for submission to the three statutory organisations
- **NOTED** that after the three statutory organisations had agreed the Terms of Reference that it would return to the ICBs for noting
- **NOTED** the once the revised Terms of Reference was approved, the three integrated commissioning committees would be able to sit concurrently in a single meeting
- **NOTED** that where meeting timings would require revision these would be agreed with Members but it was hoped that the dates should remain as is.

6. 2016/17 Clinical Priority Area Ratings (Cancer) Action Plans

6.1. Siobhan Harper introduced the IAF Cancer Improvement Plan. It was noted that City and Hackney was not performing well on the four measures and was below the national average. Much work was going on at STP and local level to improve screening uptake. On 1-year survival rates there were some good measures particularly for breast cancer, however colorectal cancer rates were not good.

6.2. Members sought and received reassurance on the range of measures being taken to address the issue and the Chair asked what a useful response would be. It was noted that since responsibility for screening had moved from local PCTs to NHSE in 2013, screening rates had been consistently falling. When screening was more locally based there had been better relations with screening centres and action could be taken more promptly on Practices that needed to improve. The persistent problem remained that the further you lived from cancer centres the worse your outcome appeared to be. Retention of staff in screening teams continued to be a problem also as it was not a high profile area within Providers.

6.3. Members asked what specific strategies were being employed to improve screening rates in the demographic groups where uptake was lowest by gender, ethnicity and age. It was noted that it was a complex picture and there were particular issues around rates of prostate cancer in Black African men and robust testing pathways were being developed. There was also an issue about higher breast cancer rates in some Jewish communities. Penny Bevan commented that

cancer treatment was not a straight line and many men die with prostate cancer but not from it. Co-morbidity was complex and for the most part evidence did not support over testing whole cohorts of patients.

6.4. Jake Ferguson commented that there were a number of small grassroots BME organisations who could work with health partners to help deliver strategies for driving up testing. SH welcomed this and stated that there was added value in Workstream Approach here. Jon Williams stated that Positive East had had great success in linking in with Black African Churches on driving up HIV testing and further work should be done on this by the Faith Forum.

6.5. Anne Canning asked whether there had been more local bespoke screening campaigns in the past which had been more effective. SH replied that she hoped that improvements in pan London arrangements, which were coming through, should address this. AC asked whether the league table was robust and whether better benchmarking was required

6.6. Clare Highton commented that there was a key link between deprivation and poor screening uptake as populations which don't have control of their lives or health don't engage. She added that she was ambivalent about the volume of resources being put into screening overall and she was in favour of more emphasis on primary prevention (such as smoking) rather than diagnostics. There needed to be a cost benefit analysis of the all the surgical interventions taking place arising from screening, she added. The Chair commented that the dilemma here was whether it was a more effective use of scare resources to give lots of different population segments money to drive up relevant screening rates rather than working to make individuals more health aware overall. SH commented that the London Cancer Tumour Pathways focus was on achieving standardization across London.

6.7. The Integrated Commissioning Board:

- **NOTED** the report and asked the TB to finalise an action plan across the partner organisations outlining the trajectory for improved performance during 18/19

7. Social Prescribing Contract Extension

Note: Clare Highton abstained from the decision on this item (see 3.2 above)

7.1 Gareth Wall introduced this report on endorsing the approval of this existing contract with the existing provider for a further 2 years. Social Prescribing was central to the delivery of the Prevention Workstream's 'big ticket' item on increasing self-management and access to self-care/advice, he added. There had been significant patient and public involvement in the design of this and more time was now required to get the scheme embedded.

7.2 The Chair asked the GPs present how effective this has been. One described the value of the Ballroom Dancing sessions in the Vietnamese community which had a great impact on the health and wellbeing of the patients involved, in controlling hypertension and better managing diabetes. Another added that patients need to be motivated and compliance was not great amongst older isolated people. Both agreed that it represented great use of social capital. Jake Ferguson welcomed the scheme and stated that they were working on drawing in more resources to develop the schemes.

7.3 Anne Canning asked how the deliverables for the providers are refined in the contract to ensure take-up. GW replied that where there was a social prescribing taking place these Practices also had Health Coaches who worked on encouraging people and actually take them to services. The challenge was that while the plan might be activity rich, were the right people taking it up.

7.4 It was noted that the plan was also delivering on wider social integration with the Kingshold services bringing together a number of initiatives in one place which drew in wide cohorts of the local population. Haren Patel cautioned that the providers to this scheme must explore why some GPs are not using Social Prescribing enough.

7.5 The Integrated Commissioning Board:

- **ENDORSED** the approval of the Chief Financial Officer of City and Hackney CCG that the Social Prescribing contract is awarded to the current provider (Family Action) from 1 October 2017, for a further 2 year period (with the option of a one year extension) as set out in the report, noting this would give the Prevention Workstream time to develop a more aligned offer

8. Service (and budget) transfer between Workstreams

8.1 Ian Williams introduced the paper. It was noted that this was a refinement of a previous system and that it was being updated to ensure there was a more robust and transparent mechanism in place to manage the transfer of service budgets from one Workstream to another.

8.2 The Integrated Commissioning Board:

- **APPROVED** the process for service transfer between workstreams.

9. Consolidated Finance (income and expenditure) reports as at July 2017 – Month 4

9.1 Philippa Lowe and Ian Williams introduced the Consolidated Finance report for month 04. Some historical finance pressures that needed to build into baseline budgets for next year were flagged. Noted that the Adult Social Care budget continued to experience a number of challenges. There would be an increase in council tax next year but even with this the scope was heavily limited. The Corporate Management Team at LBH were having to look at radical actions as the current budget could not be sustained in the longer term. There was pressure on Special Educational Needs budgets across London.

9.2 Noted that there were now 10,000 people currently in temporary accommodation in Hackney. Anne Canning stated that the long term impact on children and consequently on services of them spending their most formative years in unsuitable temporary accommodation needed to be taken into account as this was storing up challenges for the future. Noted that there was an overlap too between deprivation and Special Educational Needs demand.

9.3 Jake Ferguson stated that he'd become aware that the Metropolitan Police had 6000 residences across London and asked if LBH Finance were having any discussions with them on their potential use in reducing the homelessness burden. IW replied that there had been conversations and he would look at this further. Another possible solution being explored in London was how 'empty nesters' might be encouraged to take in lodgers. Extension of foster care campaigns was also being examined. AC commented that there were different

ways in which foster children could be supported and the Corporate Parenting Board was looking at different ways to engage people with the possibility of fostering.

9.4 The impact of Universal Credit on homelessness rates and on social care services was discussed. Ian Williams stated that following on from the pilots which had taken place in London, LBH had done its own initial analysis of the impact. The Chair asked if this could be shared with the Board as a future agenda item. He also asked if there was anything positive coming out of it. IW replied that there didn't appear to be and now only MPs would be able to take up Universal Credit issues. It was noted that delays in the first payments were causing serious issues.

9.5 **ACTION HICB 1709-1**: Ian Williams to present an analysis of the impact of Universal Credit introduction to the Oct or Nov ICB meetings.

9.6 Chair asked if there were actions for the Board or TB on this item and PL replied that the focus was to get the financial planning system for next year in place as soon as possible and there was ongoing work across commissioner and provider Chief Finance Officers to define the likely system savings targets. The Chair stated that TB would need assurance about the financial robustness of the workstreams proposals to deliver a balanced budget across the system. Paul Haigh replied that the Financial Planning process would provide the space to do this.

9.7 The Integrated Commissioning Board

- **NOTED** the report
- **AGREED** that the assumptions to inform future financial plans should come to the ICBs and then a joint workshop be held between the ICBs and TB to debate these and agree the timing and next steps

10. Minutes of the Transformation Board

10.1 The Integrated Commissioning Board

- **NOTED** the minutes of the Transformation Board on 11 August 2017.

11. Joint Community Grants Scheme (City and Hackney Innovation Fund and Healthier Hackney Fund)

11.1 Gareth Wall introduced the report on the combining of the two grant fund.

11.2 The Chair asked whether the funding of the CCG element might be under threat in the future. Paul Haigh replied that it would be going through the Prioritisation Process like everything else.

11.3 The issue of the funding of the administration of the joint scheme was discussed and GW undertook to talk further to the Academic Partners about how this might be improved.

11.4 In response to a question on co-production GW stated that they had worked with Central St Martin's on the design. Noted that the scheme incorporated 'funding plus' which means it is not just money but, when needs are identified, expertise in kind can be offered such as finance, programme management or communications.

11.5 Noted that the involvement of the University of East Anglia had been very useful in the design of the evaluation within the CCG. Penny Bevan stated she had been involved in both schemes and both approaches had had their merits. The LBH scheme was about inviting bids around key issues which needed addressing and there were sessions to help applicants with bid writing. Jake Ferguson encouraging involving the VCS more and aligning it with the Civic Innovation Hub. Paul Haigh commented that the proposal had been through 6 committees and there was a job to be done in streamlining the governance on this.

11.6 GW asked if progress could be made in ensuring that the budgets for these 2 funds could be treated as a formal pooled budget. PH undertook to progress this.

11.7 The Integrated Commissioning Board

- **NOTED** that the proposal had already been formally approved in the three statutory organisations and was coming to the Board for information.
- **AGREED** to bring together the two funding streams by pooling the budgets and aligning the fund themes to the priorities of the Integrated Commissioning Workstreams.

- **AGREED** to establish a joint working group with representation from the CCG, LBH and City of London as well as VCS reps, patients and members of the public to oversee the planning and delivery of the work
- **AGREED** to launch the joint fund in October 2018 with successful projects commencing delivery in May 2019 for the period of 12-24 months
- **AGREED** to provide non-financial support to successful grantees alongside the budget, to build organisational capacity and ensure high quality project delivery.

12. Reflection on ICB meetings

12.1 Members reflected on the operation of the Integrated Commissioning process and the TB and ICB meetings. It was suggested that there needed to be further reflection on what comes up to ICB from TB and why. It was suggested that there needed to be a deeper and more radical discussion on what can be done about public services in the context of deeper austerity cuts. Suggested that it is the role of the Workstreams to add this challenge and they need to be recognising the other drivers at play and to aim to be more joined-up. The Workstream Directors need to speak to ICB members. It was suggested that if looking at radical solutions that the whole issue of cancer screening be looked at in more depth and Workstreams were currently not in the place to deliver on something like that. It was also suggested that we cannot afford not to push forward on Cancer Screening but at the same time there needs to be more of a push on smoking cessation. It was suggested that it would benefit the Board to hear directly from Providers about their experiences.

12.2 Cllr Bramble stated that the reports coming through did not give sufficient reassurance that enough was being done to incorporate the experiences of specific relevant demographic cohorts e.g. BME groups, who would be directly impacted by specific proposals. This needed to be embedded she added.

12.3 **ACTION HICB 1709-2:** Report template to be amended to include a section in equality impacts. (Devora Wolfson/Jarlath O'Connell)

12.4 The Board discussed a priority setting session. PH stated that the financial planning process for the workstreams for next year would come to the Board. A number of proposals had now come through the integrated commissioning cycle

and there would be a need to discuss the sort of discussions and level of debate and information which had been presented and to revisit this in perhaps January.

12.5 The Board discussed how it can address the scale of the impending financial challenges which will be very significant. There will be a need for tough measures and for push back through the system it was suggested. They agreed that a joint workshop between the ICBs and TB members was required. IW added that LBH could bring to that the financial forecasting they have done for 2020-2023.

12.6 **ACTION 1709-3**: To organise a joint Workshop for ICB and TB members in November to focus on financial planning for 2018/19 (Devora Wolfson/Jarlath O'Connell).

12.7 **ACTION 1709-4:** To provide an update to the joint workshop on Financial Forecasting up 2020-2023 (Ian Williams).

13. Any Other Business

13.1 There was none.

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

Ref No	Action	Assigned to	Assigned from	Assigned date	Due date	Status	Update	Update provided by
CICB 1709-1	To examine securing more City level data on cancer performance.	Neal Hounsell/ Siobhan Harper	City Integrated Commissioning Board	20/09/2017		Open		
CICB 1709-2	To refer the issues of increased pressure for GP appointments and in particualr for Neaman Practice to the CCG's Local GP Provider Contracts Committee	Paul Haigh	City Integrated Commissioning Board	20/09/2017		Open		
CICB1705-1	To invite the CoLC Social Value Panel to discuss their work, alongside a wider discussion about how to procure to acieve social value	Jarlath O'connell / Ellie Ward/David Maher	City and Hackney Integrated Commissioning Boards	23/05/2017	15/11/2017	Open	In progress. An item has been provisionally placed on the forward plan for the November meeting and discussions are taking place to confirm.	Ellie Ward
CICB1706-5	To bring a paper to the ICB for decision outlining further proposals for pooled budgets in support of the Integrated Commissioning Programme.	Paul Haigh / Devora Wolfson	City and Hackney Integrated Commissioning Boards	28/06/2017	15/11/2017	Open	This will be included in Care Workstream Assurance Point 2, to be presented at the ICBs in October 2017. More detailed business cases on pooling will be cosnidered at the ICBs in November 2017	Devora Wolfson
HICB 1709 - 4	To provide an update on the joint workshop on Financial Forecasting up to 2022-2023	Ian Williams	Hackney Integrated Commissioning Board	20/09/2017		Closed	This will be held on 23 November 2017	
HICB 1709-1	To present an analysis of the impact of Universal Creadit introducition to a future ICB.	Ian Williams	Hackney Integrated Commissioning Board	20/09/2017		Open	To be scheduled for TB and ICB.	
HICB 1709-2	Report template to be amended to include a section on equality impacts	Devora Wolfson/ Jarlath O'Connell	Hackney Integrated Commissioning Board	20/09/2017		Closed	A revised report template will be used from the Nov meetings onwards	
HICB 1709-3	To organise a joint workship for ICB and TB Members in November to focus on financial planning for 2018/19	Devora Wolfson/ Jarlath O'Connell	Hackney Integrated Commissioning Board	20/09/2017		Closed	This will be held on 23 November 2017	
JICB1708-1	To draft a formal response from the ICBs to the NHSE letter regarding the outcome of the s75 legal review, to be reviewed and approved by the membership and signed by the Chairs.	Paul Haigh	Joint ICBs	02/08/2017	20/09/2017	Closed		

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

Integrated Commissioning Boards

Meeting of 2 August 2017

MEMBERS

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

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

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

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

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

Paul Haigh – Chief Officer, City & Hackney CCG

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

FORMALLY IN ATTENDANCE

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

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

Ian Williams – Group Director, Finance, London Borough of Hackney

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

STANDING INVITEES

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

Jon Williams – Director, Hackney Healthwatch

Geoffrey Rivett – City of London Healthwatch

Hackney

CITY OF LONDON

NHS
City and Hackney Clinical Commissioning Group

OFFICERS PRESENT

Devora Wolfson – Integrated Commissioning Programme Director

Matt Hopkinson – Integrated Commissioning Governance Manager, City & Hackney CCG (*Minutes*)

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

Ellie Ward – Integration Programme Manager, City of London Corporation

Siobhan Harper – Workstream Director, Planned Care

Mark Rickets – Primary Care Clinical Lead, City & Hackney CCG

Richard Bull – Primary Care Programme Director, City & Hackney CCG

Rozalia Enti – Assistant Director, Medicines Management, City & Hackney CCG

Jan Tomes – Project Lead, Medicines Management, City & Hackney CCG

APOLOGIES

Members

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

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

Standing Invitees

Jake Ferguson – Chief Executive, Hackney Council for Voluntary Services

Formally in Attendance

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

1. Questions from the Public

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

2. Outcome of S75 Legal Review and Next Steps

2.1. Paul Haigh presented a letter from David Slegg and Ceri Jacob of NHS England, on the outcomes of the legal review into the City & Hackney integrated commissioning arrangements. The letter summary and next steps expressed support for the partners' strategic direction.

2.2. Neal Hounsell advised that the Integrated Commissioning Steering Group (ICSG) had proposed a recommendation that the ICBs made a formal response to the letter, pressing for urgent resolution of the governance review which was now well overdue, since further extension of the 'pause' would jeopardise the impact of integrated commissioning. The ICSG had also recommended that the ICB should seek clarity on the meaning of the fifth point under next steps: "*where necessary the CCG would expect to increase its surplus to support the wider STP*". The possibility that NHSE might seek to divert savings achieved by the workstreams to a regional surplus (rather than benefit local residents) was a significant cause for concern. Jonathan McShane observed that the legal precedence of the statutory duties of the CCG over the non-statutory requirements of the STP were quite clear. It was noted that any such moves to generate surplus in support of the STP could only be approved by the CCG Governing Body.

2.3. **ACTION JCB17081 -** To draft a formal response to the letter from the ICBs to NHS England, to be reviewed and approved by the membership and signed by the Chairs. (Paul Haigh)

3. North East London Commissioning Arrangements

3.1. Clare Highton noted that an early draft paper on North East London commissioning arrangements had been shared with Board members, and a number of key points were emerging.

3.2. Responsibility for specialist commissioning was expected to be delegated to CCGs, which would place a significant financial burden on North East London as a whole, given that specialist commissioning in the region is currently in deficit by £148m.

3.3. Neal Hounsell noted that the definition and implications of an Accountable Care System (ACS) are not yet clear, and local authorities will have to consider for themselves how they wish to respond to an ACS proposal, outside of the deliberations of the CCGs. The ACS would have major implications for the prevention agenda, and it was not clear how this would work, given the variation in public health budgets across different councils.

3.4. Members noted that it is currently expected that the new accountable officer for the North East London CCGs is likely to be appointed in November, but it is not yet clear how that role will operate and concern was expressed that the post may give rise to difficult conflicts of interest.

4. Care Workstream Assurance Review Point 1

4.1. Devora Wolfson presented an update on progress made to date by the Care Workstreams; their direction of travel, priorities, governance processes and updated workstream asks. The papers presented had been reviewed by the Transformation Board and the Integrated Commissioning Steering Group, both of which had welcomed the progress made, and recognized the work planned for the coming months.

Planned Care

4.2. Neal Hounsell, Senior Responsible officer for Planned Care, reported that eight key priority projects had been identified for the workstream, and work was ongoing to determine the membership of project groups and the approaches to be taken. Members asked for detail on the focus on work on housing. Neal responded that this would look at the role of housing in prevention, and how the design of new housing can allow provision of homes which are more adaptable to suit people's changing needs as they go through life. Members sought and received assurance that there were strong links between the workstream and patients and public. In particular it was noted that patients have been involved in the anticoagulation service re-design from the outset.

Unplanned Care

4.3. The Unplanned Care workstream has been meeting since December and is now well established, with work ongoing across four key priority areas.

4.4. Haren Patel raised a query about the approach to Duty Doctor. In the absence of representation from the workstream at the ICB meeting, it was agreed that specific questions would be raised with the Unplanned Care Board outside of the meeting.

Prevention

4.5. Anne Canning reported on the eight priority areas for Planned Care, noting that at present there are no provider organisations represented on the membership of the core workstream group. This is due to there being too many providers for any group to be equitably representative, but a solution would need to be found to this issue in due course. Good progress has been made on defining the ask and on identifying areas of overlap with other workstreams and on areas which fall outside of the remit of the partners; e.g. Immunisation, which remained the responsibility of NHS England.

4.6. It was noted that the Children and Young People's workstream group would begin meeting in October, and that its first assurance point would be in the first quarter of 2018/19.

4.7. The Integrated Commissioning Boards:

- **NOTED** the responses from the Prevention, Unplanned Care and Planned Care workstreams in terms of Review Point 1;
- **NOTED** the governance arrangements for the three care workstreams;
- **APPROVED** the priorities being taken forward by the three care workstreams and note that they are broadly aligned to our strategic priorities;
- **APPROVED** the proposed process for moving budgets and services across workstreams;
- **APPROVED** the updated care workstream asks;
- **NOTED** the next steps for the workstream development set out in section 9 of the report; and
- **APPROVED** the revised process for Review Point 2

5. Better Care Fund

5.1. Siobhan Harper reported that technical guidance for the next round of the Better Care Fund (BCF) has now been published by NHS England ahead of a

submission deadline of 11 September 2017. This round of funding includes additional local authority funding; the Improved BCF (iBCF), which is being used to meet adult social care needs, reduce pressures on the NHS; supporting hospital discharge and ensuring the local social care provider market is supported.

5.2. With regards to the use of iBCF funding to address delayed transfers of care (DTC) at the Royal London Hospital, it was noted that the care navigator had built good relationships, but it had taken time to achieve this and there were ongoing communications issues between hospitals and GPs, as well as timing issues in how DTCs are reported to the commissioners.

5.3. The Integrated Commissioning Boards **RECOMMENDED** the proposals set out for the BCF for 2017/18 to the Health & Wellbeing Boards for approval.

6. Consultation on 8-8 Extended Access to General Practice

Clare Highton and Haren Patel each declared an interest in this item as General Practitioners in Hackney.

6.1. Mark Rickets and Richard Bull presented an overview of City & Hackney CCG's approach to implementing the government's commitment to giving all patients access to general practice from 8 a.m. until 8 p.m. seven days per week. At present almost all practices in the area offered some kind of extended hours service, but not to the extent of the national definition.

6.2. It was not yet clear what funding would be for 2017/18, but the drop in CCG extended access funding by approx. 5% from the previous year meant that the ability of practices to offer extended access would reduce. The plan was to provide extended access through two 'hubs'; one in the north and one in the south of the area. Without clarification on funding the CCG was not yet in a position to consult more broadly on the plans, and officers reported that engagement would continue as the process continued.

6.3. Members noted that patients were likely to be confused by the fact that there is no link between GP Out-of-Hours provision and NHS 111. Mark Rickets clarified that whilst NHS 111 was focused on urgent care, if a caller has a non-urgent problem, they may be given a non-urgent appointment at a GP Out-of-Hours hub.

6.4. Geoffrey Rivett queried the level of public and patient engagement carried out to date. It was noted that the proposals had been discussed at the Patient and Public Involvement Committee, and there would be further consultation regarding options for the southern 'hub', but it was noted that options were somewhat limited as changes were mandated by central government.

6.5. The Integrated Commissioning Boards **NOTED** the local plan; but did not endorse it at this point due to insufficient clarity on finances, etc.

7. Expansion of the Primary Care Anticoagulation Service

Clare Highton and Haren Patel each declared an interest in this item as General Practitioners in Hackney, and did not take part in the Boards' decisions on the matter.

7.1. Jan Tomes and Rozalia Enti presented the report on plans for an extended primary care anticoagulation service which aims to deliver safe, cost-effective services to all patients close to where they live, whilst delivering improved quality, innovation, productivity and prevention (QIPP) savings.

7.2. 23 Practices currently offer primary care anticoagulation services. The proposals, agreed by the CCG Local GP Provider Contracts Committee on 30 June, set out expansion of services to cover the whole population by allowing patients to access anticoagulation services in practices at which they are not registered, including first time initiation of treatment. The service would be managed under a single contract by the GP Confederation. It was noted that from a patient point of view this was preferable by far to having to register with a different practice.

7.3. Ellie Ward asked whether there was a risk of the Neaman Practice withdrawing from the service and whether there was a 'plan b' in place for this eventuality. Jan Tomes responded that the specification had changed to ensure a provider in the City, which was the Neaman Practice, but if they withdrew there was no contingency plan in place. There was, however, no suggestion that this was an actual risk.

7.4. The Integrated Commissioning Boards:

- **ENDORSED** the expansion of the primary care anticoagulation contract with the contract being awarded to the GP Confederation, as approved by the Contracts Committee on 30 June 2017; and

  NOTED the anticoagulation data set out in the report which will support longer term commissioning plans and allocation of resources particularly for the primary care prescribing budget.

8. Integrated Commissioning Evaluation Process

8.1. Devora Wolfson reported that an Integrated Commissioning Evaluation Steering Group has been set up to oversee and steer the evaluation, and presented a specification for the evaluation, which would be used to appoint evaluators and guide their work. It was anticipated that the evaluation procurement (for which the budget was up to £350k for three years) would be put out for tender soon.

8.2. The members thanked Devora for her work in setting up the steering group and devising the specification.

8.3. The Integrated commissioning Boards:

- **APPROVED** the aims, objectives and proposed process for evaluation of the Integrated Commissioning Programme; and
- **APPROVED** the timetable for evaluation and the criteria for selection of an evaluation provider.

9. Care Workstream Directors Group and Integrated Commissioning Steering Group Terms of Reference

9.1. The Integrated Commissioning Boards **APPROVED** the terms of reference for the Integrated Commissioning Steering Group and the Care Workstream Directors Group.

10. Minutes of the Transformation Board

10.1. The Integrated Commissioning Boards **NOTED** the minutes of the Transformation Board meeting on 14 July 2017.

11. Reflection on the ICB Meeting

The Boards noted that the Senior Responsible Officer or their nominated deputy should be present for future Care Workstream assurance discussions.

Dhruv Patel noted that meeting in common was a useful way of conducting business, and it was agreed that consideration should be given to the scope for carrying out future meetings in this way.

