INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Wednesday, 28 February 2018 at Time Not Specified

VIRTUAL MEETING

	Representing
Chair:	
Councillor Clare Harrisson	INEL JHOSC Representative for Tower Hamlets Council
Vice-Chair:	
Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Members:	
Councilman Christopher Boden	INEL JHOSC Representative for City of London Corporation
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representive for London Borough of Hackney
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council
Councillor Rachael Saunders	
Guests from Other Authorities	**Representing**
Councillor Richard Sweeden	London Borough

The quorum for this body is the presence of a member from each of three of the four participating authorities.

Contact for further enquiries:
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PARTICIPATING LOCAL AUTHORITIES **PAGE NUMBER**

Inner North East London Joint Health Overview & Scrutiny Committee

c/o London Borough Of Tower Hamlets
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London, E14 2BG
Reply to: daniel.kerr@towerhamlets.gov.uk

March 2018

Dear Jane Milligan,

Questions to NHS relating to the agenda items for the cancelled meeting of the Inner North East London Joint Health Overview & Scrutiny Committee (INEL JHOSC) on 28 February 2018

As the INEL JHOSC meeting had to be cancelled because of the inclement weather conditions the Committee would like to take up your offer to submit the following questions which we had intended to ask at the meeting.

Item 4 - Single Accountable Officer Spotlight

1) The one tier of governance not mentioned once in this item is the Accountable Care System. There is some confusion about whether there will be a number of borough level systems across WEL areas, or if there will be just one that runs at a WEL level. Could you please confirm?

2) Where does the buck stop in a borough when it comes to deciding "the patients' best interests" and where financial risk should be shouldered? Is it with the CCG MD or the SAO?

3) What if a borough decides they want to go it alone?

4) There aren't many specifics in this document. You state "*Working together means reducing fragmentation and duplication by adopting common approaches, and doing things where appropriate and beneficial to do so"* (p.20). What are examples of these and how is it decided which to do together or separately? And what happens if there is a disagreement on this? How will a disagreement be resolved?

5) You say "no plans to facilitate money being moved from one CCG area to another" (p.26) yet we are aware from City and Hackney CCG Governing Body meetings over the past 18 months or so that City and Hackney has been asked a number of times to use part of its surplus to provide financial balance across the STP patch.

6) We do not feel that Hackney residents will see the new NEL NHS 111 services as better than what they already receive from CHUHSE. What improvements in the service do you expect from the new model and what reassurances can you give to residents about maintaining the standard of service they currently receive?

7) What will the additional combined cost be for these new tiers of governance?

Item 4 – Joint Commissioning Committee (tabled paper)

The Committee would like to note that an issue this important appears as an additional tabled item and recommends that this requires a full agenda item at the next meeting.

1) How will the role of the Joint Commissioning Committee differ from the NEL Commissioning Alliance? Why are two bodies required and how do these new bodies relate to the ELHCP?

2) Can you provide more detail about who will sit on the JCC, what their responsibilities will be and how often the committee will meet?

3) What consultation has there been with Boroughs in setting up the JCC? What has their feedback been and how has this been incorporated into the structure of the final committee?

4) How will the JCC work with local authorities? The only local authority reps are 1 commissioning officer from each borough. Whilst we acknowledge that this is an NHS body can you explain what steps you will take to make it both more transparent and accountable to local residents considering it will be recommending very significant commissioning decisions.

5) Following on from question 4, what will each individual borough's "line of sight" be to decisions taken at the JCC? Can you provide some examples of decisions that we expect to be taken at the JCC in future

6) It is unclear what percentage of each individual CCG budget the JCC will have control over. The briefing paper seems to indicate that there is a change to the CCG constitution meaning the JCC will exercise such commissioning powers as are delegated to it by the [CCG] governing body. What powers are being delegated to it?

Item 5 – ELHCP Finance

1) The report feels incomplete as a summing up of the financial health of the current stage of the STP. Is an update on funding and ability to meet savings or income generation targets available for the various transformation plans the Committee has been informed of? Are there any specific areas that are over or under-achieving in this sense?

2) There is very significant variance in the financial position of the 7 CCGs and the 5 Acute Trusts between Inner and Outer NEL. If the new centralising finance structure levels this out Inner NEL will lose out significantly. How will ELHCP respond to residents of INEL boroughs who might argue that their CCGs statutory responsibility is primarily to them?

