



North East London Commissioning Alliance

Unex Tower
5 Station Street
London
E15 1DA

Councillor Clare Harrisson
Chair, Inner North East London Joint Health Overview and Scrutiny Committee
c/o London Borough of Tower Hamlets
6th Floor, Mulberry Place
5 Clove Crescent
London
E14 2BG

Response sent via email to daniel.kerr@towerhamlets.gov.uk

3 April 2018

Dear Councillor Harrisson

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

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

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

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

Single accountable officer/Alliance

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

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

An alliance of north east London Clinical Commissioning Groups

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

Chair: Dr Anwar Khan | Accountable officer: Jane Milligan

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

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

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

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

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

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

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

Joint Commissioning Committee

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

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

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

Other voting members:

- Jane Milligan, accountable officer

Non-voting members:

- Financial representative
- Secondary care consultant
- Registered nurse

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

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

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

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

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

NHS 111

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

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

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

ELHCP finance

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

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

- £88.5m - CCG QIPP (Quality, Innovation, Productivity and Prevention)
- £24.4m - Specialised Commissioning
- £130.3m - Trust CIP (Cost Improvement Programme)

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

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

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

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

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

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

ELHCP payment development work

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

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

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

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

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

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

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

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

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

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

Financial challenges across north east London

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

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

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

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

Deficits

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

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

King George Hospital update

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

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

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

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

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

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

Cancer

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

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

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

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

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

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

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

Cancer education programmes

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

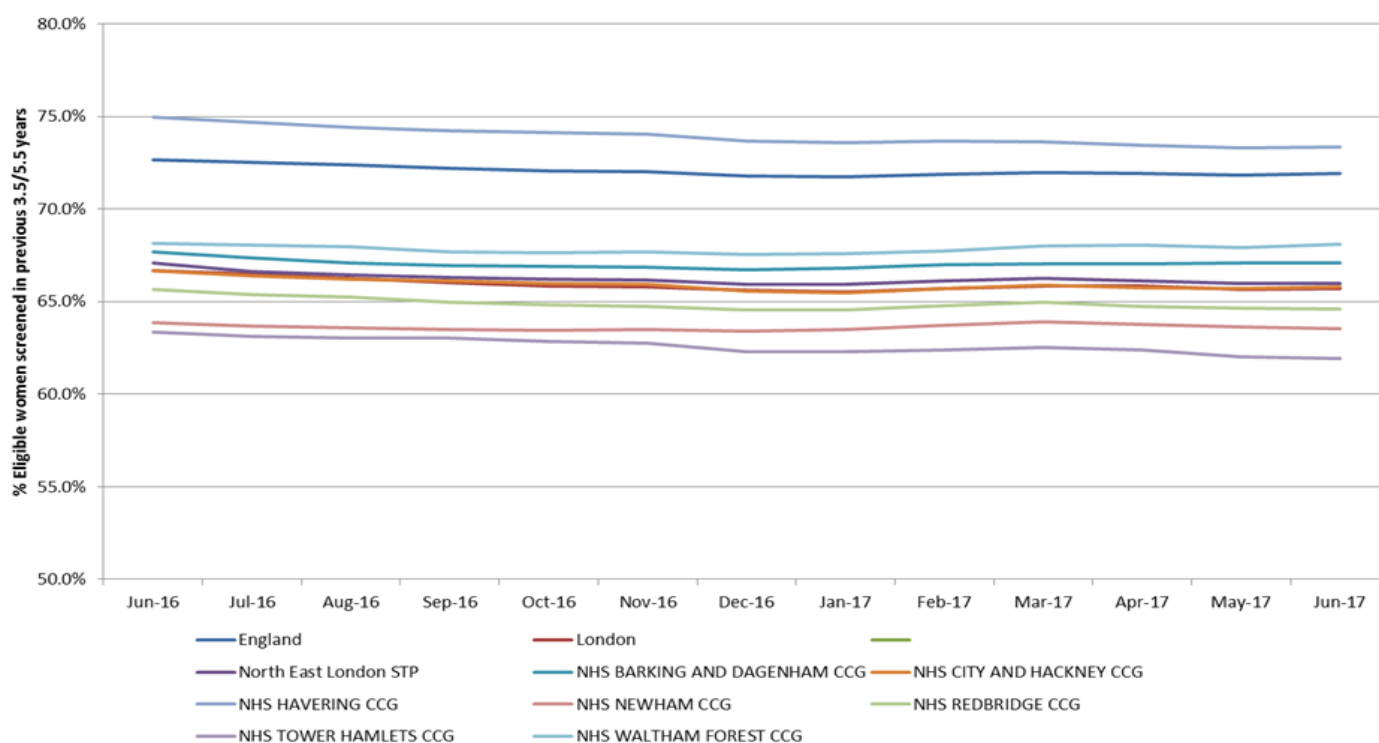
- Teachable moments: we are testing a proof of concept across the Barts and Homerton footprints throughout March 2018. Those invited have been referred on a cancer pathway but got the all clear so are invited to a healthy lifestyles event. There has been good uptake with positive feedback and more are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