ACTION JICB1708-2: To seek legal advice on how future meetings of the two ICBs can be held in common. (DW)

12. Any Other Business

12.1. None.

Title:	Framework for Risk Sharing in 2017/18
Date:	18 October 2017
Lead Officer:	Sunil Thakker, NHS City & Hackney CCG Joint Chief Financial Officer
Author:	Sunil Thakker, NHS City & Hackney CCG Joint Chief Financial Officer
Committee(s):	Tuesday 26 September 2017 NHS City & Hackney CCG Finance and Performance Committee Friday 29 September 2017 NHS City & Hackney CCG Governing Body Wednesday 18 October 2017 Integrated Commissioning Boards
Public / Non-public	Public

Executive Summary:

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

The Governing Body requested that information on any deployment of the framework be reported back to them, along with information on the benefits to patients the deployment had provided.

Questions for the Transformation Board

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

Issues from Transformation Board for the Integrated Commissioning Boards

Not applicable

Recommendations:

The Integrated Commissioning Board is requested to NOTE the report.

Links to Key Priorities:

NHS England planning guidance requires a risk sharing arrangement be in place for 2018/19. The CCG has operated a risk share arrangement with partner CCGs for a number of years.

Specific implications for City and Hackney

£1.9m will be deployed into the East London Health and Care Partnership system in 2017/18 in support of delivering a system control total.

Patient and Public Involvement and Impact:

Not applicable.

Clinical/practitioner input and engagement:

Not applicable.

Impact on / Overlap with Existing Services:

Not applicable.

Framework for Risk Sharing in 2017/18

For review and consideration by the Governing Body

29 September 2017

NHS
City and Hackney
Clinical Commissioning Group

Background to 2016/17 Framework for Risk Sharing

- In 2016/17 City & Hackney CCG deployed its 1% uncommitted strategic reserve totalling £3.7m via the Framework Agreement for Risk-Sharing. The arrangement was extended in-year to include all seven CCGs within NEL with BHR CCGs as the new entrant into the scheme.

- The process of agreeing the 2016/17 arrangement was time consuming and included discussions with external audit about engaging in the risk share and specifically cost pressures identified elsewhere in the NEL system and in particular BHR. External audit considered the risk this posed to City & Hackney CCG, its main provider, the Homerton, and patients and considered it legitimate to support BHR in the arrangement without compromising statutory responsibilities, subject to proper governance.

- Based on the review by external audit that allowed the risk sharing to progress, this set the precedent for it to continue to include all seven CCGs, subject to proper governance.

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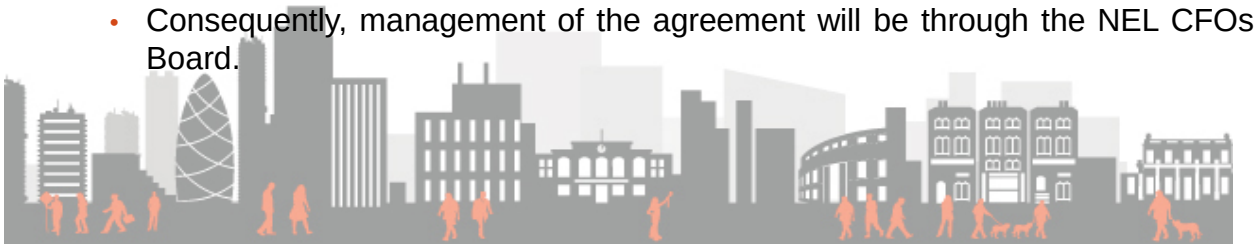
2017/18 Framework for Risk Sharing

- In 2017/18 the draft STP Framework for Risk Sharing was re-written by the City & Hackney CCG Joint CFO incorporating principals taken from CIPFA best practice guidance. The document was also shared with and reviewed by the CFOs of Tower Hamlets CCG, Waltham Forest CCG, Newham CCG and BHR CCGs.
- The uncommitted strategic reserve available in 2017/18 is £1.9m equating to 0.5% as opposed to the 1% of allocation from previous year. It has been ringfenced in line with NHS business rules.
- The uncommitted 0.5% strategic reserve totalling £220k for core primary care is excluded as per NHSE guidance.
- The full agreement accompanies this document.
- Principals embedded include:
  - That the seven CCGs within NEL STP have agreed to work in collaboration and the Framework for Risk Sharing sits within the collaborative partnership;
  - That the management of this should be though CCG CFOs group and their respective Governing Bodies;
  - That the decision to deploy the strategic reserve should not be externally influenced as funding originates from 2017/18 CCG funding allocation; and
  - Consequently, management of the agreement will be through the NEL CFOs group, with a report to the ELHCP FSC and their Board.



NHS

City and Hackney Clinical Commissioning Group

Recommendation

- City & Hackney CCG Governing Body is asked to review and consider the 2017/18 Framework for Risk Sharing for the deployment of £1.9m into the NEL system in 2017/18 in support of delivering a system control total. This will also contribute to system stability from a local provider and patient perspective.
- City & Hackney CCG Governing Body is asked confirm whether they are satisfied with the governance arrangements and, outside of the agreement, whether further internal governance arrangements are needed to cover actual proposals to deploy funds e.g. sign off by the two ICBs as Committee of the Governing Body.
- The Governing Body is asked to note the most recent high level NHSE planning guidance that requires risk a sharing arrangement for 2018/19. This has yet to be formalised and agreed with NEL STP partners.

NHS
City and Hackney
Clinical Commissioning Group

East London Health & Care Partnership

Waltham Forest, Tower Hamlets, Newham, City & Hackney, Barking & Dagenham, Havering and Redbridge CCGs

Framework Agreement for Risk-sharing in 2017/18

April 2017

Contents

This document describes a framework Agreement for the Clinical Commissioning Groups (CCGs) within the ELHCP to collaborate in handling financial risk in 2017/18. It includes the following specific sections:

Section 1: Background & Context

This Agreement is dated March 2017.

It is between:

(1) Waltham Forest NHS Clinical Commissioning Group of Kirkdale House, 7 Kirkdale Road, London E11 1HP.

(2) Tower Hamlets NHS Clinical Commissioning Group of 2nd Floor, Alderney Building, Mile End Hospital, Mile End, London E1.

(3) Newham NHS Clinical Commissioning Group of Warehouse K, Unex Tower, 5 Station Street, London E15 1DA.

(4) City & Hackney NHS Clinical Commissioning Group of 3nd Floor, Block A, St Leonards Hospital, Hoxton, London N1 5LZ.

(5) Barking & Dagenham NHS Clinical Commissioning Group, Maritime House, 1 Linton Rd, Barking, IG11 8HG

(6) Havering NHS Clinical Commissioning Group, 3rd Floor, Imperial Offices, 2-4 Eastern Rd., Romford Essex, RM1 3PJ

(7) Redbridge NHS Clinical Commissioning Group, Becketts House, 2-14 Ilford Hill, Ilford, Essex IG1 2QX

North East London has developed a five year Sustainability & Transformation Plan from October 2016 onwards. The seven CCGs within the STP area have agreed to work in collaboration and this risk share document sits within the context of that collaborative partnership.

Mechanisms for CCG collaboration have been established for some time and are expected based on statutory guidance for collaboration and NHS Operating Guidance. This document enables sets out how the guidance will be undertaken in NEL, whilst protecting the statutory duties of individual CCGs within the system.

It is recognised that risk is best managed by those best able to address the specific risk. As such there is no single place that financial risk management will best be delivered. CCGs will encompass a range of risk management approaches. These will include:

- Individual CCG financial control totals and governance of the delivery of these through adequate budget provision and contingency provisions;
- Risk-sharing with local commissioning partners, including local government, such as through joint commissioning arrangements;
- Risk-sharing with providers through contractual agreements to incentivise activity management, service change and QIPP delivery;
- Effective governance arrangements including Board assurance processes and effective CSU support ;

- Effective provision for risks impacting individual organisations within the ELHCP footprint from outside the ELHCP boundaries;
- Consideration of the wider strategic context so that actions of one party do not destabilise the health economy.

Each CCG retains individual accountability for the management of their own financial risk and will undertake to set aside a proportion of their recurrent budget for this purpose (including a minimum general 0.5% contingency reserve and other non-recurrent resources where needed).

Each CCG will operate with transparency in the assessment of risks and its mitigation plan which can be scrutinised by others within the collaborative.

This Agreement shall be overseen by each CCG's Governing Body in order to ensure that CCG financial statutory duties are met and that the CCG's financial objectives in support of their health strategies are achieved, whilst considering how the STP control total is delivered.

The CCGs are committed to achieving best practice in risk management and governance of their risk processes, individually and collectively.

Each CCG in reviewing and managing risk shall ensure that risks are reviewed and scrutinised by applicable managers and lay members in addition to CCG CFOs with an understanding of agreed actions taken or planned by whoever to manage it.

Management of the Agreement will be through the NEL CFOs group, with a report to the ELHCP Financial Strategy Committee and the ELHCP Board.

Other Collaborative Agreements

This document should be seen in the context of other specific collaborative agreements which support future at-scale developments and commissioning from providers. The various Parties may be subscribers to some or all of the other collaboration agreements, but have agreed to abide by a collective approach to risk which is set out here.

In reaching this agreement, the Parties have aimed to produce a set of principles that are adaptable to circumstances, but recognize that the approach and key principles may require future review should circumstances change.

Section 2: Principles of Collaboration

In defining this framework the CCGs have identified a number of principles which have framed the approach. These are:

- Having a clear transparent approach, based on openness and demonstrated by sharing of financial plans, the extent of exposure to risk and early warning of potential in-year risk
- Achieving the highest standard of governance, respect for legal framework(s), the roles and responsibilities of Governing Bodies and compliance with audit requirements.
- Quantifying each CCG's exposure to financial risk, and its ability to mitigate, by using a commonly-agreed methodology
- Establishing mechanisms which ensure that investment and support with common providers is linked to management of contractual risk and/or firm commitment to deliver strategic change in line with the STP financial plan.
- Establishing an agreement to pool investment and risk between specific CCGs for specific projects as set out in the STP financial plan.
- Incentivizing good performance.
- Focusing on building relationships and trust, behaving with integrity with strong ethical values.
- Acting responsibly (both collectively and individually) to ensure effective stewardship of NHS resources and meeting the duty to achieve VFM.
- A commitment that the actions of one body will not compromise the statutory duties of individual organisations.
- Ensuring transparency in reporting and accountability between organisations and the wider public in how public funds are managed and openness and stakeholder engagement with respect for individuals' legitimate circumstances or concerns
- Attaining best practice for risk management.
- Reviewing the arrangements annually or as and when required.

Section 3: Governance & Mechanisms for Risk-sharing

Accountability and responsibility for decision-making sits with each CCG as outlined in their respective Constitutions, except where this has been specifically delegated or formally agreed otherwise. Each CCG Governing Body will define schemes of delegation and responsibility for individuals. Collaborative work will occur within the agreed delegation and revert back to the Governing Body as appropriate.

The operation of the risk share will be overseen by a Group comprising the five CFOs. A consensus of all five is required for a decision to have effect.

As laid out in Section 2, the CCGs will use a common template for assessing their exposure to financial risk and their available means to mitigate. The template is shown at Schedule 2. Chief Financial Officers (CFOs) can collectively agree to vary or change this methodology e.g. by agreement to use a standard NHS England template.

The aim is to achieve best practice in risk management, by a thorough analysis of risks, the likelihood of the risk occurring, operating appropriate levels of internal control, identifying robust mitigations. This analysis will be shared with other members within the STP and open to challenge. Where the members collectively identify residual risk exists, further mitigations will be identified.

A set of stress tests, such as those operated by the Bank of England but applicable to the health economy, will be devised by CCG members and applied to individual CCG commissioning plans and consolidating into the collective STP Plan. A response plan to the risks arising from the stress tests will be developed and applied in the event the stress risk materializes. The aim of the stress tests is to examine the impact of a hypothetical adverse scenarios on the financial health of the NEL health economy and the organisations within it. This will allow local NHS leaders to test the economy's resilience to future stresses, develop a plan to deal with them if they materialize and provide confidence to the public and regulators that health systems in NEL have stability. The stress tests will be run at least annually.

The Parties agree that initial financial plans, risk exposure and mitigation will be shared between CCG CFOs. CFOs should provide an assurance on the collective position to the Group. Where CFOs identify potential and material risk that will impact on this agreement, it should form part of a report to the Group with a recommendation to address the problem.

CFOs shall repeat this exercise during the year, no less than quarterly (more frequently if risks materialize), based on actual in-year and forecast performance and report to the NEL CCG CFOs group.

In the event of a report by the CFOs which requires action, the Group will seek to find a consensus consistent with the principles of this Agreement that can be approved by officers within appropriate levels of delegation or by respective CCG Governing Bodies. The approval must also be consistent with NHSE guidance.

In order to reach a decision, the Group may collectively agree to seek advice and views or resolution from other groups identified within the STP MOU. Otherwise, where a decision is outside delegated authorities, the Group will refer that decision back to each CCG Governing Body.

A Party to this Agreement will be considered in breach of its provisions and principles if it has:

- acted recklessly or fraudulently;
- knowingly failed to declare risks which it should properly have been aware of;
- failed to comply with the requirements for information sharing or the agreed methodology; or
- failed to take adequate mitigating actions within its mitigation plan, in the view of the CFOs group.

The success of the agreement shall be judged by the achievement of the financial control total, through the early identification of risk and taking mitigating action.

CCGs are specifically mandated to hold a minimum 0.5% contingency within their individual positions. It is envisaged that this will be a first call on individual CCG risks, but will be clearly shown within the risk analysis.

A further 1% is required to be spent non-recurrently, but only 0.5% has to be uncommitted at the start of the financial year by CCGs party to this agreement. Each CCG party to this agreement has set aside 0.5%. This arrangement does not include the 0.5% relating to core primary care allocation.

Note, 0.5% of the local CCG CQUIN scheme will also be held to cover risk. This is subject to separate governance arrangements within NHSI/NHSE and is not directly linked to this agreement.

The risk analysis will ensure that adequate provision within the 0.5% is identified to cover material risks for individual CCGs outside the STP boundaries, for example, where there are significant transactions with North Central London providers. Release of this provision will be subject to the review process during the year and sign off by the CFO with direct responsibility for these risks.

Should there be a need to transact the use of these sums, and in the absence of Direction, this will be achieved by transfer via an Inter Authority Transfer to cover the risk impact, reversible in future years on terms to be determined by each organization, but expected to be in line with the phasing and mitigation of future risk.

It is noted that further reserves against risk are being held nationally and release is subject to national policy.

Section 4: Agreement

On behalf of CCG Governing Bodies, Chief Financial Officers agree the updated framework reflecting the proposed approach to collaboration on risk-sharing.

IN WITNESS WHEREOF:

The Parties signed this Agreement in March 2017.

CCG	Chief Financial Officer	Date
Waltham Forest	Name: Signature:	
Tower Hamlets	Name: Signature:	
Newham	Name: Signature:	
City & Hackney	Name: Signature:	
Barking & Dagenham	Name: Signature:	
Havering	Name: Signature:	
Redbridge	Name: Signature:	

Schedule 1: Example Methodology for Calculating Risk Exposure & Funds to Mitigate (actual methodology deployed to be determined in accordance with prevailing circumstances).

	Example Risk Analysis						
			Total	Controllable/ Planned Care/Block	Non controllable Unplanned Care	Assessed Risk	Basis of risk assessment
			£000	£000	£000	£000	
Acute	Barts Health	Contract PbR/Non-PbR	85,815	55,499	30,316	1,516	5% based on historic trend
	Homerton	Contract PbR/Non-PbR	7,897	5,353	2,544	76	3% based on historic trend
	Great Ormond Street Hospital for Children NHS Foundation Trust	Contract PbR	239	-	239	7	3% based on historic trend
	Guy's and StThomas's NHS Foundation Trust	Contract PbR	1,364	864	500	15	3% based on historic trend
	King's College Hospital NHS Foundation Trust	Contract PbR	235	118	118	4	3% based on historic trend
	North Middlesex University Hospital NFT	Contract PbR	88	44	44	1	3% based on historic trend
	Royal National Orthopaedic Hospital NFT	Contract PbR	359	179	179	5	3% based on historic trend
	Royal Brompton and Harefield NHS Foundation Trust	Contract PbR	44	22	22	1	3% based on historic trend
	Royal Free Hampstead NFT	Contract PbR	275	138	138	4	3% based on historic trend
	Moorfields Eye Hospital NHS Foundation Trust	Contract PbR/Non-PbR	5,108	816	4,292	129	3% based on historic trend
	St George's Healthcare NFT	Contract PbR	115	58	58	2	3% based on historic trend
	Whittington Hospital NFT	Contract PbR	118	70	48	1	3% based on historic trend
	Barking, Havering and Redbridge Hospital NFT	Contract PbR	469	235	235	7	3% based on historic trend
	The Royal Marsden NHS Foundation Trust	Contract PbR	63	-	63	2	3% based on historic trend
	University College London Hospitals NHS Foundation Trust	Contract PbR	1,946	973	973	29	3% based on historic trend
	Imperial College Healthcare NFT	Contract PbR	476	238	238	7	3% based on historic trend
	Chelsea and Westminster Hospital NHS Foundation Trust	Contract PbR	281	140	140	4	3% based on historic trend
	North West London Hospitals NFT	Contract PbR	72	-	72	2	3% based on historic trend
	Mid Essex Hospital Services NFT	Contract PbR	45	-	45	1	3% based on historic trend
Acute NHS Total			105,010	64,747	40,263	1,814	
Acute Other	BMI	Contract PbR	1,400	1,400	-	7	Controllable as GP referral
	Non Contracted Activity	PbR	2,590	-	2,590	130	3% based on historic trend
	ISTC	Contract Block	670	670	-	4	3% based on historic trend
	LAS	Contract Block	9,200	9,200	-	920	10% risk, based on recent
Acute Other Total			13,860	11,270	2,590	1,061	
Non-Acute	Prescribing	Per item	29,986	483	29,503	295	1% historic trend
	Primary Care	Various	52,300	32,050	10,250	205	2% assumed
	Mental Health	Block	41,372	41,372		-	Assume all 100%
	Community services	Block	42,455	42,455		-	Assume all 100%
	Continuing Care	Variable/Non Ifse	10,347		10,347	1,862	18% past 2 years performance
	LA Pooled Funds inc BCF	s75	24,090	23,000	1,090	33	3% based on historic trend
	End of Life	Variable	2,365	1,834	531	16	3% based on historic trend
	LD	Variable	2,768		2,768	83	3% based on historic trend
	Other non acute	Variable	4,464	2,232	2,232	67	3% based on historic trend
Non Acute Other Total			210,147	143,426	56,721	2,561	
Corporate Costs	Running Allocation		6,543	6,234	309	-	All controllable
	QIPP Not allocated		640		640	320	50% risk of non-delivery
	Property Costs	Non Ifse	1,230	1,200	30	20	Costs not agreed
	Other commissioning Costs		4,960	3,190	1,770	35	Project costs not confirmed
Corporate Total	Mitigations		13,373	10,624	2,749	375	
Reserves & Surpl	0.5% Contingency		1,983	1,983		- 1,983	
	0.5% Non Recurrent Reserve/Headroom		1,983	1,983		- 1,983	
	NR Commitments		1,983	1,983		- 1,983	
	Specific Risk Reserves		1,295	1,300		- 1,295	
Reserves and Surplus Total			7,244	7,249	-	- 7,244	
Residual Risk/Surplus			349,634	237,316	102,323	- 1,433	
	Other Risks						
Other risks	111 Procurement		140	120	20	20	Price risk
	Other Procurements		350		350	60	Price risk
	Miscellaneous		80		80	27	Specific risks
Total Risk Exposure			570	237,436	102,773	- 1,326	
Risk Mitigation Measures:							
	Contract Management	Detail as set out in schedule					
	GP Referrals	Detail as set out in schedule					
	Prescribing	Detail as set out in schedule					
	QIPP Delivery	Detail as set out in schedule					
	Procurement	Detail as set out in schedule					
	Primary Care	Detail as set out in schedule					
	Property Costs	Detail as set out in schedule					

Title:	Report on Workstream Assurance Point 2
Date:	18 October 2017
Lead Officer:	Paul Haigh, Anne Canning, Neal Hounsell
Author:	Paul Haigh
Committee(s):	Will be submitted to the 18 October ICBs with comments from the 13 October Transformation Board
Public / Non-public	Public

Executive Summary:

The Integrated Commissioning Steering Group met with the SRO and workstream director for planned care, unplanned care and prevention on 28 September to review their assurance point 2 submissions
The summary of the discussions and wider implications is attached for debate and agreement
Full submissions by each workstream are via a weblink rather than submitted as an appendix. These are private and confidential to Board Members.

Questions for the Transformation Board

The TB is asked to consider the proposed next steps and comment on these

Recommendations:

The Integrated Commissioning Board is asked to note the progress being made by the workstreams against the assurance point 2 gateway and to endorse the system issues and next steps outlined

Links to Key Priorities:

Assurance point 2 and gateways is focusing on workstream progress against key priorities

Specific implications for City and Hackney

none

Patient and Public Involvement and Impact:

Workstreams asked to outline PPI engagement in assurance point 1

Clinical/practitioner input and engagement:

Workstreams asked to outline clinical engagement in assurance point 1

Impact on / Overlap with Existing Services:

No service specific issues or recommendations

Supporting Papers and Evidence:

Hyperlink to full workstream submissions **www.goo.gl/N4ouvq.** These are private and confidential to Board Members.

Sign-off:

Workstream SRO _____[Tracey Fletcher, Neal Hounsell, Anne Canning]_____
London Borough of Hackney _____[*insert name and title*]_____
City of London Corporation _____[*insert name and title*]_____
City & Hackney CCG _____[*insert name and title*]_____

ASSURANCE POINT 2

SUMMARY & NEXT STEPS

OCTOBER 2017

Context

- A review of workstream submissions for Assurance Point 2 was undertaken at the IC Steering Group on 28 October
  - The detailed submissions from each workstream are here for information – www.goo.gl/N4ouvq These are private and confidential to Board Members
  - The focus of this assurance point is on:
  - Transformation plans
  - Virtual teams
  - Further pooling opportunities
  - General OD issues

Transformation plans

- All 3 workstreams are making good progress with their transformation plans and in understanding the current contractual arrangements that support each

- There is a need to now focus on
  - How plans once agreed by the TB are embedded across the partner organisations
    - It is proposed to pilot an “MOU” (memorandum of understanding) approach to define organisational contributions to plans
    - Local plans to take forward FYFV priorities are coming through workstreams to TB and these (as well as other priorities such as neighbourhoods, continuing care) can be used to pilot an MOU approach
  - Support with change management across organisations
    - Proposals are being developed for further discussion by Workstream Directors, prior to TB debate. A key issue will be engagement of middle managers who at present don’t regard some of this as “the day job”
  - Where workstreams want to use the “design lab” approach
    - This will be included in the change management support above
  - Agreeing the model for clinical leadership and engagement
    - How do workstreams get system wide support for their plans – a paper will come to the TB on this

Virtual teams

- All 3 workstreams have identified key members of staff who are critical to support plans

- Work has begun to either formally second or align CCG staff to workstreams
  - More work is needed on LA input to this
- As part of implementing this model clarity will be needed on where individuals are still carrying responsibilities for the statutory organisations and how accountability will work
  - Given this the ICSG is proposing that all responsibilities are aligned to workstreams by April with workstreams taking overall leadership, supported by current staff and that MOUs are developed to articulate how this will work
  - This will also require the 3 commissioners to agree an operating model for functions which may not sit within one workstream

Pooled budgets

- NHSE has confirmed they are happy to receive proposals for further pooling of budgets across CCG and LAs

- Workstream proposals for pooling are
  - All budgets assigned to prevention
  - All budgets in planned care associated with continuing care and residential care
- These are supported by the ICSG and will be test cases to explore process and willingness of NHSE/NEL
  - Amaka Nnadi is supporting the workstreams to develop mini business cases – once these are supported by the statutory organisations discussions can commence
  - If approved further changes will be needed to integrated commissioning governance to reflect delegation of decision making

Other OD issues

- The importance of neighbourhoods as the system wide delivery model has emerged from all workstreams
  - Unplanned care will bring proposals for further debate to the TB in November
- Work is needed on what is " good enough" – what are the expectations of the TB in relation to workstream proposals and the level of support these command
  - Propose to reflect on this collectively in January 2018 once the TB has had the opportunity to consider a number of propositions during Autumn 2017
- The need to clarify the governance across the 3 commissioning organisations and where IC fits in given the ICBs are advisory
  - More work needed on forward plan and on tracking papers via the organisations
  - Agreed that everything needs a workstream perspective as one way to embed IC
- Continuing need to ensure workstream plans articulate City- specific model or implications
  - Address via discipline of cover sheet

ASSURANCE POINT 3

- Financial planning for 1819 and beyond is about to commence
  - This will involve the workstreams in developing plans to achieve financial balance and deliver system savings, against 3 scenarios (to be agreed by the ICBs) and the TB agreeing system wide priorities
- This will be a significant ask and it is proposed that the milestones which are developed for financial planning become the key elements of assurance point 3
- Three other key issues which could form the next assurance point are
  - Progress with the “big ticket” items across the system and providing assurance to the 2 HWBBs
  - Alignment of all responsibilities and action plans to workstreams by April
  - Development of “MOUs” within workstreams (to support implementation of plans), across workstreams (eg neigbourhoods, mental health) and across the system (what the workstreams are signing up to achieve)
- More work will continue to develop these for the next TB/ICBs if supported

Title:	Prioritisation of Investments
Date:	18 October 2017
Lead Officer:	Anna Garner, Head of Performance, CCG
Author:	Anna Garner, Head of Performance, CCG
Committee(s):	Integrated Commissioning Board – 18 October 2017 (decision) Joint ICB/Transformation Board workshop on financial scenarios – 23 November 2017 (decision)
Public / Non-public	Public

Executive Summary:

Method of prioritisation of investment requests across the City and Hackney system recommended:

1. Method/timelines
   - Process approved by ICB and GB/LAs: November
   - Workstreams asked to submit their plans for new schemes, savings plans including 'invest to save' schemes (templates and guidance provided for submissions, workstreams have to provide evidence for impact of scheme on number of 'value criteria' – see below): end January
   - Financial scrutiny of submissions, assessment of robustness of savings included and impact across the system (method TBC): February
   - System prioritisation group (SPG) individually scores schemes against value criteria (1-10): February
   - System prioritisation group meets to discuss scores and moderate (to incorporate discussion on additional factors such as reach/impact of scheme, KPI performance to date, ability to impact on hard to reach groups etc): February
   - Ranked list of schemes based on value scores alone, and cost:value score ratios (£ per value point) produced: value for money ranking. This applied to amount of funding available and top ranking schemes recommended to be funded: February
   - Transformation Board discuss recommendations from SPG and approve/revise (ranked list of schemes and those recommended to be funded): March
   - ICBs discuss recommendations from TB and approve/revise: March
   - CCG GB, LBH Cabinet and CoL Court of Common Council discuss recommendations from ICBs and approve/revise: March
   - Potential role for a group (potentially the Prioritisation and Investment Committee for advice to successful schemes on commissioning, contracting and monitoring): April

2. Value Criteria

Theory: the criteria must encompass everything 'of value' to the system (and thus our aims as a new integrated system) – i.e. all aims and benefit (suggested weighting of these criteria in brackets):

I. Physical health gain (15)
II. Mental health and wellbeing and quality of life gain (15)
III. Supports increasing focus on prevention (wide definition of prevention including wider determinants of health, primary prevention, secondary prevention, and preventing increased health and social care usage) (20)
IV. Patient empowerment (10)
V. Reducing inequalities in health and care outcomes (15)
VI. Social value (5)
VII. Ensuring equity in access (5)
VIII. Supports financial sustainability (15)

Other aims of the system are around integration, efficiency, new care models etc but these are process aims rather than outcomes so that has to be reflected by the workstreams in how this will happen and what impact this will have on the population.

Evidence for impact of the scheme on the above criteria will include: published evidence, previous/existing pilots, local data analysis, clinical/practitioner support for schemes, resident/patient feedback.

3. Money

Cost of scheme are included in the information workstreams have to submit. Estimated system savings (assumptions and sources referenced) are also stated.

Some financial scrutiny of the plans is required (method TBC) to assess whether savings estimation is robust (and whether all system costs have been included), how risky/certain achievement of these savings is and then adjust the cost of the scheme according to this (when producing the cost:value score ratios).

4. System Prioritisation Group

Only meets to complete prioritisation scoring function. Makes recommendations based on the scoring to the TB.

Recommendations:

The Integrated Commissioning Board is asked:

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

Patient and Public Involvement and Impact:

Public and lay members involved in previous CCG process and input to new system process via Transformation Board.

Clinical/practitioner input and engagement:

Input to new system process via Transformation Board.

MAIN REPORT

Prioritisation of investment requests – across City and Hackney system

Need

Workstreams asked to set out their plans to deliver asks, identify transformational priorities and improve delivery/value of contracts for 2017/18 and 2018/19.

Prioritisation process needed to prioritise investment as well as disinvestment plans and will have to enable comparisons between very different schemes/initiatives (in terms of impact, reach, inequalities, cost etc) and should ensure that there is robust, transparent, fair process to decide which schemes are funded or cut (defensible to the residents/patients, the workstreams and providers, and other stakeholders).

The Integrated Commissioning system will have to decide on a process to assess value for money for suggested schemes and rank which provide most value for money for City and Hackney population.

Previous process in CCG:

- Value criteria (and weighting) consulted upon (criteria = Health gain, Patient experience and empowerment, Improving access and equity, Reducing health inequalities, Sustainability)
- Programme Boards submit templates detailed evidence behind the impact of schemes on above value criteria
- Each scheme scored 1-10 for each value criteria by each PIC member
- Output: average value scores for each scheme to be assessed against cost (adjusted for agreed system savings) = notional value for money metric

Recommendations on new process

1. Method Timelines
   - Process approved by ICB and GB/LAs: November

- Workstreams asked to submit their plans for new schemes, savings plans including 'invest to save' schemes (templates and guidance provided for submissions, workstreams have to provide evidence for impact of scheme on number of 'value criteria' – see below): end January
- Financial scrutiny of submissions, assessment of robustness of savings included and impact across the system (method TBC): February
- System prioritisation group (SPG) individually scores schemes against value criteria (1-10): February
- System prioritisation group meets to discuss scores and moderate (to incorporate discussion on additional factors such as reach/impact of scheme, KPI performance to date, ability to impact on hard to reach groups etc): February
- Ranked list of schemes based on value scores alone, and cost:value score ratios (£ per value point) produced: value for money ranking. This applied to amount of funding available and top ranking schemes recommended to be funded: February
- Transformation Board discuss recommendations from SPG and approve/revise (ranked list of schemes and those recommended to be funded): 9th February/9th March
- ICBs discuss recommendations from TB and approve/revise: 28th February/21st March
- CCG GB, LBH Cabinet and CoL Court of Common Council discuss recommendations from ICBs and approve/revise: March (CCG GB 23rd March; LBH Cabinet 23rd March; CoL Court of Common Council: 8th March)
- Potential role for a group (potentially a revised version of the Prioritisation and Investment Committee for advice to successful schemes on commissioning, contracting and monitoring – needs widened membership to include LBH and CoL): April

2. Inclusions

Services to be included in prioritisation process:

I. New schemes/service developments/contract extensions for currently non-recurrently funded services requiring investment

II. Schemes with aim to deliver system savings which require investment

III. Any disinvestment plans

IV. All contracts coming to end and requiring recommissioning (future aim)

3. Value Criteria

Theory: the criteria must encompass everything 'of value' to the system – i.e. all aims and benefit, but ideally be mutually exclusive – so you are not double scoring for any element.

The below have been revised from the previous criteria to reflect the priorities for the City and Hackney system as set out in previous devolution documents and the strategic framework for workstreams (inclusion of mental health gain as a separate criterion to reflect focus on parity of esteem, inclusion of supporting prevention focus to reflect one of the ultimate aims of C&H, inclusion of social value to reflect importance of this on wider system and as a requirement of local authorities, some revisions to wording of others). Suggested weighting of these criteria in brackets.

IX. Physical health gain (15)

X. Mental health and wellbeing and quality of life gain (15)

XI. Supports increasing focus on prevention (wide definition of prevention including wider determinants of health, primary prevention, secondary prevention, and preventing increased health and social care usage) (20)

XII. Patient empowerment (10)

XIII. Reducing inequalities in health and care outcomes (15)

XIV. Social value (5)

XV. Ensuring equity in access (5)

XVI. Supports financial sustainability (15)

Other aims of the system are around integration, efficiency, new care models etc but these are process aims rather than outcomes so that has to be reflected by the workstreams in how this will happen and what impact this will have on the population.

Evidence for impact of the scheme on the above criteria will include: published evidence, previous/existing pilots, local data analysis, clinical/practitioner support for schemes, resident/patient feedback.

4. Money

Cost of scheme are included in the information workstreams have to submit. Estimated system savings (assumptions and sources referenced) are also stated.

SPG, TB and ICBs have to decide whether savings assessment is robust, how risky/certain achievement of these savings is and then adjust the cost of the scheme according to this (when producing the cost:value score ratios).

5. System Prioritisation Group

Only meets to complete prioritisation scoring function (time consuming). Makes recommendations based on the scoring to the TB.

Includes representation from all partners on Transformation Board (no members allowed to be on SPG and ICB). Members can be on workstreams. All members have to represent the system and score based on the importance to City and Hackney residents/patients, not benefit to their organisation/workstream.

Members:

- CCG
- LBH
- CoL
- Public Health
- GP Confederation
- Homerton Hospital
- ELFT
- VCS

- LPC
- Hackney Healthwatch
- CoL Healthwatch
- Patient/lay member

Sign-off:

London Borough of Hackney - Anne Canning City of London Corporation - Neal Hounsell City & Hackney CCG - Paul Haigh, CO

Title:	PROCUREMENT OF AGES 0-19 CHILDREN AND YOUNG PEOPLE'S OBESITY AND PHYSICAL ACTIVITY SERVICES
Date:	18 October 2017
Lead Officer:	Amy Wilkinson
Author:	Kate Heneghan and Sarah Darcy
Committee(s):	Transformation Board – for information- 13 October 2017 Integrated Commissioning Board – for information – 18 October 2017
Public / Non-public	Public

Executive Summary:

This report provides an update on the redesign and procurement for healthy eating, obesity and physical activity services in Hackney and the City of London for the young population aged 0 to 19 years (up to 25 years for those with special education needs and disability), for services from April 2018. Universal and targeted healthy eating and family based lifestyle services have been designed and commissioned by Public Health, with complex obesity services designed and commissioned by City and Hackney CCG. The service design and procurement approval has been granted by Hackney Procurement Board in July 2017 for the Public Health services, with the contract award report for the services due to go to Hackney Cabinet Procurement Committee in December for approval. The proposed complex obesity service model will be presented for discussion at the 5-19's Health Oversight Group and when a costed business case is agreed for the service, a bid will be made internally for CCG non recurrent funding in 2018/19.

The redesign and procurement for children and young People's physical activity services, led by Public Health has been delayed to align with the redesign of physical activity services across Hackney Council departments.

Questions for the Transformation Board

The Transformation Board is asked to note this paper for information. The Public Health procurement processes outlined in this paper are in progress and were approved by Hackney Procurement Board on 11 July, 2017. Once a costed business case is agreed for the complex obesity service, a bid will be made internally for CCG non recurrent funding in 2018/19.

Issues from Transformation Board for the Integrated Commissioning Boards

Information to follow, after the Transformation board on 13 October, 2017.

Recommendations:

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

Links to Key Priorities:

This procurement supports the Council to meet its duties and obligations as set out by the Health and Social Care Act 2012 and the Children and Families Act 2014, to protect and improve the health and well-being of families and local children.
Additionally, it will contribute to Council wide initiatives to improve outcomes and reduce inequalities for children, young people and families. In particular, it will address the Hackney Health and Welling Board's strategic priorities which include: Improving the health of children and young people, in particular tackling childhood obesity and working with pregnant mothers and children aged under five years old.

Specific implications for City and Hackney

The 0-5's and 5-19's healthy eating and obesity services (universal and targeted healthy eating and family based lifestyle services) will be available to Hackney and City of London residents, as will the complex obesity service, commissioned by City and Hackney CCG.

The Public Health commissioned children and young people's physical activity services referenced in this report are only applicable in Hackney, not the City of London.

Patient and Public Involvement and Impact:

A programme of voluntary stakeholder engagement was undertaken through the review process. Engagement was sought with voluntary, private and statutory stakeholders as well as children, young people and their carer's. The engagement included:

- Engagement workshop with Hackney Youth Parliament
- Engagement workshop with Hackney Gets Heard
- Engagement workshop with City of London Youth Forum
- Engagement workshop with young people in a Hackney Youth Hub
- A series of workshops with parents in children's centres
- Questionnaires with service users of the current obesity and physical activity services
- Responses from Hackney and City of London residents from the pan London Great Weight Debate

The engagement sought to establish how the children and young people's obesity and physical activity services can better tailor provision to those who are most in need and to ensure that resident feedback forms a key component of the design process. The insight provided has been used to inform the final service specifications along with evidence and best-practice guidance.
The new 0-5 Healthy Eating and Obesity Services and 5-19 Healthy Eating and Obesity Services will include health promotion and outreach to children, young people and their families as part of the service specification, which will support families understanding of the new services.

Clinical/practitioner input and engagement:

A programme of stakeholder engagement was undertaken through the review process. Engagement was sought with voluntary, private and statutory stakeholders. The engagement included:

- Engagement workshop with current obesity and physical activity service providers
- An online professionals questionnaire for stakeholders from voluntary, private and statutory organisations working with the client group

The engagement sought to establish how the children and young people's obesity and physical activity services can better tailor provision to those who are most in need and to ensure that local professional feedback was a key component of the design process. The insight provided has been used to inform the final service specifications along with evidence and best-practice guidance.
The new 0-5 Healthy Eating and Obesity Services and 5-19 Healthy Eating and Obesity Services will include professional outreach and engagement as part of the service specification, which will support local professionals understanding of the new services.

Impact on / Overlap with Existing Services:

The current healthy eating and obesity services contract is due to expire in March, 2018, so the newly designed services will replace the current services. Public Health and City and Hackney CCG have been working together, and with other stakeholders including Hackney Learning Trust to ensure that future services compliment other services.

Main Report

Background and Current Position

Background

The transition of Public Health from the Primary Care Trust (PCT) to the Council in 2013 meant that PCT services were transferred over to the Council; children and young people's obesity and physical activity services are two areas that had not been formally reviewed since the transfer.

Public Health completed a children and young people's obesity and physical activity service review which evaluated the current services against best practice guidance and evidence, and utilised local evidence to identify the need of local population, to help inform and shape what future services will look like. The review included engagement with the local population and key local stakeholders. At the same time, Public Health worked with partners across the Council to map all physical activity services commissioned and delivered by Hackney Council for children and young people, to identify overlap and gaps in service provision and whether services are targeted at population groups.

Public Health have been working with City and Hackney CCG and primary care to develop a

childhood obesity pathway, as the CCG will be commissioning a complex children and young people's obesity service, to compliment the universal and targeted healthy eating and family based lifestyle services that will be commissioned by Public Health.

Findings from the review has supported the design and consolidation of children and young people's physical activity and obesity services, to ensure services are evidence based, meet the needs of the local population, are streamlined and connected to each other, with no duplication. The service go-live date April 2018.

Through the effective partnership working during the review process City and Hackney CCG has confirmed it will take on commissioning of a complex children and young people's obesity service from April 2018. This will complement the universal and targeted healthy eating and family based lifestyle services that will be commissioned by the Council through the Public Health team and the services in this report. This review process has also enabled us to work on refreshing and strengthening the shared childhood obesity pathway.

Current Position

Public Health went to Hackney Procurement Board in July, 2017 to seek approval for the proposed procurement of the below services:

- **Lot 1: 0-5 years Healthy Eating and Obesity Services (LBH and CoL)**
    - Healthy Start vitamins promotion and delivery
    - Healthy eating education workshops for families
    - Health promotion of a healthy weight
    - Training and development
- **Lot 2: 5-19 years (up to 25 SEND) Healthy Eating and Obesity Services (LBH and CoL)**
    - Weight Management
    - Health Promotion of a healthy weight
    - Training and Development

During the review process, it was identified that there were a number of successful programmes in place that could be ramped up or refined to improve outcomes. It was recommended that the below services should remain in-house, with updated SLAs. Each service will have a named service manager who will be accountable for each of these services:

- **Healthier Hackney Fund**: Physical activity and healthy eating/obesity based initiatives targeted at children, young people and their families, delivered as part of the Healthier Hackney Fund (an established Public Health VCS grants programme).
- **Eat Better Start Better**: A package of support for individual Early Years settings to implement and monitor the Children's Food Trust, Eat Better Start Better (EBSB)

guidelines. This service is currently delivered by Hackney Learning Trust (HLT), who have developed a unique and comprehensive programme and strong working relationships with early year's settings.

- **Health Heroes**: Support for primary schools and youth settings to implement and monitor the Children's Food Trust, School Food Standards guidelines and healthy eating and physical activity practices across the whole setting. To maximise the opportunities created by the well-established and valued partnership working between Public Health and schools, it is recommended that the Health Heroes programme continues to be delivered internally by the Public Health team.

Approval was granted by Hackney Procurement Board to proceed with the above recommendations. Public Health went out to advert for Lot 1 and Lot 2 over the summer, and have recently assessed and moderated the submitted bids. Public Health will go to Hackney Cabinet Procurement Committee in December for approval for this procurement.

To ensure the above services are working closely together and with partners across Hackney and the City of London, a Children and Young People's Healthy Eating and Physical Activity Alliance will be established and facilitated quarterly by Public Health. Commitment and participation to the alliance has been included in the service specifications for the above services.

Originally it was proposed there was a third lot as part of the above procurement, Lot 3: Children and Young People Physical Activity Services (LBH). After discussions with Public Health SMT and physical activity colleagues across the Council, it was decided that the procurement of this lot should be delayed to align to future physical activity services.

City and Hackney CCG are developing a children and young people's complex obesity model with Homerton University Hospital Trust (HUHT) for pilot delivery in 2018/19. The current LEAP clinic has bridged lifestyle weight management and complex obesity service, but it is recognised that there is no sufficient local complex obesity service.

The HUHT's proposed service model will be presented for discussion at the 5-19s health oversight group in November 2017 and will have considered:

- A more localised offer, reducing the need to refer to the Royal London except for medical emergencies and endocrine management
- Annual reviews for children and young people, with enhanced local interventions and screening
- Role of primary care to support a full pathway of care and offer of ongoing management if CYP disengages from the complex obesity service

- Improved joint working with adults services to enable a family approach
- Improved working with and referral to the eating disorders service
- Consideration of gym / physical activities provider partnership

Once a costed business case is agreed, a bid will be made internally for CCG non recurrent funding in 2018/19.

Options

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

Equalities and other Implications:

There are no adverse impacts in terms of equalities. The services includes universal and targeted provision and will proactively seek to reach out to children, young people and their families across all community groups, targeting the most in need. The successful providers will be required to target hard to reach groups and this will be explicit in the tender documentation.

Proposals

This report is for information, as the procurement undertaken by Public Health has been approved by Hackney Procurement Board, so there are no further proposals to make.

Conclusion

Public Health and City and Hackney CCG have been working together to design and commission children and young people's (0-19 years, 25 SEND) healthy eating and obesity services from April 2018. Public Health are in the process of procuring Lot 1: 0-5 years Healthy Eating and Obesity Services (LBH and CoL) and Lot 2: 5-19 years (up to 25 SEND) Healthy Eating and Obesity Services (LBH and CoL), and City and Hackney CCG are working with HUHT to pilot a new complex obesity service, from April 2018.

Children and Young People's physical activity services will be designed with partners across Hackney Council in Young Hackney, Leisure and Sports Development to ensure the services compliment other physical activity services. Future physical activity services are expected to go live in January 2019.

Supporting Papers and Evidence:

N/A

Sign-off:

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

Title:	Co-production Charter for Health and Social Care in Hackney and City
Date:	13 October 2017
Lead Officer:	Jon Williams, Director, Healthwatch Hackney Catherine Macadam, CCG PPI lay member
Author:	Emily Tullock, Healthwatch Hackney, Communications & Engagement Manager – Transformation
Committee(s):	Integrated Commissioning Engagement Enabler Group – for feedback – July and Sept 2017 CCG Patient & Public Involvement Committee – for feedback – 28 Sept 2017 Transformation Board – for endorsement– 13 Oct 2017 Integrated Commissioning Boards – for decision – 18 Oct 2017
Public / Non-public	Public

Executive Summary:

Background and current position

Co-production has been a stated goal of integrated commissioning (IC), linked to the ambition of creating a local health and social care system with people at the centre, who are more involved in shaping the services they use. This is in line with the NHS Five Year Forward View guidance on engaging with and empowering communities and patients in new ways by involving them directly in decisions about health and care services.

The TB committed to the principle of co-production in early 2017, and tasked the Communications & Engagement Enabler Workstream with exploring what co-production could look like locally. Co-production is defined as designing, reshaping or delivering services in equal partnership with the people who use them in order to create better services and outcomes. This Co-production Charter aims to build on the great work already taking place locally to involve the public and patients such as the Hackney Autism Board, Hackney Council Adult Social Care's Making it Real, Homerton hospital's co-production with HIV patients and the City of London Corporation's use of time credits. The charter will ensure Hackney and City remain pioneers in championing patient and public involvement and lay the foundations for this to continue as part of an accountable care system (ACS).

Proposals

The Co-production Charter has been developed to guide the care workstreams and all Hackney and City health and care organisations towards embedding co-production locally. The charter was developed with over 70 Hackney and City residents at a Co-production Conference on 6 July organised by Healthwatch Hackney and Healthwatch City. Participants looked at national and local co-production examples before writing the principles they want for local co-production.

The charter aims to enshrine the principles of co-production rather than be a set of rules, and may be a vision for IC partners to works towards. As a people's charter, it will be subject to annual review and is a living document to be managed by Healthwatch Hackney and Healthwatch City. It has been developed on the basis that it is better to have a baseline vision for co-production now and adjust accordingly if needed. Health and social care organisations in Hackney and City will be expected to sign-up to the charter. It will also be an important tool for the care workstreams as embedding co-production is one of the metrics in the external evaluation of IC.

The charter also draws on local co-production thinking from the:

- Innovation Fund workshop for the TB (Jan 2017),
- CHCCG Patient & Public Involvement workshop (Mar 2017)
- LBH Adult Social Care Making it Real 'Co-production principles'.

The charter was consulted on publicly from 11 August to 29 September 2017, and revised to incorporate additional public feedback. It has also been shared with all care workstream directors and SROs.

Equalities and other Implications:
This charter aims to ensure opportunities to be involved in co-production of local health and care services are equally available to all residents through a focus on equality and accessibility.

Conclusion
The TB and ICBs are asked to endorse and approve the Co-production Charter to further their ambition of creating a local health and social care system with people at the centre, who are more involved in shaping the services they use. ICB members and care workstream SROs/directors are asked to sign the charter to demonstrate the commitment of the integrated commissioning partners.

Questions for the Transformation Board

Issues from Transformation Board for the Integrated Commissioning Boards

To be given verbally

Recommendations:

The Transformation Board and Integrated Commissioning Boards are asked to:

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

Links to Key Priorities:

- NHS Five Year Forward View goal to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services.
- Hackney Health & Wellbeing Strategy drive towards person-centred integrated care and support.
- City Health & Wellbeing Strategy focus on listening to the views of service users.

Specific implications for City and Hackney

This charter has been jointly developed by Healthwatch Hackney and Healthwatch City of London. Both Hackney and City residents were involved in developing this charter.

Patient and Public Involvement and Impact:

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

Clinical/practitioner input and engagement:

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

Impact on / Overlap with Existing Services:

The Engagement Enabler Group includes engagement leads from commissioners and providers in City and Hackney who are working together to ensure IC engagement/PPI aligns with their organisations' existing engagement/PPI commitments without creating an overlap. This will continue to be reviewed by the group as IC moves towards business as usual.

Supporting Papers and Evidence:

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

Sign-off:

Workstream SRO _____[All]_____

London Borough of Hackney _____[*insert name and title*]_____

City of London Corporation _____[*insert name and title*]_____

City & Hackney CCG _____[*insert name and title*]_____

CO-PRODUCTION CHARTER FOR HEALTH AND SOCIAL CARE

HACKNEY AND CITY

PURPOSE:

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

This charter aims to capture the principles of co-production rather than be a set of rules. These principles are intended to guide actions to achieve the vision of people as equal partners in health and care. This document in no way replaces any organisation's statutory duty to consult the public on service change.

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

PEOPLE HAVE A RIGHT TO:

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

PEOPLE ENGAGED IN CO-PRODUCTION HAVE A RESPONSIBILITY TO:

- Encourage a partnership based on mutual trust and respect. For example by listening to each other and answering questions respectfully.
- Build connections and be answerable to wider communities and groups. This recognises that no one individual can represent everyone.

[1] Inclusive of all Hackney and City residents, citizens, service users, patients, carers, experts by experience, and other self-nominated identifiers.

- Share information with wider communities and groups and feedback their concerns.
- Commit to ongoing involvement to keep momentum going.
- Commit to working together towards shared goals.

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

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

Title:	Investment of PMS Premium: Proactive Care
Date:	13 October 2017
Lead Officer:	Tracey Fletcher
Author:	Leah Herridge
Committee(s):	Clinical Commissioning Forum – for discussion Clinical Executive Committee – for discussion PUEG – for discussion Unplanned Care Workstream Board – for recommendation Contracts Committee – for recommendation Transformation Board – for endorsement Integrated Commissioning Board – for endorsement Governing Body – for approval
Public / Non-public	Public

Executive Summary:

NHS England (London) charged London CCGs with agreeing local PMS plans including phased-withdrawal of PMS Premium (Premium) and its redistribution across all practices with associated Commissioning Intentions. This paper sets out the proposal for how the PMS Premiums should be spent within C&H.