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

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

Cancer statistics

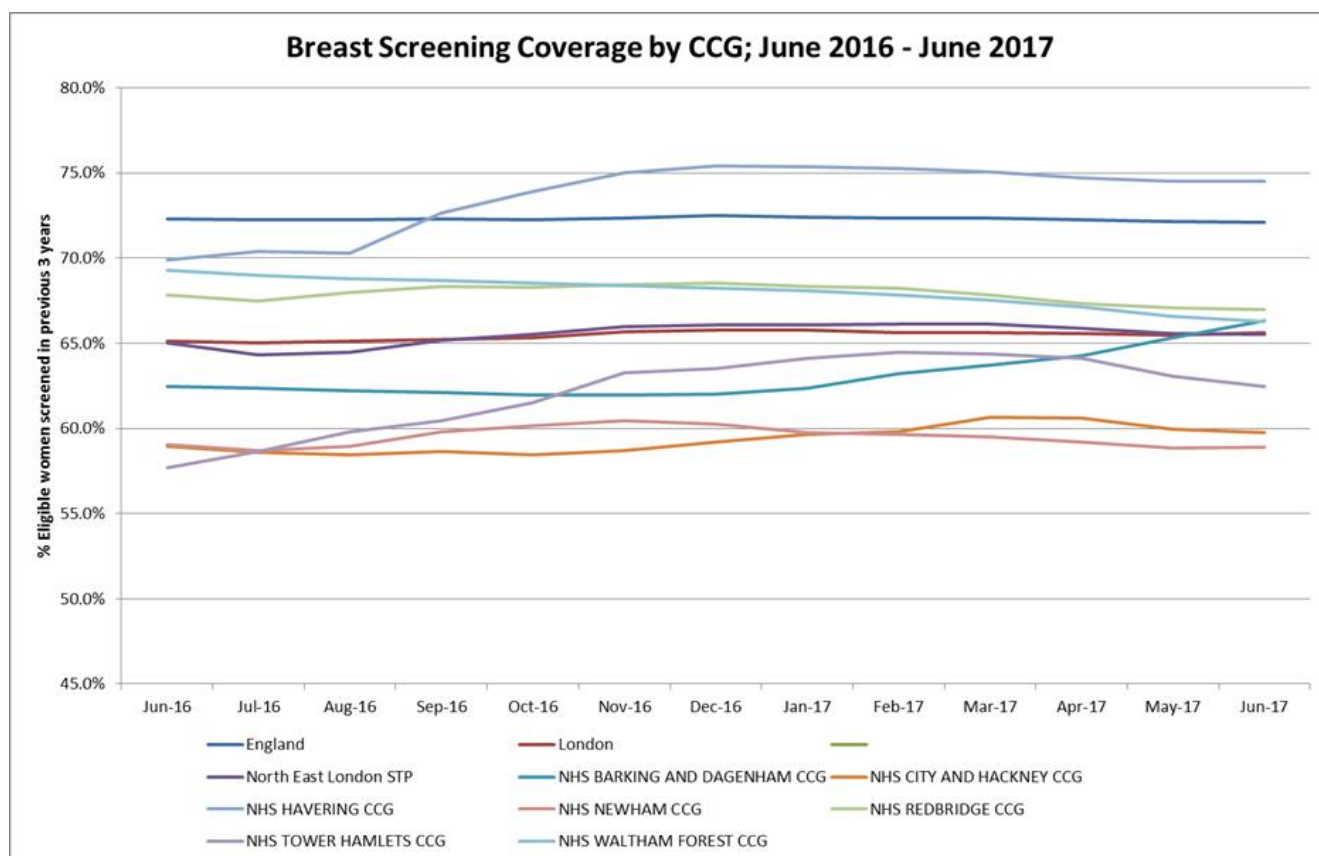
Cervical Screening Coverage in women aged 25 - 64 by CCG: June 2016 - June 2017



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

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

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



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

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

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

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

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

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

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

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

Update on reconfiguration of urology cancer services

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

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

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

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

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

Workforce

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

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

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

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

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

Estates

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

Integrated care systems update

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

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

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

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

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

Yours sincerely



Jane Milligan

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

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