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

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

Questions for the Transformation Board

The Transformation Board and ICBs is requested to consider the proposals and make recommendations to the Governing Body.
The Contracts Committee has provided external assurance and scrutiny on the proposals. The proposal was heavily scrutinised by the CCG Contracts Committee on Friday 29th September and the Committee we comfortable with the proposal presented.

Issues from Transformation Board for the Integrated Commissioning Boards

N/A

Recommendations:

The Transformation Board and Integrated Commissioning Boards are asked to endorse the recommendations of the CCG Contracts Committee.

Links to Key Priorities:

This will support prevention strategies for TB, including: contribution to the focus on prevention and proactive community based care; Reducing avoidable hospital admissions; Delivering a shift in focus and resource to prevention and proactive community based care

Specific implications for City and Hackney

N/A

Patient and Public Involvement and Impact:

Item has been discussed at the CCG Patient User Engagement Group (PUEG)

Clinical/practitioner input and engagement:

Item has been discussed at the CCG Clinical Commissioning Forum (CCF)

Impact on / Overlap with Existing Services:

Enhance existing Frail Home Visiting (FHV) contract, reduce pressure on acute services

Main Report

Background and Current Position

Please see Executive Summary in document

Options

N/A

Equalities and other Implications:

Extension to a proactive case management system

Proposals

Proposal to support key strategic priorities, support contracts, patients and clinicians

Conclusion

N/A

Supporting Papers and Evidence:

N/A

Sign-off:

Workstream SRO	Tracey Fletcher
London Borough of Hackney	Simon Galczynski
City of London Corporation	Ellie Ward
City & Hackney CCG	Paul Haigh

Investment of PMS premium: ***Proactive Care***

Leah Herridge Unplanned Care

October 2017

City and Hackney Clinical Commissioning Group

Recommendations

- Endorse recommendation from Contracts Committee that PMS Premiums will be used to fund a service for patients at risk of admission but who do not currently meet the criteria for the existing Frail Home Visiting service. The service will start in April 2018 and come under the umbrella of the FHV Contract. The specification for the new service will be brought to Contracts Committee in November 2017 for scrutiny
- Endorse recommendation from Contracts Committee to approve a variation to the 2017/18 FHV Contract to allow the 2017/18 PMS Premium money to be used to fund practices between November 17 – March 18 to identify patients who are at risk of admission and meet the service criteria, and create a practice register ready for the service to begin in April 2018

Background 1

- NHS England **ceased funding the Avoiding Unplanned Admissions DES (AUA DES)** from the 31/3/2017. Practices were previously required to hold an AUA register and undertake a review of the care plan on an annual basis. At the point the register ceased to exist 5265 patients were on the register in C&H (3333 on the register when FHV and EoLC patients were excluded)
- NHS England transferred the money funding the AUA DES into the core primary care contract and as of 1/7/17 is used to support the **new contractual requirement on Identification and Management of Patients with Frailty**. Practices are required to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty a clinical review is required each year. Patients with moderate frailty are only required to be coded as such

Background 2

- NHS England (London) charged London CCGs with agreeing local PMS plans including phased-withdrawal of PMS Premium (Premium) and its redistribution across all practices with associated Commissioning Intentions
- After extensive consultation with practices the CCG proposed to invest the Premium in the CCG's existing Frail Home Visiting Contract (FHVC), initially for 17/18 and 18/19. The FHVC sits under the Unplanned Care Board which has approved this proposal in principle
- Practices via the GP Forum have also approved this proposal in principle – they will be consulted on the actual detail at their Oct 17 meeting
- Patients have been consulted via PUEG
- The decision to invest the local premium into the FHVC has been approved by NHS England who have also taken a view that the proposal is above the core primary care contract
- The LMC have also been consulted

Funding

- 2017/18 funding is 5% of the Premium = £89,628
- 2018/19 funding is an additional 10% of the premium = £274,581.40 (inc. the above £89,628)
- Although the service will sit under an Unplanned Care Contract (FHV), the funding is ring-fenced to Primary Care

The Proposal – Overview

- An FHV Development Steering Group made up of GP Clinical leads from the CCG and the GP Confederation put together the proposal, advice was also sought from an Independent GP
- Proposal set out has been approved in principle by the CCG's Primary Care Quality Board and the Unplanned Care Board and discussed at CCF in . Discussion of the proposal took place at CEC in September
- From 4/2018 expand the FHVC to cover patients at risk of emergency admission who would benefit from a proactive case management, a multi-disciplinary and a care planning approach (using CMC) **but who do not** currently meet the eligibility criteria of the existing FHV service
- Currently for a patient to be included on the FHV Register patients are required to be **housebound or unable to attend the surgery independently**, the complexity of their health status requires that a home visited is undertaken by a GP
- The proposal is to introduce **an additional register** and provide a service for patients who are at risk of emergency admission **but do not require a home visit by a GP**
- After consultation with PUEG the working title for the register/service is ***Proactive Care.*** Suggested that FHV would also change name to *Proactive Care*. i.e. there would be a *Proactive Care – HouseBound* Register and a *Proactive Care – Practice Based* Register under one contract

Proactive Care Service 18/19

- The aim of the service will be to provide more personalised support to patients most at risk of unplanned admission, readmission, and A&E attendances to help them better manage their health. In order to achieve this, under this service practices will be required to;
  - ✓ Identify patients who are at high risk of avoidable unplanned admissions (and who do not meet the threshold for FHV) and proactively case manage these patients
  - ✓ Collaboratively develop personalised CMC care plans with any new patients on the register, and where applicable their carer
  - ✓ Care planning should include holistic care needs, taking into account social factors as well as clinical (eg. the GP Practice should link with Connect Hackney and the work on social isolation where applicable)
  - ✓ Undertake a minimum of 2 face to face appointments per annum with each patient on the register and review the care plan at each appointment. The appointment can take place wherever is most appropriate.
  - ✓ A named accountable GP will have overall accountability, and will be responsible for ensuring that the creation of the care plan and review of the care plan takes place, and the appointment of a care co-ordinator if different to the named accountable GP.
  - ✓ The care co-ordinator can be the GP, practice nurse or practice pharmacist (which ever is most clinically appropriate) and will create the care plan and undertake the appointments and care plan reviews and act as the main point of contact for the patient
  - ✓ The practice will undertake monthly MDT reviews of the register to consider any actions which could be taken to prevent unplanned admission of the register
  - ✓ The GP Practice should consider proactive follow up after discharge if deemed appropriate but will have flexibility to decide when the most clinically appropriate time is to undertake a review
  - ✓ The GP Practice will be required to undertake quarterly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the register
  - ✓ Undertake an audit of care plans created to ensure their quality – ensure cross section of care plans across HCPs
  - ✓ Proposed that patient cannot be on both Time to Talk and Proactive Care register to avoid duplication
  - ✓ Appointments provided under the Proactive care Service will need to be in addition to any appointments provided under the Frailty Index requirement to ensure the service is over and above core contract.

FHV versus Proactive Care: Key Differences

	Existing FHV Register	Additional Proactive Care Register
Lead	GP led review	GP/Practice Nurse/Practice Pharmacist led review
Appointment Type	Home visit	Appointment can be conducted wherever most appropriate e.g. in the practice, in the patient's home, in carer's home, etc
Minimum number of appointment and time	Minimum of 2 home visits per year, and practices must achieve an average of 3.5 visits per patient on the register	Minimum of 2 appointments per year which last for a minimum of 30 minutes
Model across Both Services	• Patients have protected time to discuss their needs and wishes holistically • Focus on making referrals for social, medical, nursing, mental health, and voluntary sector help for their patients • Practice MDT meetings allow coordination of care for individual patients and for services to work together well • Care Planning undertaken – using CMC as care plan and care plan reviewed at each appointment • Carry out a yearly randomized audit of 10% of the patients on both registers which will measure the quality of care plans created on CMC • Patients cannot be paid for under both the FHV register and the new additional register. Patients at risk of admission will be included on either register depending on their complexity and mobility. • As with the FHV register and service it is proposed that there are no age restrictions on the service • Previously there has been patients on the FHV register which practices gave one home visit to and create a care plan for, but did not end up getting paid for this work because the patient hadn't receive two visits. If it is possible for that patient to come into the practice and be seen by either a GP/nurse/pharmacist for their review, then the patient can be moved onto the new Proactive Care register instead of the FHV register.	

Payment on 2018/19 Contract

- For the 2018/19 Contract Year, £167 will be paid per patient on the Proactive Care register
- In order for the patient to be eligible, the GP practice must have undertaken and recorded:
  - ✓ A minimum of two face to face appointments
  - ✓ A care plan created on CMC which must be reviewed at each appointment
- In establishing the price per patient a benchmarking exercise was undertaken against existing services (FHV, Time to Talk, Time to Cancer, Extended Access, AUA) and hourly rates
- The price mirrors the funding paid on the AUA register. This was felt sensible and fair as although the practice will be required to undertake two reviews rather than one, the practice is not required to complete a 6 month report, monthly reviews of admissions or requirements under practice availability which is covered by the Duty Doctor Service)
- Proposed that practices are remunerated on register size weighted by emergency admissions. All practices will receive an equal share of 30% and the remaining money is split based on proportion of emergency admissions. This will enable additional investment into those practices where the emergency admissions rate is higher whilst making sure that there is service provision across all practices

Avoiding Double Payment with Frailty Index

- In developing the additional register and extending the existing FHV we need to ensure that double payment with the GMS Standard Contract Frailty Index is avoided
- The FHV Steering Group has considered this when developing the service model for the new register
- The minimum of two reviews required under the Proactive Service will be in addition to any review undertaken under the Frailty Index
- Confirmation is being sought from NHS England that the proposal is above the core contract - we believe it is

Frailty Index	Proposed Service Model/Existing FHV Register
• Review required for severely frail only over the age of 65	• Both register's are wider than severe frailty and include patients most at risk of admission, severe frailty is one of the measures used to identify at risk patients of all ages
• Clinical review, with annual medication review and where appropriate discussion of a fall	• Review is holistic, focusing on social, medical, nursing, mental health, and voluntary sector help
• One review per annum	• To be payable, patients on the register's must receive a minimum of 2 reviews per annum
• Care Plan not specified	• CMC care plan required for each patient
• Type of review not specified	• Both registers will require face to face reviews to take place (FHV in the home and new register in appropriate setting)
• There is no minimum size register required. Practices are only required to code clinical interventions appropriately. Data will not be used for performance management or benchmarking	• Both registers require a minimum number of patients to be included on the register

Creating a Proactive Care Register using 17/18 PMS Premium Money

- The GP Practice will establish a case management register of patients identified as being at risk of an unplanned hospital admission without proactive management
- 2017/18 funding will be used to create the new register. All practices will be expected to have a register. The Premium (£89,628) is available to pay practices for creating a register, and in addition Practices are required to participate in an education session on creation of the register
- Between October 2017 and March 2018 practices will be asked to identify patients and create the new register, ready for the service to start in April 2018
- We have an indicative budget for 2018/19 of £274,581.40 - based on the price of £167 per patient this enables practices to create a maximum Proactive Care register of 1644 patients across C&H
- Number of the register is just over half the number of patients on the AUA register (not on FHV/EoLC). The need for a more intensive input with higher need patients (based on risk stratification data) rather than less intensive but for a higher number of patients has been consistent feedback from Practices through the round of MDTs ran by the GP Confederation looking at care planning approach earlier this year

Identification of Patients for Proactive Care Register

- As with the FHV register, patients will be put on the new register via practice identification of patients at risk of emergency admission
- Practices will identify patients for the new register via the following methods:
  - Frailty Index (severe or moderate frailty)
  - NELIE Risk Tool
  - Frequent Attenders at A&E and patients frequently admitted
  - Local clinical knowledge
  - Risk stratification being developed under the Unplanned Care Board
- The methods used to identify patients for the register should give equal consideration to both physical and mental health conditions, in the event that the risk stratification tool does not account for mental health conditions, the practice should endeavour to use knowledge of their patients with mental health conditions to ensure these patients are considered

Education Session – 17/18 Requirement

- Requirement for practices to participate in an educational event to support building of the register. This will cover:
  - ✓ Understanding the data and how practices should work through it
  - ✓ Feedback from the case notes review undertaken at Homerton and implications for primary care in terms of admission avoidance
  - ✓ What services are available for practices to refer patients into to provide support
  - ✓ Ensure links are made work on the frequent attenders
  - ✓ Criteria for how high risk patients should be identified - when utilising the tools available what are the key characteristics of patients that would suggest the patient should be included on the register
- Mandatory attendance by the clinical lead for the service from each practice
- The money available to practices in 17/18 will cover backfill for attendance
- Event to take place in Q3 (webinar to be considered)

Contracting arrangements

- The existing FHV Contract expires at the end of 3/18, a contract extension will be brought to Contracts Committee once discussed by the Unplanned Care Board (ref Governance slide)
- This proposal for the new Proactive Care Service is based on the assumption that the Unplanned Care Board will approve the extension of the FHVC for a one year period from April 2018
- The additional specification included for the new Proactive Care register/service from April 2018 funded via the Premium will be included within the FHV Contract. However a separate specification for Proactive Care will keep reporting and budget arrangements separate from the existing FHV service
- Creation of the Proactive Care Register in year will be managed by a variation to the existing FHV contract

Summary of next steps and governance

Service	Proposal	Workstream/budget	Governance
Proactive Care Service	a) Variation to the 17/18 FHV contract to include building of a new register, budget ring-fenced to Primary Care	a) Primary care enabler: Core/aligned b) Primary care enabler: Core/aligned	→ Primary Care Quality Board **→ LGPPCC Part 1 (Sep) – approval of use of PMS premium** → GB – for information → Unplanned Care Board → TB (already approved) **→ LGPPCC Part 2 (Sep) – approval of contract variation** → ICB (Oct) – for information → GB (Oct) – for approval
	b) Specification for the 18/19 Proactive Care Service		→ Primary Care Quality Board **→ LGPPCC Part 1 (Sep) – approval of use of PMS premium conditional to LGPPCC Part 2's scrutiny of the specification** → Unplanned Care Board → TB (Nov) → LGPPCC Part 2 (24 Nov) – scrutiny of spec → ICB (Dec) – for information → GB (Dec) – for approval
FHV Contract	a) Extend the existing FHV Contract, with minor amendments only, to Mar 19 b) Include the Proactive Care Service in the extended FHV Contract, budget ring-fenced to Primary Care	a) Unplanned care workstream: Aligned b) Primary care enabler: Core/aligned	→ Unplanned Care Board → TB (Nov) → LGPPCC Part 2 (24 Nov) – scrutiny of minor amendments → ICB (Dec) – for information → GB (Dec) – for approval

Title:	Winter Readiness Plan
Date:	Transformation Board - 13 October 2017
Lead Officer:	Tracey Fletcher
Author:	Leah Herridge
Committee(s):	Unplanned Care Workstream Board – for decision Transformation Board 13 October – for information Integrated Commissioning Board 18 October – for information
Public / Non-public	Public

Executive Summary:

City & Hackney A&E Delivery Board (i.e. the Unplanned Care Board) were required to submit the Winter Plan to the NHSE and NHSI teams on Friday 8th September. It is expected that the plans were cross locality and cover resilience arrangements from the start of December up to Easter 2018.

The Unplanned Care Board reviewed and signed off the Winter Plan and provided input from a system perspective. The submission was agreed jointly by the membership of the A&E Delivery Board.

In developing the Winter Plan, in addition to any local initiatives already planned or underway, the A&E Delivery Group were asked by NHSE to prioritise the following:

- Demand and Capacity Plans
- Front door processes and primary care streaming
- Flow through the UEC pathway
- Effective discharge processes
- Planning for peaks in demand over weekends and bank holiday
- Ensuring adoption of best practice as out in the NHS Improvement guide: Focusing on Improving Patient Flow

Overall the A&E Delivery Board rated our Winter Plans as Green. We are awaiting feedback from NHS England.

Questions for the Transformation Board

The Transformation board are requested to note the C&H Winter Plan.

Issues from Transformation Board for the Integrated Commissioning Boards

N/A

Recommendations:

The Transformation board are requested to note the C&H Winter Plan.

Links to Key Priorities:

This item is considered an NHS 'must-do'

Specific implications for City and Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

Providers have submitted their winter plans to the CCG for review – these have been turned into a comprehensive plan for the CCG

Impact on / Overlap with Existing Services:

N/A – covers all services

Main Report

Background and Current Position

This document has been reviewed and approved by the Unplanned Care Board (UPC)

This is considered an NHS 'must do'

The UPC Workstream submitted this plan to NHSE on 8th September 2017 – we are awaiting feedback

Options

The plan contains risks within each action

Equalities and other Implications:

N/A

Proposals

N/A no proposal

Conclusion

The plans we have received from our providers are considered robust- we are in a good

position to execute our winter plans as detailed in the attached report

Supporting Papers and Evidence:

N/A

Sign-off:

Workstream SRO	Tracey Fletcher
London Borough of Hackney	Simon Galczynski
City of London Corporation	Ellie Ward
City & Hackney CCG	Paul Haigh

A&E Delivery Board 2017/18 Winter Readiness Checklist

A&E Delivery Board (AEDB) name:…City and Hackney……

Name and contact details to where initial queries regarding this return should be directed…Leah Herridge leahherridge@nhs.net (between 8th – 25th September please contact Anna Hanbury ahanbury@nhs.net)……

Please confirm that this submission has been agreed jointly (electronically is acceptable) by the membership of the AEDB…YES…….

Individual/s signing off the return on behalf of the AEDB……Tracey Fletcher (chair of AEDB)……

This checklist is intended to support AEDBs with winter readiness and planning for 2017/18 winter period - 1 October 2017 to Easter 2018 - as outlined in the winter planning letter. Please return this checklist by 8 September 2017, to england.london-winterhub@nhs.net

	Readiness Checklist Area	A&E Delivery Board commentary to support readiness assessment	RAG rating based on current status	RAG rating based on status by 1 Nov
1	**Wider System Preparation**			
1.1	• Please assess your current compliance with the embedding of good practice on patient flow across the organisations within your AEDB – provide an update on current plan to improve this where necessary, and your expected status by winter 2017/18	• Considerable work has been undertaken by health and social care within the local health economy (internal and cross-boundary) over the past 12 months to develop and embed good practice on patient flow. This work builds on the good learning during the winter 2016/17. • The Homerton has reviewed current compliance against the *NHS Improvement Guide: Focus on Improving Patient Flow* and the AEDB is assured that in each of the focus areas the key principles are either being met, plans are in place to achieve the guidance, or that alternative arrangements are in place. Plans to improve patient flow, as per the guidance include:		

		• In line with the UEC Milestone Tracker, Homerton are aiming to hit 85% of patients handed over within 15 minutes of an ambulance arriving by March 2018. • In line with the Pan London Streaming and Redirection Guidance, later this year Homerton will be introducing redirection into their streaming model. Part of this development will be to work towards the Non-Clinical Navigators making direct GP bookings into primary care. • The Homerton are piloting an Ambulatory Care Unit (HAMU) for 12 months a. Extending provision to 14 hours a day, 7 days a week will be considered as part of the evaluation of the pilot. • The guidance requires that acute assessment services should aim to receive clinically stable GP referred patients directly, not via the ED. At the Homerton patients will be referred to the surgical duty doctor (registrar). Once the patient has been assessed in the ED as requiring admission under the surgeons the patient will be transferred to the ACU under the care of the surgical consultant on-call. The full process is outline in operational policy (draft). • The Integrated Independence Team (IIT) Geriatricians currently runs an Enhanced Geriatrician at the Front Door Service for ED, OMU and ACU Monday to Friday. Geriatrician assessment within 24 hours of admission is not currently being met due to vacancies in staffing although work is being undertaken by the Homerton to recruit. The needs of this cohort are being met through an integrated medical take and through the IIT service for crisis response. • Currently 80% of wards at the Homerton have the SAFER Patient Flow Bundle Implemented. HUH will aim to have all wards covered by December 2017. • A red and green day approach has been considered but not implemented at Homerton. Due to the role out of the SAFER patient flow it is felt at this point that this		

		approach will not provide any added value however this will be reviewed in time. • The guidance requires that on admission, the expectation should be that people will be discharged to their usual place of residence, with additional support if required, and assessment of their longer term needs undertaken there rather than in hospital. C&H are partially achieving this - Rapid Discharge Pathway now in place on ECU and Bridging the gap proposals being worked up. Further work on discharge to assess model is required which will be taken through Delayed Transfer of Care (DToC) operational meeting and discharge steering group. Considerations will be given to Bexley Model particularly around required capacity to deliver this model. • The guidance requires that duplication of assessment should be minimised using trusted assessors, building on the functional information collected on admission. And that there should be a single point of access for health and social care to support 'discharge to assess'. Integrated discharge service should be linked to an integrated intermediate tier of local services. In C&H the MDM is used as trusted assessor for Rapid discharge from ECU. The Bridging the Gap proposal begins use of an early discharge to assess pathway with the IIT. MDT undertaking the assessment. Intermediate bedded provision being considered.		
1.2	• Please outline the processes in place to receive weather related warning information (Met Office alerts / NHS England daily winter briefings) and the actions taken as a result to consider the likely impact on activity levels and mitigating activities (e.g. hot clinics, reduced electives, increased speciality staffing etc)	• Systems are in place within the local health economy for the receipt, onward communication of weather related warning information to the various provider organisations (primary, secondary and community) and monitoring of actions by NEL CSU Surge and Resilience Service, and the CCG. These systems are reviewed and tested as part of pan-London resilience work involving key stakeholder organisations. • The Homerton's cold weather plan details the acute and community response to weather alerts. The Met Office		

		Weather Alerts are received by the Homerton's Emergency Planning Liaison Officer, and communicated internally to Trust operational teams for appropriate escalation and de-escalation actions to be undertaken in response to the alert levels. These actions are reviewed by the Trust at the multidisciplinary ward meetings. Externally, the CSU communicates the weather alerts levels to local commissioners and provider organisations. The NHS England daily winter briefings, and Met Office are communicated to key primary, secondary and community stakeholders across the local health economy by the CSU's surge and resilience team, and C&H CCG. Progress on managing system pressures are reviewed at the system level resilience teleconference meetings with local provider. • A SITREP reporting rota is in place within the Homerton managed by senior nurses in the Trust, which includes both A&E and PUCC performance. The Trust's Senior Manager on Call receives three daily reports relating to admissions, discharges and available bed state, and informed by weather alerts and other wider system pressures impacting on the operational work of the Trust. The SITREPs reporting is used to inform updating of CMS by the Senior Manager on-call in line with the Trust's bed management plan and informs operational activity and decision making. The SITREP reporting system is on the Trust's intranet system, however in the event of IT or power failure, there is a hard copy back up which can be used instead.		
1.3	• Please confirm you have updated the Directory of Services and MiDOs are up to date with the most appropriate services especially those services providing alternative care pathways to support the London Ambulance Service crews	• The NEL CSU Directory of Services (DoS) Team have been validating all services on the DoS periodically as specified in the DoS Specification for City and Hackney. This feeds through to DoS for NHS 111 and MiDoS for LAS/Clinician use. • The DoS team are currently working with NHSE to ensure that all commissioned primary care services are profiled correctly on the DoS. The DoS team are		

		undertaking a similar exercise with the Homerton to ensure that the current list of community services shown on the DoS are up to date. The DoS team has recently completed work to ensure that all services provided by ELFT and show on the Trust website are correctly profiled on the DoS. As part of its existing processes the DoS Team will check and update the DoS records shown for NHSE commissioned primary care services, the Homerton community services, and ELFT, every quarter to ensure all service information is accurate. • Paradoc: C&H CCG, the NEL CSU DoS Team and Paradoc have discussed a range of pathways that could be put in place to support admission avoidance. Paradoc provides an admission avoidance service. The work streams discussed during the meeting included: providing access to MiDoS for the service to use; how Paradoc can help NEL CSU with piloting the MiDoS app within Care Homes; clarifying the information added onto the Paradoc profile; exploring how we can use Paradoc as a service to accept referrals from NHS 111 green ambulance re-triage queue. The NEL CSU DoS Team is arranging a meeting with PELC to obtain clarification about the green ambulance re- triage queue. • *LAS Wallet Cards* – The NEL DoS Team have been working with CCGs to pull together LAS Alternative Care Pathway Wallet Cards. The Wallet cards list the key services which LAS can refer into rather than referring patients to A&E. The DoS Team are in the middle of distributing these cards to LAS Hubs across the patch. • *Care Home Pilot* – The NEL DoS Team are rolling out the MiDoS tool to the top four care homes who contact LAS regularly to support preventing conveyances to A&E. The tool can be used to utilise community services to provide treatment to patients rather than sending patients directly to A&E.		

		• *Scenario Testing* – The NEL DoS Team have been working through scenario testing tool on the DoS to ensure alternative services are profiled to return to patients above A&E. • *LAS CHUB* – The NEL DoS Team have been visiting the LAS CHUB in Bow and Waterloo to increase usage of MiDoS. The use of MiDoS allows the LAS CHUB to locate suitable services that can accept a referral rather than sending the patient to A&E. The usage has increased rapidly over the past months to on average 900 hits a month.		
1.4	• Please assess your ability across organisations within the AEDB to access Mental Health crisis Plans, GP Care Plans, End of Life Care plans and to extended patient data either through the Summary Care Record or local care record sharing services across the Emergency Department (ED) and Urgent Care Centre (UCC)	• The Homerton A&E and PUCC can now access summary patient information from Barts Health, Homerton community, GPs and ELFT using the eLPR (east London Patient Record), also known as Health Information Exchange (HIE) system. Information available includes medication, allergies, alerts, diagnoses, problems, assessments, test results, discharge summaries and clinic letters. ELFT also provide care plan information and some child health data. • The London Borough of Hackney is now connected to the Child Protection Information System (CP-IS), enabling clinicians to be alerted to children on a child protection plan or with safeguarding concerns. • The CCG agreed in 2016/17 that Coordinate My Care (CMC) will be used for care planning across as many care settings as possible to improve patient care for patients most at risk of admission. Implementation of CMC has focused on CMC as the shared urgent care plan for the frail elderly and those patients at the end of life in primary (including OOH), secondary and community care. Between the 1st July 2016 and 1st July 2017, 2358 care plans have been created on CMC. Within Homerton, CMC has been rolled out within the Elderly Care Unit, Palliative Care, Community Nursing		

		and view of care plans will be in place in the ED and PUCC ready for Winter 2017.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
2	**NHS 111 / primary care**			
2.1	• Is the AEDB assured that there are robust plans for GP OOH providers to deal with known activity peaks in demand across the winter period?	• CHUHSE the provider of GP OOH's has set out predicted activity figures and relevant maximum capacity to cover the predicted activity. Predicted activity has been mapped by hour of the day and has been based on last year's activity.		
2.2	• **Primary Care Access (100% coverage 7 day 8am-8pm)** • What is the current and projected coverage of extended access to primary care in evenings and weekends? • What plans are in place to ensure performance to deliver the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	The current coverage of extended access to primary care in evenings and weekends is zero and the projected is 100% population cover by the end of Q3 2017/18. Plans are in place to ensure performance to deliver to this threshold. This work includes: *Project Governance*: Primary Care Extended Working Group/OOH/111 working group have met once and are now meeting monthly; Terms of Reference agreed and signed off; Membership from all relevant stakeholders including OOH to ensure City and Hackney hubs are used as part of the IUC solution; project plan, risk register and action log live; project reporting into the Unplanned Care Board and the Primary care Quality Board *Selection of North Hub*: Practices have nominated themselves if they want to be one of the North hub sites from 1st November 2017; nominations to be assessed against an evaluation matrix that reflects the London Specification particularly relating to access, equity and resilience. Decision made by the Working Group on 17th August 17; north Hub to be on 2 sites. Programme Director has visited all nominations to speak to clinical and non-clinical staff; once selected, the Programme Director will work with the selected practices to draw up an operational plan.		

		IT Solution: EMIS Interoperability Co-ordinator recruited. Starts on 11th Sept 2017; schedule of receptionist training identified to ensure maximum uptake for appointments; work with IG Lead commenced to approve data sharing agreements and privacy impact assessments. *Communications and Engagement*: detailed schedule of presentations continues to be delivered; programme Office and City & Hackney CCG are working together to draw up a comms strategy to ensure the service is widely advertised and in line with HLP London wide comms/campaign re extended access; series of practice visits are ongoing. *Operationalisation*: Standard Operating Procedure being drawn up to be signed off at the September Working Group; Programme Director has met with local Pharmacy Leads re accessibility to pharmacies during extended opening times in particular Bank Holidays; Clinical governance protocols to be agreed; Project Team are working with Lantums (formally known as Network Locums) to identify and implement clinical rota; Rota co-ordinator to be recruited for October 17; Telephony function to include a dedicated hub line for patients to access outside of core hours being explored.		
2.3	• **111 Capacity (51% threshold)** • What is the current and projected percentage of 111 calls with clinical contact? • What plans are in place to ensure performance to deliver the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	• The 111 team has reported that the current level of calls with a clinical contract through NHS 111 Clinicians and the Clinical Assessment Service (CAS) is c.37%. • The trajectory is to achieve >40% by December 2017 and >50% by March 2018. • Introductions of new enhanced pathways for specific patient cohorts (<2's and >75's) and an increase in Emergency Department and Green Ambulance Enhanced Clinical Assessment will ensure the performance trajectory is delivered. The incumbent provider submissions to NHS E align with the planned trajectory.		

2.4	• Does NHS 111 have access to Mental Health crisis Plans, GP Care Plans and End of Life Care plans and to extended patient data either through the Summary Care Record or local care record sharing services?	• PELC the provider of the 111 service has access to Coordinate my Care (CMC), enabling 111 to view GP and End of Life Care Plans. • The NHS 111 service has access to a range of resources for accessing special patient notes, crisis plans and End of Life plans through the Patient Relationship Manager (PRM) platform and is supplemented with SCR access and access to the locally devised shared care record.		
2.5	• Can NHS 111 book into UCCs?	The NHS 111 service can currently book into 1 Urgent Care Centre (King Georges, Redbridge CCG) which is currently in the pilot phase. The service cannot currently book into other UCCs but this is under active consideration as part of UTC standards. The specification for the new 111 IUC service includes the requirement for direct booking into PUCC when this is possible.		
2.6	• Can NHS 111 book into primary care?	• The 111 service has reported that a Direct Appointment Booking pilot with Primary Care has been initiated with 14 practices across the STP footprint being classed as early adopters. All 14 practices will be live with the new functionality by November 2017. The rollout is being locally managed through the STP supported by the Healthy London Partnership (HLP) resources. • Within City and Hackney, the 111 service is not currently in a position to directly book into primary care. We are in the process of defining the model for our 24/7 response to face to face referrals from the NEL IUC 111 service. A workshop with a range of key stakeholders was held in March 2017 and there was emerging consensus on the following: The in hours response will be based on the duty doctor service contracted from the GP confederation. • In September 2017, we are planning to test the proposed pathway for direct booking into GP practices in-hours prior to system go live in 2018. This work will be used as an opportunity to ensure that the route to appointments from 111 to GP practices works well for		

		patients and practices. Two practices have signed up to this pilot in C&H. The out of hours response will need a number of currently commissioned services to come together to offer both face to face base and home visits. Existing providers are currently working up a more detailed model based on what was discussed at the workshop, and developing an alliance approach to both proposition and delivery model which will enable direct booking from 111 into primary care.		
2.7	• What are the AEDB's plans to seamlessly route electronic prescriptions from NHS 111 and GP out of hours to pharmacies via the Electronic Prescription Service (EPS)?	• The 111 service has reported that the EPS functionality does not currently exist within the Adastra platform and is not available for consideration. • The NEL IUC specification states a requirement for the provider to be able to issue FP10 prescriptions and send them to the appropriate pharmacy to dispense. Currently this is only possible by faxing to the nominated pharmacy but providers are required to work with Commissioners and NHS England to implement e-prescribing when this is possible.		
2.8	• What are the AEDB's plans to develop and test new specialist modules of clinical triage through NHS 111 for paediatrics, mental health and frailty?	• The 111 service has reported that new pathways have been implemented for Paediatrics (<2's) and Frailty (>75's); these will be routed to the Clinical Assessment Service (CAS) through new shortened pathways. • Warm transfers to Mental Health Direct are in the process of being agreed at an STP Level and are underpinned by a co-designed Standard Operating Procedure (SOP).		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
3	**Care home support:**			
3.1	• Please assess your AEDB's compliance against the British Geriatrics Society Guide on Care Home Medicine	Local partners have begun to review the Enhanced Health in Care Homes Framework as part of the High Impact Change Model and a care home working group will be established. Discussions are also underway with a local GP to become a clinical lead for this work.		

		Residential homes, housing with care schemes and one nursing home receive medical support through a Frail Home Visiting (FHV) Service for vulnerable/housebound patients. Two nursing homes are supported through contracts with two GP practices and the fourth nursing home which is predominantly for CHC patients is managed by the Homerton University Hospital.		
3.2	• Please outline the AEDB's risks around care home capacity this winter e.g. closures, plans to open or commission new care home beds	There are no residential or nursing care homes within City of London boundaries and these placements are spot purchased. The City of London Corporation maintains the social care responsibility for any residents they place. There are currently 30 city funded residents living in residential or nursing care. Where any provision may fail or be able to meet needs at short notice, the City of London would seek to meet the person's needs in the short term and then facilitate a place of choice. The additional iBCF funding allows some flexibility to be able to do this. The LBH plan to commission out of borough beds to help with our winter planning. Current discussion with Care homes outside of Hackney has commenced.		
3.3	• Are there any CQC issues affecting care homes in the AEDB's geography e.g. self-embargos, local authority embargos?	No.		
3.4	• How many care homes in the AEDB's geography are receiving support from your quality and safety team?	All care homes in the London Borough of Hackney receive support from the LBH Quality Assurance team whether directly commissioned or not. The Quality Assurance Officer completes a monitoring visit and where actions are identified a service improvement plan is submitted to the provider and is follow up by the Quality Assurance Officer.		
3.5	• Is there sufficient therapy and specialist nursing capacity in the community to offer in reach support to care homes in AEDB's geography?	Yes there is sufficient therapy and nursing support available. Community Matrons and District Nurses provide nursing support to care homes without nursing. The Integrated Independence Team also provides therapy support within care homes.		

3.6	• Please confirm you are providing the *567 access to a GP through NHS 111 for care homes and crews. Please confirm what marketing you have provided to care homes on the service offer available	C&H are not promoting the *567 numbers. A decision was taken locally not to provide care homes with information on the service offer available. Care homes in Hackney have been provided with information on local pathways including Paradoc operating 12-12 seven days a week (an admission avoidance service with access to a GP and Paramedic) and Duty Doctor operating during core hours Monday to Friday, which is delivered in each GP Practice. C&H CCG also commission enhanced GP provision to nursing homes in two of the nursing homes which provides direct access to GP support.		
3.7	• Is there a tele-health service to reduce 999 calls and ED attendance? Please provide explanatory commentary	Yes we have telecare rapid response service commissioned by LBH.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
4	**Front Door**			
4.1	• Is the AEDB assured that the acute provider has a rapid assessment service in place? If so, is the rapid assessment service aligned with social care? • How has the AEDB ensured that there is a clear process for primary care referrals (including OOH) to acute specialities to bypass ED? • What alternatives to immediate referrals are available, including 'hot' clinics?	• The Homerton IIT (Integrated Independence Team) responds to referrals from the ED usually within one hour. The service provides home treatment and reablement and works in partnership with the out of hours GP service Paradoc. There are dedicated Social workers as part of the IIT service. • Social work screener now in place (3 month Trial) seeing people early on ACU to gather information and alert Integrated Discharge Service (IDS) to need for further intervention. • The model currently in place within the Homerton is for all patients to have an initial assessment and safety medical review in the Emergency Department by an ST4+ doctor. If appropriate and stable, these patients are then admitted directly to ACU. However, the AEDB are assured that Homerton has Pathway protocols are in place for a number of conditions (i.e. sickle cell crisis, gynaecology & obstetric presentations) for speciality wards to receive agreed patients directly following referral from GPs and emergency departments		

		• Processes are in place to allow general practice & the Emergency Department immediate telephone access to discuss urgent referrals for the major admitting specialties which for the Homerton include Medical, Surgical, Orthopaedic, Gynaecology and Paediatrics. • Aside from the individual speciality pathways managing immediate referrals, the GP advice line provides ED Consultant advice directly to GPs. The aim of this is to support the GP and encourage collegiate working, provide advice on attendance and admission avoidance and offer advice on appropriate specialty referrals. The consultant led advice line for GPs operates during the hours of 8am to 10pm.		
4.2	• How is the AEDB ensuring that EDs have sufficient clinical input from surgical and clinical specialties? • Does the ED have access to Records (EOL/GP Care Plans / Mental Health) • Are there plans in place for winter for UCCs and EDs to book into primary care?	• The AEDB are ensured that Homerton ED has sufficient input from surgical and clinical specialities. There are agreed specialty pathways (e.g. gynaecology, surgery, general medicine) to ensure clinical input. • Homerton ED has access to CMC records (EoL/GP Care Plans). Homerton has worked with Intersystems and CMC to develop the IT links between the Homerton Millennium EPR system and CMC. The IT link went live on the 24th April and provides a flag that alerts care professionals within the hospital that a patient has a CMC care plan. Enable EPR users in ED to click a hyperlink that takes them directly to the patient's CMC care plan on the CMC system without the need to exit from EPR, start up a new system and search for the patient again. • The ED has access to HIE and all notes recorded on EPR by the Homerton Psychological Medicine (HPM) team. The Ed team do not have access to the RiO system used by ELFT. • In line with the Pan London Streaming and Redirection Guidance, later this year Homerton will be introducing redirection into their streaming model. Part of this development will be to explore enabling A&E to make direct GP bookings into primary care, this will be		

		facilitated by the Non-Clinical Navigators. The Aim will be to have this in place for April 2018.		
4.3	• What actions are in hand or planned to ensure that LAS handover delays are reduced to a minimum?	• The Homerton is aiming to achieve 85% by March 2018 for handovers within 15 minutes. The Trust's 15 minute ambulance handover performance remains one of the best in London, averaging 67.6% during the period Mar17 – May17 compared with the London average of 44.5%. • Ambulance handover KPIs are monitored by the Trust on a regular basis, with arrangements in place to enable patient handover to be take place as quickly as possible once ambulances arrive. There are regular meetings between the Homerton and LAS to trouble shoot any issues that arise. A pathway for handover has been developed, and both organisations are in regular email and phone contact to escalate any issues at the earliest opportunity. The Homerton has its own transport mechanism that can facilitate transfers and escalation process within this. The Homerton uses the LAS decision tree to determine what transport response may be needed and book accordingly. If any significant delays are experienced, communication with LAS control occurs and then escalated to the operational team internally to review any issues or points of learning.		
4.4	**Streaming (50% threshold)** • What is the current and projected trajectory for percentage of patients streamed at the front door? • What plans are in place to ensure that streaming performance is within the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	• Homerton A&E includes streaming to its primary urgent care centre (PUCC) and encourages patients to use primary care as the first option for future care requirement where appropriate. This is supported by a non-clinical navigator service operating in the Emergency Department, which supports sign-posting and GP registration. The co-located UCC is mostly integrated and operates under the umbrella of Homerton's A&E. Staff are partially integrated with some dedicated strictly to the UCC (three GPs) with nursing cross cover between the UCC and ED. In terms of streaming the patients' first point of contact is with a receptionist where they are booked in. After		

		which a band 5* nurse – equivalent to a band 6 due to training in streaming and A&E – will stream to the ED, UCC or other areas within the hospital. • For quarter 1 of 2017/18 the average percentage of patients arriving at Homerton A&E that were streamed to PUCC (passed through PUCC) was 28%. • A joint review of PUCC is currently underway between C&H CCG and Homerton. A case notes review of low acuity HRG cases in ED suggested that streaming is largely appropriate based on the existing PUCC service that is currently commissioned. This joint review has found that since 2013/14 there has been a reduction in PUCC activity, and analysis of HRG activity suggests that a higher complexity of patients are now being seen within PUCC. The review so far has supported an argument that lower acuity patients are being effectively managed in primary care by the Duty Doctor Service. The PUCC service specification requires updating, and the joint review will give consideration to the scope of activity which can be seen within the PUCC service. The review has recognised the need to increase the percentage of patients streamed, however given that the case notes review has indicated that streaming had largely been appropriate, and in order to increase the rate a wider group/categories of patients would need to be seen within PUCC. • By the end of September 2017 the PUCC Review will: - Undertake the clinical work to establish additional cohorts of patients that could be streamed to PUCC - Consider what this means to the organisation/clinical management process in PUCC - Review the service specification to reflect these changes - Set a streaming rate based on PUCC operating as above		
4.5	**Ambulatory Care**	In April 2017, the Homerton established the Homerton Ambulatory Medicine Unit (HAMU). This service is being piloted for 12 months and is being delivered by 4		

	• What proportion of patients presenting at the ED are for ambulatory care sensitive conditions? • What plans are in place to increase service provision for these patients?	consultants with junior doctor and nursing support. The HAMU operates from 0800-2000 Monday to Friday (consultant cover) and 1000-1400 (nurse led) at the weekend. Extending provision to 14 hours a day, 7 days a week will be considered as part of the evaluation of the pilot. There are no rigid eligibility criteria; any patient can be considered suitable for ambulatory care by discussion with the consultant covering HAMU. Information on the proportion of patients presenting at the ED for ambulatory sensitive conditions will become available following the analysis of the HAMU pilot.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed.	N/A		
5	**Mental Health**			
5.1	• Is the AEDB assured that there is a 24/7 liaison psychiatry service available. Does the service include a consultant psychiatrist?	• The Homerton Psychological Medicine (HPM) Service (Psych Liaison) operates at A&E 24/7. This service includes a consultant psychiatrist. • The HPM service rota is finalized at least a month in advance and reviewed daily; increased staffing can be booked to meet service demand/cover sickness. There is an established pool of nurses that can be called on. Back-up support can be provided if needed by senior manager and consultant on-call, and Duty Senior Nurse based at City & Hackney Centre for Mental Health. A 24 hour Approved Mental Health Professional service is available all over bank holiday period. Contingency plans in place for vulnerable clients. There is 24 hour cover via A&E CAMHS, SPR and Consultant on call rota. A 24 hour/7 day a week service is provided by the Coborn Unit for elective and emergency inpatient admissions. Urgent cases will be seen during working hours via the CAMHS duty rota.		

		• HPM/HTT continue to provide a daily service throughout the holiday period to the most vulnerable service users. CMHT's and other community services continue to provide support apart from bank holidays. Non-statutory/voluntary services provide increased social support – and lists of what is available are distributed to all services before the holiday period to inform crisis/contingency planning with service users and carers.		
5.2	• What training/competencies do staff, including doctors have against the Mental Health Act and the Mental Health Act Code of Practice? Have the upcoming (Autumn) MHA legislation changes been considered?	All relevant staff, including doctors, have received training on the requirements of the mental health act and mental health act code of practice to ensure that they are able to operationalise them on a daily basis.		
5.3	• Is the AEDB assured that the provider is compliant with NICE guidance on short-term management and prevention of recurrence of self-harm?	Yes, the service is compliant with guidance		
5.4	• To support the timely delivery of care for individuals detained under s136 and requiring physical health input has consideration be given to a parallel and concurrent mental health assessment and treatment by medical staff?	Yes. If necessary, individuals under Section 136 are medically cleared in A&E before being brought across to the Section 136 Suite, which is in our Psychiatric Unit, and only 5.minutes' walk from A&E.		
5.5	• In line with the pan-London s136 pathway, what protocols are in place for patients arriving under s136? Are these protocols recognised by the police and ambulance service?	• A draft London wide compact has been developed (May 2017) which informs the work of the Trust; police and ambulance services were co-signatures to the report. This document builds on the pan London section 136 pathway report launched December 2016). • There is an existing Section 136 Protocol which works well and is recognised by ELFT, the Police and Ambulance Service		
5.6	• What arrangements are in place between the acute and mental health trust to ensure robust clinical pathways and reduce the number of patient transfers between sites?	ELFT provides the (RAID) Psychiatric Liaison Service in Homerton Hospital including A&E and this ensures there are effective clinical pathways and constructive working relationships between Homerton Hospital and ELFT for the benefit of patients.		

5.7	• What area is provided for patients to wait in until transport for admission to a psychiatric service or other follow-up action is arranged?	• Patients wait in the appropriate setting depending on their clinical presentation and need. In A&E they would either wait in A& E reception, with a family member or in the Assessment Room in A&E with a member of staff. • The Section 136 suite is not in A&E, but adjacent to a ward in our Psychiatric Unit and patients waiting there would either remain in the suite or move temporarily to a side room on an Acute ward, accompanied by a member of staff.		
5.8	• What arrangements are in place with the community and ambulance service to reduce the number of frequent attenders?	• The service is undertaking cross boundary work through the mental health CQUIN involving acute, mental health, community and voluntary sector to reduce the number of frequent attenders. This work has been considered by system partners at the July 2017 C&H urgent care board. • C&H have a Frequent Attenders Group which meets regularly and reviews frequent attender data from across the system. Representation on the group includes LAS, GP OOH, Homerton, ELFT, CCG, Paradoc, GP Confederation, and the Tavistock and is led by a Frequent Attenders Nurse Lead. Patients identified as frequent attenders can be referred to the A&E Well Family Service provided by Family Action which provides practical and emotional support to individuals, couples and families who are frequently presenting to A&E. • In community services, a database is kept of all vulnerable adults, which is updated when necessary, this ensures that the service has an up to date list of the vulnerable adults within the services. The health and social care partnership has a draft Vulnerable Persons plan in place. Any vulnerable patients that GP's have concerns about are faxed through to the out of hour's provider on a daily basis to ensure they are aware of them. The Trust has a dedicated consultant led psychiatric liaison service (Homerton Psychological Medicine) located within the ED department. The		

		overall aim of the service is to work with staff in the hospital to prevent unnecessary admission to inpatient care, reduce length of stay on acute general wards, to resolve immediate issues and concerns, and direct patients to primary and secondary care services that can provide on-going care, treatment and support. The service specialises in the assessment, treatment and management of mental health problems including anxiety, depression, dementia, psychosis, and any other suspected mental health or psychological problem. The team works collaboratively with hospital substance misuse team who provide specialist alcohol and drug support. The service operates 24 hours a day, 7 days a week inclusive of bank holidays and has a response time of one hour to the ED department, four hours for ACU and 24 hours for the wards. Referrals with urgent acute problems are seen immediately.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
6	**Flow**			
6.1	• What is the current status on the implementation of the SAFER Patient Flow Bundle • Implementing SAFER reduces stranded patient numbers and reduces deconditioning that results from prolonged hospital stays. If not implementation is not 100%, please describe the plans to drive full implementation, including AEDB oversight.	• Currently, 80% of wards at the Homerton have the SAFER Patient Flow Bundle Implemented. The Homerton will aim to have all wards covered by December 2017. The SAFER patient flow bundle is mainly in place across all Homerton wards (medical and surgical). The job plans allow for senior review before midday where possible at consultant level. The winter resilience plan includes a ward transfer nurse to facilitate flow from the ACU (Acute Assessment Unit) to downstream wards as early as possible. The medical and surgical wards are monitored on their number of discharges before midday and we have set the target at 2 per ward. • Ward round checklists are carried out through medical checklists, ward handovers, safety briefings and		

		huddles. The consultant job plans for the consultants running the medical take allows for medical patents to be reviewed within 14 hours of admission. A plan of care is documented and an estimated discharge date with key actions to meet that date, all patients are also reviewed the following day by the consultant (day 2 review) if they remain on the acute admissions ward. For those patients transferred to the speciality ward they are reviewed at the white board meeting. • There is a weekly peer review meeting for medical patients which is MDT focused, the LOS is not the sole reason for referral to this process, it is also coupled with those discharges that are not taking place for a non-specific reason. For surgical patients MDT reviews are held on a daily basis. • Discharge coordinators are ward aligned and robust in supporting simple discharges. Morning discharges are encouraged as is use of the discharge lounge. Age UK is available to support simple discharges		
6.2	• How is the AEDB area monitoring and managing 'stranded patients'? • Are you making use of 'mini-MADE' (Multi-agency discharge events) early when stranded patient numbers rise, rather than as an urgent measure during escalation. It is essential to identify the number of stranded patient that should trigger the mini-MADE • Please describe the local arrangements which address this	A weekly report is generated identifying long-staying patients. Patient with a LOS over 90 days trigger and are documented on an exception report which is discussed at a weekly multi-professional operational meeting as part of the medical productivity work stream. Complex patients are referred to a Peer Review; patients are referred early in an attempt to avoid them becoming "stranded." Patients on the DTOC list are discussed daily at multi-professional handover meetings. If DFTOC numbers reach 12 or more on 3 consecutive days, an exception report is triggered and escalated via the medical productivity work stream.		

6.3	• Is the AEDB assured that the trust has a Full Capacity Protocol (FCP) in place? • If it does not, please confirm that this is either because the trust has sufficient capacity available not to require one, or, that the trust wards have been surveyed and judged unsuitable to support the use of a FCP. • If this is the case, please articulate the trusts plan to manage a crowded ED safely, without recourse to an ED redirect or closure *NB The use of FCPs is supported by the Royal College, but their use should be kept to an absolute minimum, and they must be introduced with suitable governance, in a planned manner.*	There is an escalation bed capacity guidance document which outlined the process for bed management including opening extra beds to maintain safe and efficient flow of patients within the Trust including ED. The document outlines the roles and responsibilities of the clinical teams and management teams along with guidance on staffing.		
6.4	• If there were 12 hour trolley breaches within your AEDB geography last year, what were the causes, and what actions have been put in place to prevent them occurring this year?	There were zero 12 hour trolley breaches during the financial year 2016/17. However, there was a 12 hour trolley wait at the Homerton during April 2017. A route cause analysis was completed and the breach was due to a mental health patient who remained in ED while awaiting a bed within Camden and Islington FT. The pan-London compact has been designed to help minimise the risk of similar incidents in future.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
7	**Capacity**			
7.1	**Bed Occupancy (92% threshold)** • What is the current and projected non-elective bed occupancy? • What plans are in place to ensure performance is within the threshold level? • Please provide justification if planned trajectory is below threshold levels	**Bed Audit provided to NHS England** City and Hackney have plans in place for flexible capacity that can be increased in the event of winter surge, across the acute and community. Homerton has assessed the potential for additional bed capacity based on previous experience and has identified an area where additional beds can be opened. Daniel Defoe Ward offer up to an additional 22 beds that can be opened in line with the		

	N.B. this metric will be monitored daily/weekly depending on AEDB categorisation	Trust's bed management and escalation policies at short notice. When beds are very limited there is daily contact with social services and there is one lead for discharge planning across community and acute services; therefore, discharges will be both pushed and pulled to free up beds, non-acute beds such as Mary Seacole will also be used if required. Flexibility capacity is based on demand and capacity modelling with seasonal refinement. The Trust has a relatively even distribution of elective demand for inpatient beds across the week; however Mondays are usually the highest demand for elective inpatients post op. As a result, the additional capacity will be available for surges in demand for emergency beds. During the Christmas and New Year break, the Trust is likely to scale down the level of elective and day case activity. In the community, capacity is reviewed regularly to ensure that the services are able to respond rapidly to any winter 'surges', including facilitating early discharges from hospital and preventing hospital emergency admissions. These plans are detailed in the Homerton's cold weather plan.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
8	**Discharge**			
8.1	• Describe the current status of implementing the Eight High Impact Changes for Managing Transfers of Care locally across your AEDB	The City of London has undertaken a self-assessment for the High Impact Change Model and is in a good position in relation to this. In terms of actions identified to be taken forward, these include ensuring that there is adequate information, advice and support for self-funders and their families in hospital, streamlining discharge planning to ensure earlier discharge and addressing the issue of intermediate care provision. The City of London Corporation has a generic adult's social care team which includes qualified social workers, an AMHP, an in-house reablement team and an occupational		

		therapist. It commissions a care navigator to work in hospitals to support City residents with a safe hospital discharge and a reablement plus service which aims to avoid hospital admissions and facilitate discharge to assess with the provision of 24 hour social care support for up to 72 hours with clinical support provided by health professionals where required. This means that weekend discharges are possible. For acute admissions, most City of London residents get taken to UCH or Royal London hospitals. Very rarely do City of London residents get taken to Homerton hospital which is the main commissioned hospital for City and Hackney CCG. City of London social care maintains contact with the two most used hospitals for residents as well as with Homerton Hospital. The LBH has also undertaken a self-assessment for the High Impact Change Model and has set milestones that will predominantly be completed by Q3 of this year. Both of the HICM's are attached as appendix 1 & 2.		
8.2	• Has the AEDB modelled discharge capacity (workforce, beds, equipment, funding) to ensure that health and social care can meet daily demand, including variation, across the whole of winter? • Please provide supporting narrative regarding any gaps or issues which are of concern and where further work is required, including timescales for completion	The Homerton has set out its approach to demand and capacity modelling in its cold weather, and business continuity plans. This organisational wide strategic approach is flexed on a daily basis in response to capacity and workforce pressures as they arise. Continued use of DTOC funding to enhance Integrated Discharge Service capacity to support discharges using rapid discharge pathway from Elderly Care Unit (ECU), as well where appropriate "top up" provisions of care to facilitate discharges. Vacant Discharge Coordinators posts have been filled. LBH contract for ICES (Integrated Community Equipment Store) ensures continuous service throughout the year. Satellite equipment stores are located at Homerton to mitigate against bad weather conditions.		

		Given the size of the Adult Social Care Team at City of London, combinations of leave and/or sickness could have an impact on delivery of services during periods of pressure. Leave is planned appropriately and with potential pressures in mind and this has never been a significant issue but were it to become so, the City of London would use locum staff in order to maintain the service. The Social workers in the City of London have previously been able to access flu jabs through occupational health and discussions are taking place about options for this year.		
8.3	• How many additional home-care packages have been commissioned to support 'discharge to assess'. Systems that have done this find that Continuing Health Care (CHC) delays and social care delayed transfers of care (DToCs) are reduced. This additional capacity can be realised before winter and used for surge	LBH Domiciliary Care commissioning now moved to Quadrant working with tier one and two providers for each quadrant. This has stabilised the local domiciliary care market and increased availability and skill levels. Two additional agencies available for meeting specific cultural needs of Orthodox Jewish and Turkish speaking service users. Provider forums used to brief providers on surge and winter pressure issues. We are also in process of implementing an enhanced re-ablement and intermediate care service through Integrated Independence Team. This service would bridge the gap with regards to speed of hospital discharges while facilitating an initial discharge to assess model out of acute setting. The City of London wouldn't buy additional care packages in advance due to low numbers; however, they have the capacity to arrange packages at short notice. Both local authorities are able to utilise the iBCF funding to support increases in demand.		
8.4	• In previous winters, acute trusts have reported difficulties in discharging patients because non acute providers cannot provide the level of care that the acuity of the patients demand. Has this been an issue for your AEDB area? If so, what action has been taken to provide additional services to non-acute care settings, in	We are normally able to find provision of non-acute care; however, sometimes this is required to be outside of the AEDB area in order to find speciality provision. This is more likely to be the case for CHC eligible patients.		

	order for them to be able to support acutely unwell, but medically fit patients?			
8.5	• What work has been undertaken to promote maximising earlier in the day discharges? • Do you have targets for the numbers of patients to be discharged before 9/ 10am? • Are they being achieved, how is this monitored, who at board level is responsible?	• Work to support early morning discharge includes Consultant ward rounds occur in the mornings, enabling senior decisions to be made earlier. Phlebotomy rounds commence at 07:00 daily to ensure results are ready for review in the morning ward round. Daily white board rounds take place on every ward with senior medical and nursing input. This gives the team an allocated time to discuss any blockages to discharge and expedite any additional actions that may be required. Multidisciplinary whiteboards embedded in all medical wards with full engagement from all members of the MDT, including social care. Medical productivity project looking at effectiveness and increasing focus on LOS. Utilisation and active management of Planned Discharge Dates for all patients is continuing on the wards. This maintains ward team's focus on discharge. • HUH have a target of 30% of patients to be discharged from the acute wards by 1pm (this could be either home or to the discharge lounge). HUH are currently at 23% over the last 8 weeks. This is being monitored though a report sent weekly by the information team, discussed by the medical productivity board and then taken to the Divisional director on a fortnightly basis. This is also being monitored by the Chief of Operations. Discharges before 9/10 would be very low as they would not have been seen by the consultant on the ward round yet and if they are medically optimised then they should really have been discharged the day before.		
8.6	• Is a 'placement without prejudice' process in place? *This ensures that when a patient has been identified as potentially requiring CHC, he/she is discharged to an appropriate environment out of hospital while the assessment and decision is made. A local agreement should exist between the CCG and Local Authority*	Not yet achieved in C&H. Initial discussions are underway between the CCG and the LBH whereby the local authority would provide an initial package of care pending a CHC assessment, and if the patient is determined eligible, there would be a process of reimbursement to LBH.		

	specifying which party will initially pay for the care or placement. If CHC is agreed, the costs should be met by the CCG backdated to the date of discharge.	Recently completed review of Continuing Health Care (CHC) Team and functions which has identified a number of areas that would require further consideration and development. This work will be taken forward through a dedicated task and finish group to ensure that going forward we have a more robust CHC service. Agreement in terms of joint commissioning, procurement and brokerage will form part of this work and would support the development of the placement without prejudice model. CHC team is currently under capacity to undertake quick community DSTs within any placement without prejudice model. Discussions have taken place between the CCG and LBH on the need increase social worker (SW) capacity to support such a process. CCG will lead on CHC operational improvement group with involvement of LBH/HUH Integrated Discharge Service and LBH commissioning.		
8.7	• Are plans in place to use the trusted assessor guide, designed to support hospitals, primary and community care and local councils deliver trusted assessment as a key part of the High Impact Change Model described in Chapter 2 of *the Five Year Forward View Next Steps*?	The guide has been reviewed and will be utilised. The London Borough of Hackney's DTOC operations group is considering an options paper on how to develop a Trusted Assessor scheme locally. This group is expected to report by December 2017. To enable the development of the AHP role to be a trusted assessor and facilitate senior therapists referring to Integrated Independence Team directly, a referral process is expected to be completed by October 2017.		
8.8	• What specific trusted assessments are happening in the AEDB geography? • Does the Local Authority have trusted assessor models of working? If so, what kind? • Does your CHC team follow a trusted assessor model? • Does the AEDB have plans in place for non-prejudice funding agreements with the Local Authority for patients	Discharge Coordinators at the Homerton are being trained to undertake some social care tasks such as restarts of packages of care; this work is planned to be completed by September 2017. The community CHC team do not follow a trusted assessor model; however, acute based DSTs are completed by the ward based MDT staff.		

	not eligible for CHC but do have health needs. For example: patient with grade four pressure sore	In LBH three unqualified social care staff in Information and Assessment team are trained as Trusted Assessors with regards to basic occupational therapy equipment. The City of London has reported that in terms of trusted assessors, currently the Care Navigator undertakes a basic assessment which can be used as the basis of a re-ablement or care needs assessment. Re-ablement workers are also trained as trusted assessors in relation to basic equipment.		
8.9	• What specific work is being undertaken to support capacity at the end of the festive period? • Please outline current work with internal teams around re-ablement and external teams re community support / social services etc., so that options are not exhausted straight after the return after the New Year, increasing the risk of long ED delays, ambulance handover delays and 12 hour breaches.	The resilience plans outlined above include measures to ensure sufficient capacity is in place at the end of the festive period. Annual leave will be planned in order to manage capacity.		
8.10	**Medically Optimised (3% threshold)** • What is the current and projected MOs performance during winter? • What plans are in place to ensure that the percentage of patients that remain within the threshold level? • Do you have sufficient community therapy and domiciliary care capacity to manage the medically optimised patients who are discharged form hospital sooner? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	HUH collect 'Medically Optimised Patient' information twice per week on each IMRS acute ward (except the Stoke Unit and ACU). The % of medically optimised patients differs per ward. The average for all of the covered wards was 31%. We have determined that Homerton include patients within their medically optimised coding that are not within the NHS E definition, including predicted discharge on the day of reporting and DTOC. Therefore the levels reported by the Homerton are above the threshold. The CCG and the Trust are working together to refine the coding to align with NHS E reporting. Commissioners from the CCG and LBH are reviewing the capacity of the Integrated Independence Team and determining how additional therapy demand can be met. Both this need and additional domiciliary care will be supported through the iBCF.		

8.11	**Continuing Health Care (threshold 75% by end Oct-17, 85% by end Jan-18)** • What is the current and planned trajectory for CHC assessments taking place outside of an acute setting? What plans are in place to ensure performance is within this threshold level? • What plans in place to ensure that the 80% threshold of CHC assessments taking place within 28 days during winter is met? • Please provide justification if planned trajectory is below threshold levels • How will the AEDB assist acute trusts with choice issues related to CHC placements and care offers? • How will the AEDB work with the Local Authority to ensure residential home patients are regularly reviewed to ensure cross over from residential to nursing care is seamless to avoid admissions for re-banding to Funded Nursing Care or CHC *N.B. CHC assessments will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	The CCG had 51% of DSTs taking place in the acute setting in Q1 of 17/18 and a plan is being created to provide assurance that the trajectories will be met by the required milestones. Discussions are taking place with the local authority to put in place a placement without prejudice model and ensure that CHC patients are supported within the model. The Rapid Discharge Pathway now in place on ECU will also be reviewed to include CHC patients. The CCG is currently meeting the 80% threshold for assessment taking place within 28 days. An operational improvement group is being developed to respond to the findings of a recent review of the service and will take into account the threshold levels. The capacity of social care staff and the potential need for additional social workers has been identified as an issue to be discussed further between the LBH and the CCG.		
8.12	**DTOCs** • What plans are in place to ensure performance is aligned with the expectations set out in London DTOC Expectations – Winter 2017/18 (Appendix 4)? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on Delivery Board categorisation. Recovery plans will be requested should performance fall below the threshold*	• DTOC trajectories have been set to meet threshold levels. • The LBH will utilise some of the iBCF funding to purchase additional social care packages when required. • The Homerton holds weekly Delayed Discharge meetings with Hackney Social Services to review lists and patients. These meetings are stepped up to daily meetings between the hospital and social services where there are significant bed pressures. There is one lead for discharge planning across community and acute services; therefore, discharges will be both pushed and pulled to free up beds. There is a 10.30am meeting every day within the Trust to review all the patients on Acute Care Unit (ACU) regarding care and		

		discharges. When beds are tight all the Consultants and SpR's are mobilised to review their patients and identify potential discharges. The discharge planning team will also review potential discharges every morning. The Integrated Discharge Management Service support ward staff to plan and manage the discharge of patients with complex health and social care needs from the Homerton. They work closely with the Integrated Independence Team and Adult Community Nursing service to facilitate better GP communications and more 'community pull' for discharge. The team also provide the hospital social work service for all out of borough hospitals. • The Homerton also works very closely with out of borough social workers, ensuring that DTOCs for out of area patients are minimised. The London Borough of Hackney Assessment and Care Management services operate Monday to Friday, 9.00 to 5.00pm. Both the Access team and Adult Services have duty systems in place, which can be contacted during the above times. Hospital Social Work Department operates between Monday and Saturday; 9.00am to 6.00pm. Details of this this team is included within the Homerton's Business Continuity Plan. Outside working hours and over weekends and bank holidays the Out of Hours service will respond and ensure co-operation and co-ordination of services; this includes the periods of increased pressure. The London Borough of Hackney has a corporate Business Continuity Plan in place. All community services are able to refer to Integrated Independence Team enabling a multi-agency approach to avoiding hospital admissions and facilitating rapid discharges. • Residential and Nursing Homes: Hospital discharge pathways to care homes are in place, and any issues are regularly discussed at the monthly meetings. Each		

		care home has an identified GP who will complete an initial assessment upon transfer to the home. Mary Seacole Nursing Home is also available, depending on permanent capacity for interim support for people with high health needs. Both are available for small numbers of clients. • Each local care home has an identified Community Care Manager who attends on a regular basis as well as ad-hoc at the request of the home. Community Matrons also work jointly with GPs in case managing complex patients with Long Term Conditions in order to prevent emergency admissions. The Clinical Nurse Specialists in Palliative Care, Tissue Viability, Continence, MS and Parkinson's disease provide on-going support to all patients in their own homes and in residential and nursing homes and prioritise response (24 hours) to referrals. Adult Community Nursing also provides on-going generic nursing support to patients for catheter care and wound management. It is currently in the process of developing a service for IV therapy in care homes. The discharge planning team have a presence on all the wards to facilitate early discharge with a particular focus on the Elderly Care Unit. • The City of London has reported that 75 per cent of City residents are registered with the one practice in the City, the Neaman Practice which is part of City and Hackney CCG. A further 16 per cent on the east side of the City are registered with GPs which are part of Tower Hamlets CCG. Most City of London residents get taken to UCH or Royal London hospitals, more rarely to the Homerton hospital. City of London social care maintains contact with the two most used hospitals for residents as well as with Homerton Hospital. The City of London Adult Social Care Team is able to provide a responsive service and put in place care packages promptly, without the need to go to panel, in		

		order to avoid any potential DTOCs. Part of the iBCF funding for the City of London Corporation will be used to purchase additional social care packages when required. When there is the potential for any issues in terms of agreeing care packages, the Re-ablement Plus service can provide an interim solution to this, providing a short term care package to bridge the gap. • The City of London has excellent performance on Delayed Transfers of Care (DTOCs) that are attributable to social care (in 2016/17 there were 76 days of DTOCs attributable to social care recorded nationally although these are disputed). However, the number of delayed days attributable to the NHS has been rising. Going forward these will be addressed as part of a system wide response. • Due to the small number of acute admissions that City of London has at any one time and the percentage of these who require follow up services in terms of reablement, social care or continuing health care, the City of London does not take part in weekly or daily discharge reviews. However, procedures are in place for an escalation procedure at UCH and this is currently being worked on with the Royal London Hospital. UCH provide details of all admissions to the social care team to ensure that no one slips beneath the radar. This is not yet in place with the Royal London Hospital but is being progressed following recent discussions.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
9	**Public Health including managing flu and Infection control**			
9.1	• Is the AEDB assured that public health and prevention measures are a comprehensive part of system-wide winter resilience plans which include all providers? This	The flu strategy within C&H builds on the existing planning and operational arrangements in place by primary, secondary and community providers within the health		

	should include the local plans for responding to Influenza or Influenza-like illnesses	economy. This strategy is in collaboration with NHS England. City and Hackney CCG discusses flu plans with Homerton and ELFT annually, as part of CQUIN discussions. Each provider has a local plan for responding to influenza or influenza-like illnesses. The North East North Central London Health protection team(part of PHE London) is responsible for providing advice and updates to the CCG and our residents in case of pandemic flu and other infectious diseases plus all biological incidents.		
9.2	• Is the AEDB assured that local leadership from public health commissioners and providers are involved as part of winter resilience planning? *N.B. The main commissioners are Local Authorities and NHSE for certain immunisation programmes.* *In partnership with Local Authorities, London Pharmacies are offering influenza vaccines to LA Care Home staff to build resilience in these care homes and hopefully affect delayed discharges.* *Providers include general practice and pharmacy.*	There are longstanding and effective local partnership arrangements in place within City and Hackney which involve public health commissioners and providers as part of winter resilience planning.		
9.3	• Does the AEDB have assurance around compliance with hand washing levels in trusts? • What is the target level and what is your achievement of that to date? • What is being done pre-winter to re-enforce the messages around good infection control?	The Homerton has in place robust Environment and Isolation room cleaning policy and an Isolation policy. All patients are assessed on admission as standard for symptoms of diarrhoea and/or vomiting and isolated automatically as part of routine practice. The policy for the Control of Infection Diarrhoea and Vomiting includes details for when cohort procedures will be activated. The Trust has a major outbreak policy which details the communication plan to inform staff, our local population and other partners of a major outbreak. This plan includes how the Trust will communicate with GP's as necessary. Homerton University Hospital NHS Foundation Trust monitoring systems have an early identification of types/volume of cases which would then inform the implementation of different protocols, this is covered by their Major Outbreak Policy. Included within the		

		major outbreak policy is contingency staffing plans to separate clinical teams to provide care for infected patients and non-infected patients separately. Within the Homerton, all wards and departments have separate entry and access points, therefore isolation facilities would not be compromised. Support to Residential and Nursing Homes by community services are also covered in this policy. All homes have identified lead Community Matrons and GP's who can provide increased support as necessary. City and Hackney reviews the hand hygiene audit data for the Homerton on a monthly basis and underperformance is discussed at the Clinical Quality Review group meetings held with the Trust. The Homerton audits show compliance with standards above 98% since December 2016. The CCG discusses infection control with ELFT annually at the Clinical Quality Review Group (CQRG) meeting but does not monitor ELFT hand hygiene; at the last CQRG discussion held in July 2017 no issues were identified. The CCG does not monitor hand hygiene standards for primary medical care services. The Homerton has one of the best infection control performances in England with one of the lowest thresholds for cases of C.Diff in England which it meets. MRSA cases are low. The Homerton DIPC ensures IC messages are delivered to staff all year around and data supports this is effective. See above for ELFT and primary medical care.		
9.4	• Is there a comprehensive local flu strategy in place? • Is the AEDB assured that plans are in place for the delivery of seasonal flu immunisation across all population groups and that monitoring of these plans will be part of your routine reporting? • Do those plans include the at risk groups in your population? • Are plans in place to routinely review and act on the PHE weekly flu surveillance reports in order to understand the indicators on flu in circulation amongst	The flu strategy within C&H builds on the existing planning and operational arrangements in place by primary, secondary and community providers within the health economy. City and Hackney CCG discusses flu plans with Homerton and ELFT annually, as part of CQUIN discussions. The CCG has only taken over delegated commissioning for primary medical care services since April 2017 so our approach to flu in terms of primary medical services are not yet developed. However, as in previous years the primary care plans seek to encourage uptake by at risk and vulnerable population groups. Flu immunisation		

	the population as well as support the management of the health and care system?	invitations will sent to patients during early Autumn months with a view to secure maximum uptake. Front line staff within primary, secondary acute and mental health, and community providers will be encouraged to take-up the offer of flu immunisation. Flu immunisation is discussed with the Homerton for maternity services by the C&H CCG maternity programme board. As in previous years, arrangements are in place to review and monitor the PHE weekly flu surveillance reports plans, and discuss actions across the local health economy through the surge and resilience teleconferences.		
9.5	• How is the AEDB using data from the sepsis CQUIN, the PHE Fingertips AMR dashboard and RX-Info to assure itself that all patients are receiving effective 3 day antibiotic reviews?	The CCG and Homerton have worked closely to ensure improvement in sepsis management in line with CQUIN requirements. Performance at the beginning of 2016/17 was poor in terms of 3 day review but has significantly improved subsequently although still requires attention, is monitored closely. CQUIN performance is discussed quarterly at CQRM meetings and prescribing issues are discussed at least annually in the CQRM including CQUIN performance.		
9.6	• Is the AEDB assured that the targets for staff immunisation will be exceeded? How will this form part of your routine reporting? It is important that this includes all providers of NHS Services across acute, community, mental health and primary care. • Did organisations meet their targets for staff vaccination rates last year? • Is your staff vaccination rate target sufficiently stretching? • If targets were not met, what is the strategy to do better this year? • How will this be monitored?	Seasonal flu immunisation is being offered to all front line staff within primary, secondary acute and mental health and community settings with a view to build on the work undertaken last year. However, the CCG is not confident that Homerton (acute and community) target will be exceeded as immunisations for staff are voluntary and there is resistance by staff, particularly nurses to be immunised. ELFT had one of the most improved performances in London and an amazing staff campaign that the CCG has shared with Homerton and NHSE as an example of exemplary practice that delivered an impressive performance. The CCG has not yet considered the position of primary medical care staff. Last year the Homerton missed the CQUIN target, and ELFT achieved it. C&H CCG does not have a CCG staff vaccination rate. Based on learning from previous winters the CQUIN vaccination target is sufficiently stretching for acute and mental health. The Homerton will not be paid the CQUIN if they don't meet the vaccination target. The CCG has shared a		

		best practice example with the Homerton and asked the Medical Director to liaise with a local acute Trust that has an impressive performance year on year. The CCG discusses CQUIN performance quarterly with acute and mental health providers.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
10	**Workforce**			
10.1	• What review of workforce plans has been undertaken within the winter planning process? How has this been overlaid to fragile services, including identification of key operational/staffing gaps via profession/service/speciality and plans to address and the confidence levels of this within the winter timeframe?	The Homerton has implemented new medical and nursing rotational posts to address some of the long terms resource gaps as a result of the lessons learnt from last winter 2016/17. It has enhanced resilience in the urgent care centre through recruiting a stable GP workforce from mid-Feb17 onwards. The Homerton has employed a dedicated resource within the Department to directly manage all temporary and additional medical staffing requirements. The Homerton's business continuity plan outlines arrangements to support delivery of service where there are staff shortages.		
10.2	• Has an impact assessment and risk mitigation of Brexit been undertaken and how this plays into winter and operational plans?	An initial Brexit impact assessment has been undertaken as required by NHS Improvement. HUH are currently undertaking more detailed work to understand if any specific areas will be disproportionately affected and how the Trust might plan/mitigate any potential loss of EU Nationals.		
10.3	• Is the AEDB assured that the Trust holding firm on agency use and caps across all workforce groups, in particular medics, and staying within authorised frameworks – how is this being assured over the winter period?	The Trust is committed to limiting the use of agency staffing in line with NHS Improvement requirements as well as the trust's drive for quality and cost efficiency. Where agency staff are used only framework agencies are contacted and only in extremis with permission from NHSI do the trust go 'off framework'. On a national basis procuring agency medical staff at or below NHSI agency caps has proven unachievable. The trust is committed to working with London Trust's and the London Procurement Partnership to re-set limits on hourly		

		rates for doctors. These are planned to be implemented in October 2017. The rotas have been reviewed for the winter period to ensure safe staffing for the ED department.		
10.4	• Describe the wider links to Flu planning and exception planning in terms of workforce and impacts and risk management associated with this including outstanding risks	Seasonal flu immunisation is being offered to all front line staff within primary, secondary acute and mental health and community settings with a view to build on the work undertaken last year.		
10.5	• Have you identified any high risk workforce issues? What are these and what is the impact of not mitigating? Are they being addressed and managed within the trust or do they depend on a wider solution across STP/speciality etc?	Key for the trust at the moment are: • Newly qualified Nurse recruitment and retention • Medical skills shortages in some specialties The trust is engaged in a wide range of mitigating actions at Trust, Sector and Regional level to ensure trust services or finances are not adversely affected. The AEDB has identified that a workforce issue risk comes with the development of extended hours. From November 2017 it is expected that there will be Extended Access to Primary Care available at a 'Hub' level for at least some of the time GP OOH is operating. This has the potential to lead to decreased shift fill with the GP OOH's service if local GPs choose to work for Extended Access rather than CHUHSE due to its reduce Professional Indemnity burden. However, the Extended Access may in fact alleviate demand on GP OOH services. This risk will be overseen and managed by the AEDB/Unplanned Care Board and assurances will be sought from both the provider of GP OOH and Extended Access for these periods.		
10.6	• Are your trust plans on workforce risk assessment and mitigations going to Trust Board for review and when is this scheduled for? Are these plans drawn together by clinical, medical and speciality managers and senior staff working in an integrated way to provide assurance across all services?	Workforce Risk is articulated on the Trust Risk Register as well as mitigating action. The Risk Register is regularly reviewed by the Risk Committee which is a subcommittee of the Trust Board chaired by a Non-Executive Director. The Risk Committee report is a standing item on the Trust Board Agenda.		

		In articulating risks managers and clinicians work together to scope them and devise mitigation strategies.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
11	**Escalation arrangements**			
11.1	• Is the AEDB assured that the Trust has remedied and tested escalation arrangements internally and with system partners if there were issues last year?	• Inward and outward facing system level escalation arrangements are in place within the local health economy. Within the Homerton the escalation arrangement are outlined in business continuity and supporting policies. Where pressures upon the Trust have reached a point where support from external partner organisations is required Escalation is then done via the Surge Hub or the CSU Director on call out of hours at weekends. Depending on the severity, the CCG Director will be contacted and depending on the nature of the pressure, the actions may include working with the City and Hackney GP Confederation to seek to reduce GP direct referrals upon A&E for a time limited period. A system call will be coordinated by the Surge Team/CSU Director on call if necessary to help with the de-escalation process. • The STP escalation framework in relation to OPEL is still extant and for the Homerton, there was no need to use this last year. • The Trust's escalation arrangements where tested during a live Major Incident Exercise in June 2016 and a further exercise is planned for October 2017.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
12	**Business continuity**			
12.1	• Have business continuity plans been reviewed recently, in particular, regarding those elements geared to coping with cold weather?	The Business Continuity Plans, and supporting planning documents by AEDB partner agencies are reviewed regularly to capture lessons from previous winters and local issue so that resilience is built into their ability to support		

	• Do all parts of the organisation know what to do in the event of receiving cold weather alerts? • Does the trust have adequate stocks of salt and grit, and is it assured regarding the BC arrangements of its suppliers?	the system in the event of a BCP incident. Table top exercises of this plan and other BCPs within the CSU is planned before the winter period. There are existing plans and process in place to support the weather alerts and response appropriately to the different alert levels. The CSU supports resilience work by informing partner organisations of the escalation level. Progress on managing system pressures are reviewed at the system level resilience teleconference meetings with local provider. The Homerton's business continuity arrangements are reviewed regularly through EPPR planning exercises and as part of winter review to ensure that the plans in place remain fit for purpose. Assurance has been sought from the Homerton that it has adequate stocks of salt and grit and that it assured regarding the business continuity arrangements of its suppliers. The Trust uses NGS who are on an automatic call out, on MET office red alert. This includes footpaths & roads within the Homerton site. The contract is renewed on an annual basis.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
13	**Communications**			
13.1	• Has the AEDB reviewed the communications plans used last year, both internally with staff, but also externally with patients and partners, to ensure that it remains up to date and fit for purpose? • Does the plan focus on high risk groups and attendance avoidance best practice through self-care, pharmacy and NHS 111? • Have you made any changes as a result of learning?	The system level communication strategy and supporting communication plans of partner agencies within the local health economy are reviewed regularly and updated to reflect learning from last winter and major incident planning exercises. The communication plans draw on attendance avoidance best practice, with a particular focus on high risk groups and vulnerable population. The Homerton's Media Policy sets out the arrangements for handling media enquiries, including an escalation process for handling media out of hours and mechanisms for informing the Director On Call and the Press Officer. The Trust's Major Incident Policy also includes arrangements for managing		

		the media in the event of a Major Incident. The Homerton has a number of resources to direct patients to appropriate services, including on site signage and banners to direct patients to our Non-Clinical Navigators service, which supports patients who are not registered with a GP to complete their registration. Online signposting is undertaken through the Trust's website and through both corporate and individual service social media accounts. The CCG communications and engagement team will look to carry out communications activity alongside the current strategy that complements and supports it. The CCG can utilise it's own social, digital and traditional media channels for such supporting activity and will also look to liaise with local authorities, when relevant to ensure key messages and information is disseminated as widely as possible. The CCG will also work with all partners to ensure messaging and information reaches key target audiences and hard to reach groups and communities. The CCG communications team have also discussed being able to support the Homerton should a major incident occur and they need additional media and comms support.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed	N/A		
14	**Summary Statement**			
14.1	Please provide a summary statement regarding your AEDB preparations for winter, demonstrating (if not clearly captured above) the lessons learned from last winter and where you have actioned these.	The NHSE/I site visit of the Homerton in May 2017, followed by a peer led review of the Trust in June 2017 focusing on delayed transfer of care found that it was a system that generally performed well, despite volatility in DTOC performance. The Homerton was one of the highest performing system in London for the 4-hour quality standard during the winter period 2016/17. The reviews found that system leadership structures were clear providing a firm basis for joint working. There was clear demonstration of a joint ownership of issues between all system partners, with a high degree of consistency in how		

		each group talked about them and a collective drive for change. Based on the lessons from winter 2016/17, the Homerton will seek to maintain a quick ambulance handover process; with administrative support in place to enable a streamlined process at the front end and mitigate against any delays. The Trust will optimise where possible the staffing levels to maintain capacity. It will continue to develop new initiatives to improve quality of care including the introduction of the Homerton Ambulatory Medical Unit (HAMU) which will continue to focus on admission avoidance. As well as build on the existing links with neighbour tertiary providers to minimise delays and strengthen patient pathways. With regard to discharge arrangements, the June peer led review found that there is a good infrastructure in place, including the IDT and IIT to enable rapid progress to be made in implementing Discharge to Assess, although there is scope for further work on discharge arrangements to develop a shared 'home first culture'. It was noted that operational processes affecting discharge have tended to be too linear and sequential, adding to delays. Work to develop a clear shared system wide DTOC improvement plan, underpinned by a system wide demand and capacity plan which does not depend on significant increases in the bed stock may serve to mitigate this matter.		
Overall RAG status				

NB. Assurance of ambulance service planning will be undertaken once across London by the Ambulance Commissioners in NW London and results shared with Delivery Boards

Appendix 1

High Impact Change Model
London Borough of Hackney

Action plan

Impact change	Aim	Steps	Lead	When will it be done by?
Early discharge planning	Set up discharge dates for emergency admissions with full commitment of all stakeholders	1)Add as part of medical productivity project 2) dates and counter added to daily DTOC sheets to show Length of stay (LOS)	Simon Cole/ Carlo Prina	August 2017
	Develop a pathway for complex discharges that are identified at or soon after the point of admission	1)Graham Stroke Unit Complex discharge pilot group established and meeting fortnightly to plan complex discharges 2)Evaluate pilot and review impact on LOS 3) Consider roll out to other wards	Ella O'Reagan/ Lucy Gayton/ Simon Cole	June 2017 September 2017
		East London Foundation Trust (ELFT) /London Borough of Hackney (LBH) to discuss and develop pathways for complex cases early in admission. Weekly dialogue with LBH/Homerton University Hospital (HUH) Integrated Discharge Service (IDS) based on patients identified on weekly teleconference between ELFT manager and older adults wards	Waleed Fawzi /Tony Madden/Simon Cole /Ilona Sarulakis	

				October 2017
	Organise multidisciplinary and at all levels discharge action events Identify IDS "screening role" within the integrated team	1) Ward briefing sessions included in medical productivity project plan 2) Briefing ward managers 1) proposal written 2) SW Screener role in place 3) Screener role evaluated	Carlo Prina/ Jo Bennett Simon Cole /Nikki Sands Louise Dickson / Frances Oni	August 2017 Sept 2017 June 2017 October 2017
Systems to monitor patient flow	Develop robust system for withdrawals of assessment and discharge notices Agreed joint sign of of DToC in line with guidance Social workers/discharge planners attendance at all MDM and "white boards" meetings To consider impact of attendance at all daily 10.30 site meetings To be able to flex capacity in IIT to facilitate timely discharges	1) Revisit revise current policy with Discharge Coordinators (DC'S) to take lead 2) Agreed protocol signed off by HUH/ LBH 1) DTOC ops Group 1) Consistent and regular attendance of SWs at all key Whiteboards and ward based Multi-Disciplinary Meetings(MDM's) 1) Trial attendance of Discharge Coordinators at 10.30 Acute Care Unit (ACU) meeting 2) Evaluation of impact of attendance	Simmone Burrowes / Vicky Grieg DTOC ops group Simon Cole / Nikki Sands Louise Dickson / Frances Oni Vicky Grieg/ Simon Cole	September 2017 October 2017 August 2017 Ongoing August 2017

		3) SW to attend 10.30 ACU meeting on Saturdays	Frances Oni/Simmone Burrowes	September 2017
Multidisciplinary/multi-agency discharge team including voluntary and community sector	Age UK Home from Hospital Settling Service Representative (service commissioned by CCG) to attend DToC meetings on a monthly basis	1) Invitation issued	Simmone Burrowes	August 2017
Home first/ discharge to assess	Progress discussions in relation to "discharge to assess" and to consider different models to include use for ELFT patients. This builds on the existing Integrated Independence team (IIT) rehab and re-ablement service and will include those identified by checklist as potentially CHC eligible.	1) Pilot use of immediate service to rapidly assess and discharge from ECU 2) Proposal written 3) SW's briefed 4) ECU consultants briefed 5) Rapid discharge evaluated 6) Develop Initial Discharge To assess model (Bridging the gap service) 7) Proposal agreed 8) Working policy written 9) Recruitment started 10) Service available 11) Evaluation of impact	Louise Dickson / Shazia Deen Louise Dickson /Simon Cole Mervyn Freeze/ Simon Cole	July 2017 October 2017 September 2017 September 2017 October 2017 November 2017 February 2018
	Develop provision of bed based interim intermediate and long term nursing provision outside of hospital	Service available	Ilona Sarulakis / Simon G ?	Summer 2018

	Develop placement without Prejudice model to facilitate CHC eligibility assessment outside of acute setting	Proposal written for consideration by DTOC ops group	Ilona Sarulakis/Osian Powell/Simon Cole	November 2017
Seven-day services	Define model across health and social care for seven days working building on current 6 day service from LBH /IIT Social workers and 7 day service from IIT therapists Consult staff on contracts/job descriptions	1) Develop proposal and action plan to include consideration of establishing multi - disciplinary weekend discharge team 2) Staff consultation 3) Implement 7 day working	Ilona Sarulakis / Simon Cole	September 2017 April 2018
	Develop market place through joint commissioning to cater for seven days working or alternatively enhance IIT	1) Agree action plan with LBH commissioning working with small group of homes and domiciliary care providers	Simon Cole/Cynthia Davies	September 2017
Trusted Assessor	Use Developing Trusted Assessor schemes : Essential Elements document as basis for considering further trusted assessor developments	DTOC ops group to consider options paper	Simon Cole/Ilona Sarulakis	December 2017
	Develop "Trusted Assessor" model including giving discharge planners access to social care data base and evaluate	1) DC's trained to undertake some social care tasks eg restarts of POC	Vicky Grieg /Louise Dickson	September 2017
	AHP's role developed as trusted assessors. Senior therapists able to refer to IIT direct.	1) Referral process agreed	Louise Dickson/ Wayne Gillon	October 2017

Focus on choice	Ensure through systems and performance management that best practice (above) is implemented and applied Ensure common presentation to patients and families of "one story" in terms of choice and discharge plans Benchmark "Choice Protocol" Develop robust escalation process and	1) Escalation process developed and shared with partner agencies	Simon Cole / Louise Dickson	July 2017
Enhancing health in care homes	Set up bi-monthly meetings with local care homes providers with representation from HUH and /IDS/ LBH Commissioning to promote all elements of the Enhanced Health In Care Homes Framework Issue and promote guidance with regards to resident/patient hydration developed for local implantation Work with Dementia Alliance to determine what support is being provided in Care Homes.	Given lack of care home provision in LBH need to about how we influence and improve the market. This should include developing the current Housing With Care (HWC) provision to meet higher levels of need Establish short life Care Home HWC working group Provide hydration workshop and training materials Dementia Alliance to develop support to care homes (and HWC schemes)	Simon G/Ilona Sarulakis Simon Cole Martina Agho	October 2017 March 2018 March 2018

Appendix 2

High Impact Change Model
City of London

Action plan

Impact Change	Where are you now?	What do you need to do?	What challenges/ problems do you envisage?	What sort of help would you find most useful?
Early discharge planning	Discharge planning starts as soon as admission notification is received from the hospital. A care navigator visits the client on the ward and does an initial assessment to identify what needs the client may have. After this assessment, there is a default to a reablement service for all unless it is considered that a full social care assessment is needed at the point of discharge. The reablement service is flexible and can provide more than 6 weeks of support if necessary and is not subject to a charging assessment.	Ensure a robust process for data on DTOCs between provider and local authority Ease the pathway of sharing secure information between provider and local authority and developing better liaison for discharge planning. earlier notification – less chasing from us. Explore whether we need a take home and settle service. Review equipment responsibilities and access of providers to facilitate discharge Self funders – ensure that there is adequate information for self –funders and their families to assist discharge.	Technical issues around sharing information securely and the interaction of different systems. Need to look at integrated working between the whole system – complicated as City of London overlaps a number of different LA area hospitals so liaison is difficult but not impossible. Lack of intermediate care provision. Access to specialist equipment e.g. hospital beds to use in the home can	Ensuring that City of London is attending the right forums to discuss these issues, whilst recognising that capacity is limited. Intermediate care provision might be useful. Would need to scope out the demand.

	A reablement plus service (up to 72 hours of 24 hour care) can be provided for out of hours or urgent discharges. The reablement team have weekly meetings to scan the horizon and identify those who may need support. There is an issue about communication with providers. All have different secure systems for communication which don't always work well together. There are no referrals about elective surgery from hospitals. Currently undertaking a review of assistive technology offer to identify if more can be done to facilitate discharge Also reviewing our DFG and adaptation processes to identify if they can play a greater role in the discharge process.	Identify how discharges from A&E can be reported and managed (link to exploration of take home and settle service) Mental health front door liaison – ensure that mental health discharges are treated in the same way as acute discharges – need early alert about admission and discharge dates.	take some time and is often complicated by difficulties with the person accepting the need for care. Difficulties sharing client sensitive information across different systems.	All agencies to understand the Mental Capacity Act and the limitations to what agencies can do. Better shared information systems.
Systems to monitor patient flow	We do not have one as there is no acute hospital in City boundaries.			

Multi-disciplinary, multi-agency teams (including voluntary and community sector)	There is good multi-disciplinary team working including: - Reports from the hospital OT to ASC of the needs of the person being discharged - ASC and the care navigator attend practice MDTs and also a mental health MDT at the practice in the City - Regular meetings with housing and estate managers to ensure people maintain tenancies City of London commissions a number of services who can provide advice and support when someone is discharged. This includes a Reach Out Network (providing to support to carers, those with memory problems and dementia and those over the age of 50 who may have additional needs) and a City Advice Service who can provide advice on social care and support available.	The voluntary sector within the City itself is small but a vital contributor to support.A previous scheme called One Hackney and City included a voluntary sector framework which the City could call on to use a wider range of voluntary sector services – for example a rapid response to house clearance to ensure it was safe to go home from hospital. This may be considered again in developments as part of integrated commissioning. Explore how we could identify / be aware of other discharges who are not considered to need social care but could benefit from preventative services.	Effectively engaging practices and professionals across different CCG boundaries	

Home First Discharge to Assess	The City of London has a Reablement Plus service which can provide 24 hour social care support (with clinical support alongside) for up to 72 hours to enable out of hours discharge, urgent discharges and admission avoidance. Where people are discharged urgently or out of hours, social care is provided until the next working day when a social care assessment can take place.	Raise more awareness amongst professionals of the Reablement Plus service.	Linking in effectively with other developments and schemes in the wider system to ensure that there is no confusion about the pathways for City residents whilst being able to use additional services that may be useful.	
Seven-day services	The social care out of hours service is provided by LB Hackney. The Reablement Plus service can facilitate out of hours and urgent discharge.	More streamlined information and communication from the out of hours service Ensure contingency is in place for Reablement Plus service in case of any provider issues (sole provider)		
Trusted Assessors	In terms of social care trusted assessors, the reablement team are trained to do assessments for equipment	Joint / shared assessments being considered as part of work within the system Development of standardised Assessment form for use by	City residents are admitted to hospitals which are commissioned by different CCGs – there needs to be clarity on who provides what in terms of equipment.	

	The Care Navigator also carries out assessments of people being discharged from hospital. These are accepted by the Social Care Team. The City of London is very responsive in carrying out assessments once aware of the discharge.	Care Navigator that can then be used as a basis by social workers in the team Ensure process is in place for sign off of work by trusted assessors (issue of when Social Care Team Manager is on leave) Explore issue of access to equipment by trusted assessors such as OTs in hospital – different CCGs have different arrangements (provision by health or by social care). Need robust process for this.		
Focus of choice	There are no care homes within City boundaries so there is no choice for residents who wish to remain within the City. There is a spot purchase arrangement for residential care which means that there is no constraint in relation to a block contract. The City of London offers lots of choice and a personalised focus through individual budgets and direct payments.			

Enhancing health in care homes	N/A as no care homes within the City			

Title:	Consolidated Finance (income & expenditure) report as at August 2017 - Month 5
Date:	13th October 2017
Lead Officer:	Anne Canning, London Borough of Hackney (LBH) Paul Haigh, City & Hackney Clinical Commissioning Group (CCG) Neal Hounsell, City of London Corporation (CoLC)
Author:	Integrated Finance Task & Finish Group CCG: Dilani Russell, Deputy Chief Finance Officer CoLC: Mark Jarvis, Head of Finance, Citizens' Services LBH: Jackie Moylan, Director – Children's, Adults' and Community Health Finance
Committee(s):	Transformation Board – 13th October City Integrated Commissioning Board – 18th October Hackney Integrated Commissioning Board – 18th October
Public / Non-public	Public

Executive Summary:

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

Year to date or cumulative finance performance as at month 5 (August) is a reported variance of £4.3m from plan on combined pooled and aligned budgets.

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

Questions for the Transformation Board

Issues from Transformation Board for the Integrated Commissioning Boards

To be reported verbally.

Recommendations:

The 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:

NA

Impact on / Overlap with Existing Services:

NA

Sign-off:

Workstream SRO _____[N/A]_____ London Borough of Hackney _____[Ian Williams]_____ City of London Corporation _____[Mark Jarvis]_____ City & Hackney CCG _____[Philippa Lowe]_____

City and Hackney Clinical Commissioning Group

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

Integrated Commissioning Fund Financial Performance Report

Month 05 Year to date cumulative position

CICB 152

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Consolidated summary of Integrated Commissioning Budgets

			YTD Performance			Forecast	
	Organisation	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Fcast Variance £000's
Pooled Budgets	City and Hackney CCG	24,947	10,394	10,394	-	24,947	-
	London Borough of Hackney Council	LBH split between pooled and aligned not available.					
	City of London Corporation	462	53	32	21	456	6
Total		25,409	10,447	10,426	21	25,403	6
Aligned	City and Hackney CCG	366,046	149,124	149,124	(0)	366,046	(0)
	London Borough of Hackney Council	LBH split between pooled and aligned not available.					
	City of London Corporation	5,778	2,172	2,282	(110)	6,096	(318)
Total		371,824	151,296	151,406	(110)	372,142	(318)
ICF	City and Hackney CCG	390,993	159,518	159,518	(0)	390,993	(0)
	London Borough of Hackney Council	102,127	42,553	46,772	(4,219)	106,211	(4,084)
	City of London Corporation	6,240	2,224	2,314	(89)	6,552	(312)
Total		499,360	204,295	208,604	(4,308)	503,757	(4,397)

In Collab	Organisation	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Fcast Spend £000's	Fcast Variance £000's
	CCG Primary Care co-commissioning	44,183	17,581	17,581	0	44,183	-
Total		44,183	17,581	17,581	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

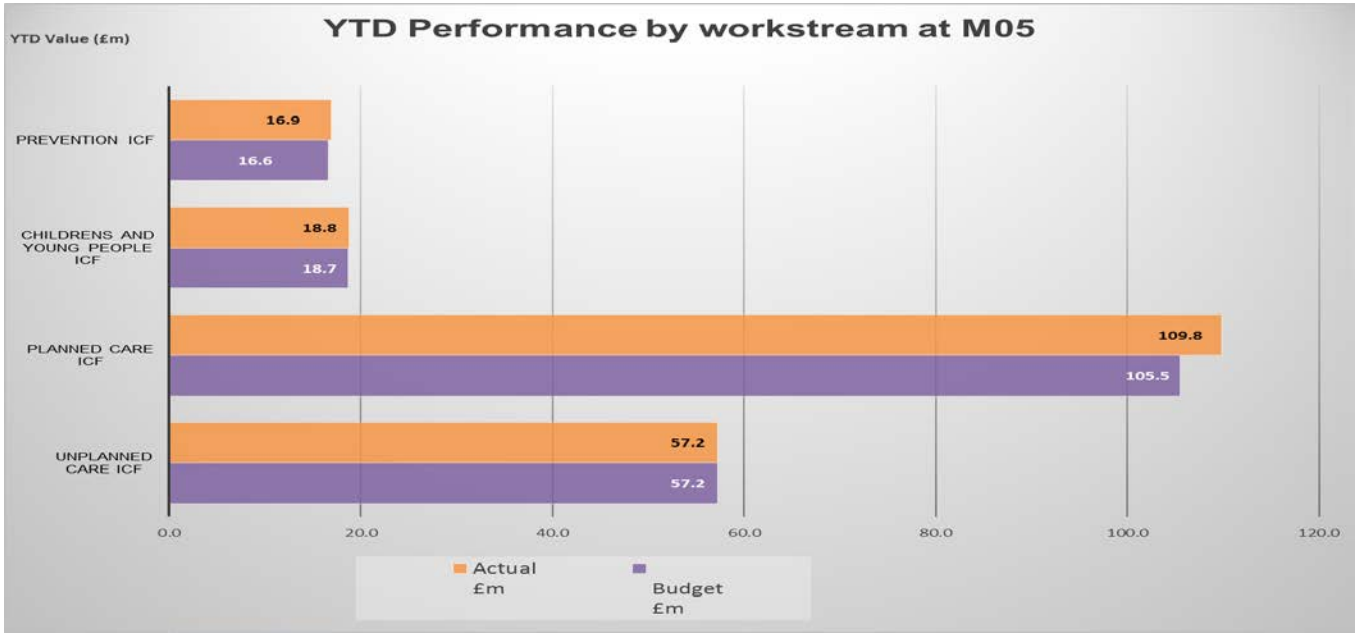
Summary Position at Month 05

- The reported position for the Integrated Commissioning Fund at Month 05 (August) is £4.3m adverse with a forecast variance of £4.4m adverse at year end.
- Driving the forecast position is LBH, which is forecasting a £4.1m over spend for the year .The adverse position relates to Learning Disabilities commissioned care packages.
- The CoL forecast is also an over spent position of £312k, however this over spend is expected to be met by a request for additional ASC funding and Public Health reserves
- 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 LBH budgets are not split between pooled and aligned due to the fact that pooled funds are contributing to towards the services in aligned funds.

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
Unplanned Care ICF	136.8	57.2	57.2	(0.0)	135.8	0.8
Planned Care ICF	253.8	105.5	109.8	(4.4)	259.7	(4.1)
Childrens and Young People ICF	44.9	18.7	18.8	(0.0)	45.0	0.1
Prevention ICF	40.8	16.6	16.9	(0.3)	40.9	(0.1)
All workstreams	**476.3**	**198.0**	**202.7**	**(4.7)**	**481.4**	**(3.4)**
Corporate services	22.1	5.8	5.3	0.5	21.2	(0.9)
L ocal Authorities (DFG Capital and CoL income)	1.0	0.5	0.5	(0.1)	1.1	(0.1)
Not attributed to Workstreams	**23.1**	**6.3**	**5.9**	**0.4**	**22.3**	**(1.0)**
Grand Total	**499.4**	**204.3**	**208.6**	**(4.3)**	**503.8**	**(4.4)**



Performance by Workstream.

- The report by workstream combines 'Pooled' and 'Aligned' services but excludes chargeable income .CCG corporate services is also shown separately as they are not attributable to any work streams.
- The combined position for the workstreams for month 5 is a £4.7m year to date over spend and a forecast over spend position of £3.4m.
- Across the CCG, LBH and CoL, the Planned Care workstreams is reporting a year to date (YTD) adverse position with corresponding year end adverse forecast position.
- Driving the adverse position

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

City and Hackney CCG – Position Summary at Month 5

	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
Pooled Budgets	Commissioned	Unplanned Care	18,735	7,806	7,806	0	18,735	0
		Planned Care	6,202	2,584	2,584	0	6,202	0
		Prevention	10	4	4	0	10	0
		Childrens and Young People	0	0	0	0	0	0
	Pooled Budgets Grand total		24,947	10,394	10,394	0	24,947	0
Aligned	Commissioned	Unplanned Care	111,298	46,666	46,478	188	111,199	99
		Planned Care	184,019	76,338	76,979	(641)	184,910	(891)
		Prevention	3,753	1,564	1,564	(0)	3,754	(0)
		Childrens and Young People	44,896	18,707	18,754	(47)	44,959	(63)
		Corporate and Reserves	22,079	5,849	5,349	500	21,225	854
	Aligned Budgets Grand total		366,046	149,124	149,124	(0)	366,046	(0)
SUBTOTAL OF POOLED AND ALIGNED			**390,993**	**159,518**	**159,518**	**(0)**	**390,993**	**(0)**
In Collab	Primary Care Co-commissioning		44,183	17,581	17,581	0	44,183	0
GRAND TOTAL OF POOLED, ALIGNED & PRIMARY CARE CO-COMMISSIONING			435,176	177,099	177,099	(0)	435,176	(0)
CCG Total Resource Limit			465,374					
SURPLUS			30,198					

- Primary Care Co- commissioning services passed on to the CCG on 1 April 2017 with a budget of £43.9m. At M05 this increase to £44.1m and the position is forecasting to break even at year end.
- At Month 05, the budgets are based on 1st April 2017 list sizes. Work is currently underway to estimate the additional costs in property charges (included as a potential financial risk in risk slide). Any variation to plan will be factored into the forecast outturn position once quantified.
- *Continuing Health Care

- At Month 05 the CCG is reporting a year to date break even position .
- **Pooled budgets** reflect pre-existing integrated services of the Better Care Fund (BCF), Integrated Independence Team (IIT), Learning Disabilities and are break even.
- **Aligned budgets**: The Planned Care workstream is reporting an over spend of £641k. This relates to over spends in CHC* - £330k (51% of the total Planned Care overspend) which is being driven by an increase in patient numbers fast track and physical disability activity. The year end forecast for CHC (as per the Broadcare system) is £0.63m - challenges are being made to the information reported by the CSU through workstream CHC Improvement Group. The remainder of the planned care over spend relates to over performance across a number of providers – mainly UCLH, Barts and Moorfields.
- Unplanned Care is under spent across a number of the Acute lines (Barts, UCLH) YTD but is being managed to date via unallocated acute budgets.
- Corporate (Running Cost Allowance - RCA) underspends and reserve funding are off setting overspends at an organisational level YTD, however total workstream budgets are adverse in the year to date.

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

City of London Corporation – Position Summary at Month 5

				YTD Performance			Forecast	
	ORG Split	WORKSTREAM	Annual Budget	Budget £000's	Spend £000's	Variance £000's	Fcast Spend	Variance £000's
Pooled Budgets	Commissioned & *DD	Unplanned Care	65	26	18	8	65	-
		Planned Care	208	24	14	10	202	6
		Prevention	10	3	-	3	10	-
		IBCF funding	179	-	-	-	179	-
Pooled Budgets Grand total			462	53	32	21	456	6

	ORG Split	WORKSTREAM	Annual Budget	Budget £000's	Spend £000's	Variance £000's	Fcast Spend	Variance £000's
Aligned Budgets	Commissioned & *DD	Unplanned Care	29	-	-	-	29	-
		Planned Care	3,850	1,723	1,613	110	3,935	(85)
		Prevention	2,170	539	725	(186)	2,307	(137)
		Childrens and Young People	-	-	-	-	-	-
		Non - exercisable social care services (income)	(271)	(90)	(57)	(34)	(175)	(96)
Aligned Budgets Grand total			5,778	2,172	2,282	(110)	6,096	(318)
Grand total			**6,240**	**2,224**	**2,314**	**(89)**	**6,552**	**(312)**

* DD denotes services which are Directly delivered .

- It should be noted that overspends relating to Public health will be met by the public health reserve at the end of the financial year, this has not been reflected in the forecast.
- **Note**: Local Authority YTD position does not include accruals and prepayments. Commentary is provided on the forecast outturn position (which takes into account any timing differences).

- At Month 05 the CoLC reports an overspend of £89k.
- Pooled budgets are under spent by £21k attributable to BCF services - Care Navigator Service and Reablement plus which are £12k and £8k over spent respectively.
- Aligned budgets are over spent by £110k. This is being driven by the Prevention workstream which is £186k 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. The public health pressure follows expanded use of existing services. A request for additional funding to cover the overspend is to be made. The position does not reflect the anticipated application of reserve funding.
- In addition, there has been a broadening of the substance misuse and healthy weight / exercise services that are being offered and taken up by City residents. This is impacting the year end forecast variance of £312k adverse.
- The adverse forecast position includes a 38% shortfall against the chargeable income projections.

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 5

						YTD Performance			Forecast	
Pooled and Aligned Budgets	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
	Commissioned & Directly Delivered	LBH Capital BCF (Disabled Facilities Grant)	1,299	1,299	-	541	597	(56)	1,299	-
		LBH Capital subtotal	1,299	1,299	-	541	597	(56)	1,299	-
		Unplanned Care (including income)	6,452	1,593	4,859	2,688	2,933	(245)	5,576	876
		Planned Care (including income)	59,509	22,640	36,869	24,795	28,641	(3,845)	64,469	(4,960)
		Prevention	34,867	-	34,867	14,528	14,601	(73)	34,867	-
		LBH Revenue subtotal	100,828	24,233	76,595	42,012	46,175	(4,163)	104,912	(4,084)
Grand total			**102,127**	**25,532**	**76,595**	**42,553**	**46,772**	**(4,219)**	106,211	(4,084)

* DD denotes services which are Directly delivered .

102,127

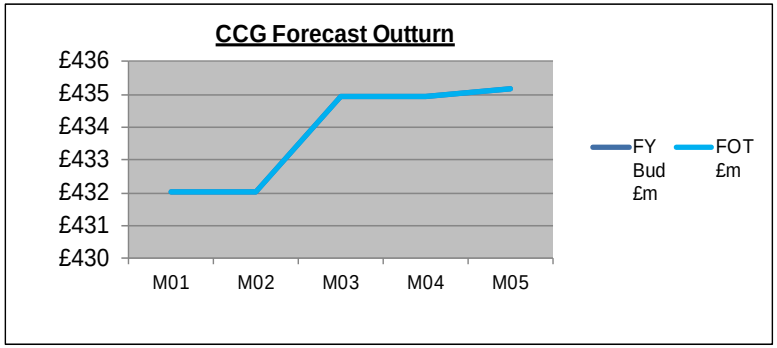
- Public Health, which represents the totality of LBH budgets within the Prevention workstream is forecasting a breakeven position.
- The delay in implementation of Telecare charging coupled with the undelivered savings to date in Housing Related Support are being partially offset by one off additional income.

- At Month 05 LBH reports a forecast overspend of £4.1m
- The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (including the Integrated Independence Team IIT) and Learning Disabilities.
- Learning Disabilities Commissioned care packages which are within the Planned Care workstream are the main area of overspend, with a £4.5m pressure.
- The LD pressure includes undelivered savings from previous years (£3m) and increases in complexity of clients resulting in higher cost packages. Management actions through the implementation of initiatives such as the Care Funding Calculator (CFC) will seek to mitigate some of this pressure.
- The Unplanned Care workstream is now forecasting an under spend (a movement from the Month 04 break even position) as a result of adjustments being made following a review of the forecasts across the workstreams. The under spend relates to Interim Care and is being offset by over spends on care packages expenditure which sits in the Planned Care workstream, with the corresponding deterioration of the Planned Care forecast.
- Included in the Unplanned Care forecast an underspend in Substance Misuse - £262k due to declining activity levels.

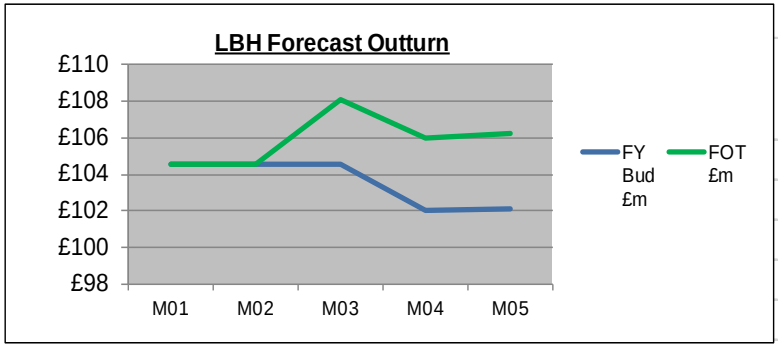
Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Forecast Run Rate at Month 05

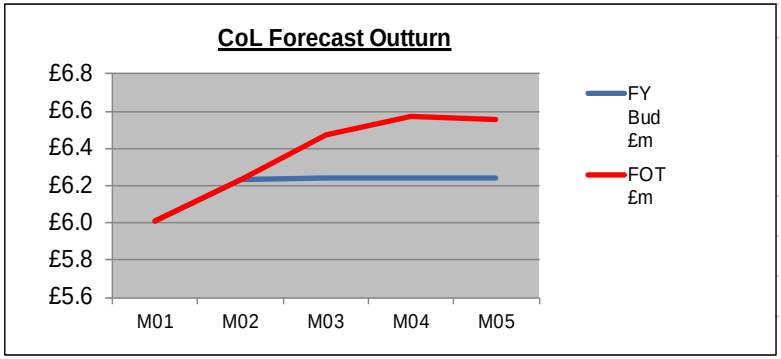
City and Hackney CCG Forecast Summary			
Month	FY Bud £m	FOT £m	FOT Variance £m
M01	432.0	432.0	-
M02	432.0	432.0	-
M03	434.9	434.9	-
M04	434.9	434.9	-
M05	435.2	435.2	-



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)



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)



- At Month 05 the CCG is forecasting a breakeven position at year end.
- At Month 05 LBH is forecasting a £4.1m 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 05 the CoLC is forecasting an adverse position of £0.3m for year end due to in creasing 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.

Risks and Mitigations Month 5 - City and Hackney CCG

Ref:		Description	Risks/ (Opps) £'000	Prob. %	Adj. Recurrent £'000	Adj. Non Recurrent £'000	Narrative
1	Risk	Homerton Acute performance	1,500	37%	550	0	Gross position based on historic trend. Net risk based on the trend relating to claims and challenges.
2		Homerton Identification Rule (IR) changes	1,700	0%	0	0	Agreed adjustment to action in month 6 of Identification Rule changes relating to high cost drugs within the Homerton acute contract. Net impact will be a reduction in CCG allocation contra a reduction in the Homerton acute contract.
3		Bart's Acute performance	1,250	68%	850	0	Gross position reflects over-performance risk and possible NHSE disputed misattribution.Net risk based on the trend relating to claims and challenges.
4		Outer sector - Acute performance	2,500	44%	1,112	0	Increased NCL provider over-performance risk contained by reserves.
5		Non-Contracted Activity (NCA) performance	500	0%	0	0	Applicable risk that reflects uncertainty of costs, including mental health choice, resulting in a recognised cost pressure.
6		Continuing Healthcare, LD & EOL	2,000	31%	628	0	Risk relating to activity increase above plan, high cost patients packages and service provision. Gross risk high given worsening 2016/17 trends and increased FNC tariff pressure.
7		Non Acute performance	800	20%	156	0	Non acute cost pressure across the portfolio.
8		Programme Costs	750	0%	0	0	Possible in-year non-recurrent cost pressures in support of the integrated commissioning programme and other non-recurrent schemes.
9		Property Costs	550	0%	0	0	Property services potential cost pressure.
10		Non Recurrent Investment Cost Pressure	2,500	43%	0	1,080	Underwriting NR investment programme, dispute resolution and other pressures.
11		Primary Care - Rent Revaluation	750	0%	0	0	Consequence of retrospective rent increases in 2017/18.
12		Primary Care - Rates	250	0%	0	0	Consequence of increased rateable value on properties in 2017/18
13		QIPP Under Delivery	900	0%	0	0	Potential under-delivery of QIPP schemes.
Total Risks			**15,950**	**27%**	**3,296**	**1,080**	
1	Opps	Acute contract Claims and Challenges	(1,750)	57%	(1,000)	0	Based on historic trend.
2		Homerton Identification Rule (IR) changes	(1,700)	0%	0	0	Agreed adjustment to action in month 6 of Identification Rule changes relating to high cost drugs within the Homerton acute contract. Net impact will be a reduction in CCG allocation contra a reduction in the Homerton acute contract.
3		Acute Reserves	(500)	100%	(500)	0	Release of reserve to offset activity pressures.
4		Non-Contracted Activity (NCA) performance	(500)	60%	(300)	0	Projected underspend based on current trend.
5		Contingency (0.5%)	(2,200)	37%	(810)	0	Release of contingency.
6		Prescribing	(500)	17%	(86)	0	Projected underspend based on current trend.
7		Running Costs	(1,400)	43%	(600)	0	Headroom/underspend declared and allows cost pressures to be contained elsewhere in the portfolio.
8		Prior year Items	(4,000)	27%	0	(1,080)	Opportunities arising from settlement of disputed items, accruals etc. invoices provided for in prior year resulting in an upside available 2017/18.
9		Non Recurrent Investment slippage	(500)	0%	0	0	Reviewed and risk assessed with position contained at month 5
10		QIPP Over Delivery	(500)	0%	0	0	Possible over delivery of QIPP.
11		QIPP - new schemes / CEP Programme	(1,434)	100%	(1,434)	0	QIPP in addition to the £5.0m recognised within the Operating Plan, to be ring-fenced and deployed on a year to go basis as directed by NHSE.
Total Opportunities			**(14,984)**	**39%**	**(4,730)**	**(1,080)**	

Risks and Mitigations Month 5 - City of London Corporation

City of London Corporation

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

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

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	4,084	100%	4,084	100%
TOTAL RISKS	**4,084**	**100%**	**4,084**	**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	4,084	100%	4,084	100%
Uncommitted Funds Sub-Total	**4,084**	**100%**	**4,084**	**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.

Integrated Commissioning Fund – Savings Performance Month 5

City and Hackney CCG

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

- The CCG has identified an additional QIPP of £1.4m which is over and above the £5m target is not reflected in the position as advised by NHSE.
- QIPP reported at M5 is an achievement of £2.1m against a plan of £2.1m
- The full year forecast has been reported achieve the target of £5m. Weekly QIPP delivery meetings are the platform to address any slippage and identify mitigations.
- Progress of monthly QIPP is expected to rise from August onwards as schemes become live and acute based schemes gain traction.
- 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 it is anticipated that there will be an achievement of £3.0m against this target for 2017/18.

The £0.5m shortfall in savings relates to:

- Housing Related Support (£1,062k savings agreed) - the savings achieved to date are £724k, a shortfall of £338k which is partly offset by additional income leaving an in year pressure of £0.2m.
- Telecare (£300k 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:	Briefing on National Ambulance Response Programme implications for London
Date:	18 October 2017
Lead Officer:	Paul Haigh
Author:	Jarlath O'Connell
Committee(s):	Hackney Integrated Commissioning Board - 18 October 2017
Public / Non-public	Public

Executive Summary:

The attached paper was issued by NHSE to update members of Clinical Commissioning Group (CCG) Governing Bodies (GB) across London on the new national ambulance response times and the London Ambulance Service (LAS) readiness for the introduction of the new response time standards.

Recommendations:

The Integrated Commissioning Board is asked to NOTE the information.

Sign-off:

City & Hackney CCG _____[Paul Haigh]_____

National Ambulance Response Programme

Briefing for Clinical Commissioning Group Governing Bodies

1. Introduction and purpose

The purpose of this paper is to update members of Clinical Commissioning Group (CCG) Governing Bodies (GB) across London on the new national ambulance response times the London Ambulance Service (LAS) readiness for the introduction of the new response time standards.

2. Background

On 13th July 2017, the Secretary of State announced changes to the ambulance national standards. The current national 8minutes response standards are being replaced by a new call prioritisation system which sets the standards for all 99 calls to ambulance services including those passed to ambulance services via 111.
The new national standards were established under an initiative called the Ambulance Response Programme (ARP) led by NHS England. The aim of ARP is to ensure that:

- The sickest patients receive the fastest response
- All patients get the best response allocated to them first time
- No one is left waiting for an unacceptably long time for an ambulance to arrive.

The development of ARP focused on:

- Giving call handlers a new set of questions to help them work out which patients are the most seriously ill and need the fastest response.
- More time for call handlers to assess 999 calls so that patients in non-life threatening situations can get the right care first time.
- Introduction of a new set of codes to make describing the patient care better.

Ambulances services across England are expected to transition into ARP between 13th July and end of November 2017 and should introduced ARP by the national deadline of 30th November with the exception of Isle of Wight. The new national response times are set out in Table 1.

Table 1 – New Response Time Standards

Category	Basic definition	Response time standard
1	Life threatening injuries and illness (e.g. anaphylactic shock or bee sting)	Response within an average of 7 minutes.
2	Emergency calls (e.g. stroke)	Response within an average of 18 minutes
3	Urgent calls (e.g. uncomplicated diabetes - some of these may be treated in patient's own home).	Response before 120 minutes for 9 out of 10 calls.
4	Less urgent likely requiring transport or hear and treat	Response before 180 minutes for 9 out of 10 calls.

3. London Ambulance Service (LAS) Readiness

LAS has been involved with the ARP development and the Trust is planning to 'go live' with ARP on 31st October 2017. Key areas of activity that must be completed by 31st October are:

- Upgrading of the LAS triage tool and implementation of the ARP categories and new response profiles.
- Further upgrading of the Trust dispatch system to ensure that it can interface with the triage tool.
- Work to switch on key internal and external reports from the go-live date which reflect the new model.
- Changes to fleet management to ensure flexibility to respond to new operational requirements.
- Ensuring all relevant operating policies are updated to reflect the ARP requirements and that all required staff training is completed.
- Completion of NHS England readiness checklist and assurance process

4. NHS 111 Progress

- The codes used by NHS 111 providers and the codes used by LAS have been cross referenced to ensure that patients receive an equal response regardless of which route they choose to access urgent and emergency care.

- 111 providers need to upgrade their systems by 24 November 2017 to recognise the new ARP codes. There will be a transition period from when LAS move to ARP and all 111 providers across London complete their upgrade.
- There is a national agreement that all 999 services will manage the transition for all calls until all 111 providers have completed their upgrade.

5. Implications for LAS

- The new standards will mean that the number of calls requiring an 8mins response will likely reduce daily from approx. 1500 to around 250. (this will be patients requiring a response within 7 minutes).
- Fleet reconfiguration and frontline staff rota changes

6. Other implications

- CCG commissioners will need review of current Appropriate Care Pathways (ACP) to ensure suitable functionality.
- Acute trusts - currently no change anticipated to activity for Emergency Departments however overtime there is potential for reduced conveyances.

7. Performance reporting

Due to the nature of the technical changes required to introduce the new operating model, there is no opportunity for a period of dual reporting on the existing and new performance regimes. The following actions have been agreed to mitigate this position:

- Minimum national dataset submitted to UNIFY will be used for reporting and monitoring performance from 31st October to early January 2018 to give an opportunity to establish the baseline for a performance trajectory.
- Performance will also be monitored via benchmarking of LAS against other ambulance providers using the national UNIFY data.
- Achieving the required response time for the sickest patients i.e. within an average of 7mins will be priority.

8. Communications

- LAS has presented on ARP to all three contractual forums.
- Brent CCG briefing to London Chief Officers

- Brent CCG briefing to CCG Governing Bodies

Integrated Commissioning Boards Forward Plan, 2017/18						
Title	**Summary of Decision**	**Originating Organisation**	**IC Decision Pathway**	**Care Workstream**	**Reporting Lead**	**Notes**
15-Nov-17						
School-based and Vulnerable Children's Health Services	Paper seeking LBH approval to procure services: Discabled Children's Services; Looked After Children's Health Services; Safeguarding School Health Services and Family nurse Partnership **ICBs For Information**	LBH	LBH CPC - 10 Oct 2017 - *For decision; TB 15 Nov for endorsing*	Children & Young People	Angela Scattergood / Amy Wilkinson	
Quarter 1 Quality & Performance Report	To review and discuss. Issues raised then taken to Dec TB.	CCG	GB - 27 October 2017; TB 8 Dec 2017	All	Sunil Thakker / David Maher	
Adult Social Care Budget	Seeking additional funding for Adult Social Care Budget	CoLC	Prevention Workstream Boar; Community and Children's Services (TBC) - *For decision, 13/10/2017*	Prevention	Neal Hounsell / Ellie Ward / Gareth Wall / Jayne Taylor	
Procuring for Social Value	City ICB to discuss and endorse **City ICB only**	CoLC	Community and Children's Services Committee - TBC	Planned Care / Prevention	Ellie Ward / Neal Hounsell / Devora Wolfson	
Future vision for Outpatients Services	Discuss and endorse	CCG	Transformation Board 10 Nov	Planned Care	Neal Hounsell/Gary Marlowe/Siobhan Harper	
Analysis of impact of Universal Credit	Discussion and to note	LBH		All	Ian Williams	
Carers Service	Provisin of Carers service across City and Hackney. For information.	LBH	Transformaiton Board - 10 Nov	Prevention	Simon Galczynski/ Gareth Wall and Jayne Taylor	
Learning Disabilities - New Model	Discuss and endorse	CCG	Transformation Board on 10 Nov	Planned Care	Simon Galczynski/ Siobhan Harper	
Impact of QIPP programmes on City of London	Review and discuss specific impact of QIPP schemes on CoL residents	CCG	**City ICB Only**	All	Sunil Thakker / Dilani Russell	
Local Response to NEL Integrated Urgent Care		CCG	Unplanned Care Board - Oct	Unplanned Care	Anna Hanbury	
S256 Supporting hospital discharge and avoiding admissions		CoLC	**City ICB only**		Ellie Ward/Neal Hounsell	
S256 Supporting delivery of the locality plan		CoLC	**City ICB only**		Ellie Ward/Neal Hounsell	
Hackney Community Strategy 2018-28	Overarching vision for Hackney over next decade.	LBH	LBH Cabinet 27 Nov; LBh	All	Anne Canning	
13-Dec-17						
LBH Older People Strategy	Approval of strategy	LBH	Transformation Board - 10/11/2017 Cabinet - 18/12/2017 - *For decision*	Planned Care / Unplanned Care / Prevention		
Children & Young People's Workstream Ask	Approval of Workstream Ask	CCG	Transformation Board - 10/11/2017	Children & Young People	Angela Scattergood / Amy Wilkinson	
London Streaming and Redireciton Model		CCG	Unplanned Care Board - Oct	Unplanned Care	Leah Herridge	
Workstream Assurance Review Point 3 - 18/19 Workplans, Financial Plans and Capability, management of risk, competence and capacity for delivery	Discuss and approve the workstream assurance documents for Planned Care, Unplanned Care and Prevention	All	TB 10 November 2017	Planned Care / Unplanned Care / Prevention	Devora Wolfson / Clara Rutter / Nina Griffiths / Siobhan Harper / Gareth Wall / Jayne Taylor	

Additional money for Social Care		CoLC	**City ICB only**		Ellie Ward / Neal Hounsell	
31-Jan-18						
Stop Smoking Service	STA to transfer existing contract to GP Confederation and extend the service by 9 months to facilitate procurement of new service	LBH	Transformation Board 8/12/2017 - *For discussion* Cabinet Procurement Committee 13/2/2018 - *For decision*	Prevention		
Quality & Performance Report 2017/18 - Quarter 2	Discuss and comment on reporting for Quarter 2	CCG	CCG Governing Body - 26 January	All	Philippa Lowe / Sunil Thakker	
Commissioning Intentions					David Maher/ Devora Wolfson	
Contract Award for Evaluation of Integrated Care	Discuss and endorse contract award for evaluation work	All	Integrated Commissioning Evaluation Steering	n/a	Anna Garner	
Integrated Commissioning Governance - 6 Month Review	Review and discuss outcomes of governance review and agree next steps	All	n/a	All	Devora Wolfson	
28-Feb-18						
Care Workstream Assurance Review Point 4	Approve assurance of transfomation capacity and capability	All	Transformation Board - 9/2/2018 - For disussion	Planned Care / Unplanned Care /	Devora Wolfson / Clara Rutter / Nina	
21-Mar-18						
Unscheduled Items						