3) ELCHP Payment development work – 1st bullet point (i) *Agreed should introduce evolutionary changes to payment*. What are these changes? (ii) *Longer term payment*. What are these?
What responses were received on the consultation about capitated budgets? And how has this fed in to developments?

4) In reference to the system bridge diagram, even if we achieve all our targets, we are still left with an £81 mill deficit. How will that be addressed?

5) How far can you make £20mill of efficiency savings without compromising quality or reach of services?

6) What do the 13 co-developed 'principles of payment' referred to? Which groups have endorsed them and how many people do they represent?

7) You say that payment reform has already been tested in the Vanguard area of Tower Hamlets. What did this consist of and what were the outcomes?

8) What support will there be for CCGs in deficit or with red ragged risks and how will this affect the resources of those who aren't?

9) In the RAG assessment, what do you mean when you talk about unidentified risks? How can these be measured if they're unidentified?

10) The Barts Health Trust has high levels of deficit and yet it would appear to be the BHR area that is in deficit. What are the specific challenges to dealing with this?

11) Could you please provide an update on King George's? When will a decision be made on the downgrading of services?

12) The government has now delayed plans to lay Regulations on ACOs before Parliament until a public consultation completes and the Health Select Committee reports. Also, the two Judicial Reviews on STPs are making progress. In the High Court last week one of the campaigns won a cap on costs should they lose. What's ELHCP's contingency plan here if these succeed?

Item 6 – ELHCP Cancer

1) Our STP might have the poorest performance across certain cancer indicators but it's clear that issues are at their most acute in Newham. What extra resources or plans are there to address prevention and look at improving screening levels, particularly within the communities who are particularly poorly represented? What research has been carried out into these issues?

2) In particular what work is being done to address levels of bowel cancer screening, breast cancer screening and lung cancer screening (particularly in the Asian community)?

3) What work is being done to address workforce gaps

4) Many studies have shown that there is lower awareness of cancer symptoms amongst BME communities and those lower down the socio-economic scale. Thinking of the NEL populations can we have some more details about the education programmes planned by the ELHCP (pg10).

5) Can you provide further information on how the pathway works for those who will go on to die from cancer? Work steam 5 talks mainly about recovery and living with disease. How are patients passed on, supported and managed into end of life care if their prognosis isn't good.

6) What are our statistics like for early/scheduled/routine screening take up i.e. cervical smears, mammograms? How does this compare with national and London statistics?

7) Hackney Public Health team has published a Migrant Health Needs Assessment. Could this be of use in designing services? There are shocking statistics on cervical screening take up by BAME women.

8) Members in Hackney performed a review a few years ago on 'cancer survivors' and one thing we found was that the Acute sector was pushing against any spend on wellbeing approaches (e.g. alternative therapies, social prescribing etc.) for those living with and beyond cancer. These very beneficial therapies and group sessions (often provided via Macmillan) kept people well and motivated and out of A&E but their funding was drying up. Unless there is serious movement of some funding from Acute to Prevention isn't this just rhetoric?

9) We participated in various JHOSCs on reconfiguration of cancer services the focus of which was broadly to consolidate specialist cancer services at St Barts, UCL, Royal Free to maximise expertise and drive up survival rates with the remaining hospitals being effectively reduced to providing follow-up care. Outer NEL was very

resistant to these changes but Inner supported them, for obvious reasons. How has this worked out? Have the survival rates for Urology (one of the initial areas of focus) gone up?

AOB

- **Estates**

  The Committee asked to receive a brief verbal update on Estates, with a view to a more detailed agenda item coming to the Committee meeting in the summer. Could you please provide an update on the progress made in this area, detailing how the strategy is set to be developed (detail timelines, meetings etc.), and how local authorities will be engaged?

- **Questions from the public**

  1) First, given the lack of recent substantive information on the NEL Health and Care Partnership website, we would be grateful if representatives from the Partnership can provide an update on the current plans and progress on developing:

     - Accountable Care Partnerships (that, we understand, may also be called Integrated Care Partnerships now)
     - Integrated Care Systems and
     - Accountable Care Organisations across the North East London footprint.

  2) What position does the INEL JOSC take on these developments and how is the Committee ensuring scrutiny, given the increasing public concerns emerging about these models for so-called 'integrated care'.

  Yours sincerely,

  Councillor Clare Harrisson
  Chair of Inner North East London Joint Health Overview and Scrutiny Committee

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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 Comissioning 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).

There are many areas of change where is it 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.

ELCHP 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

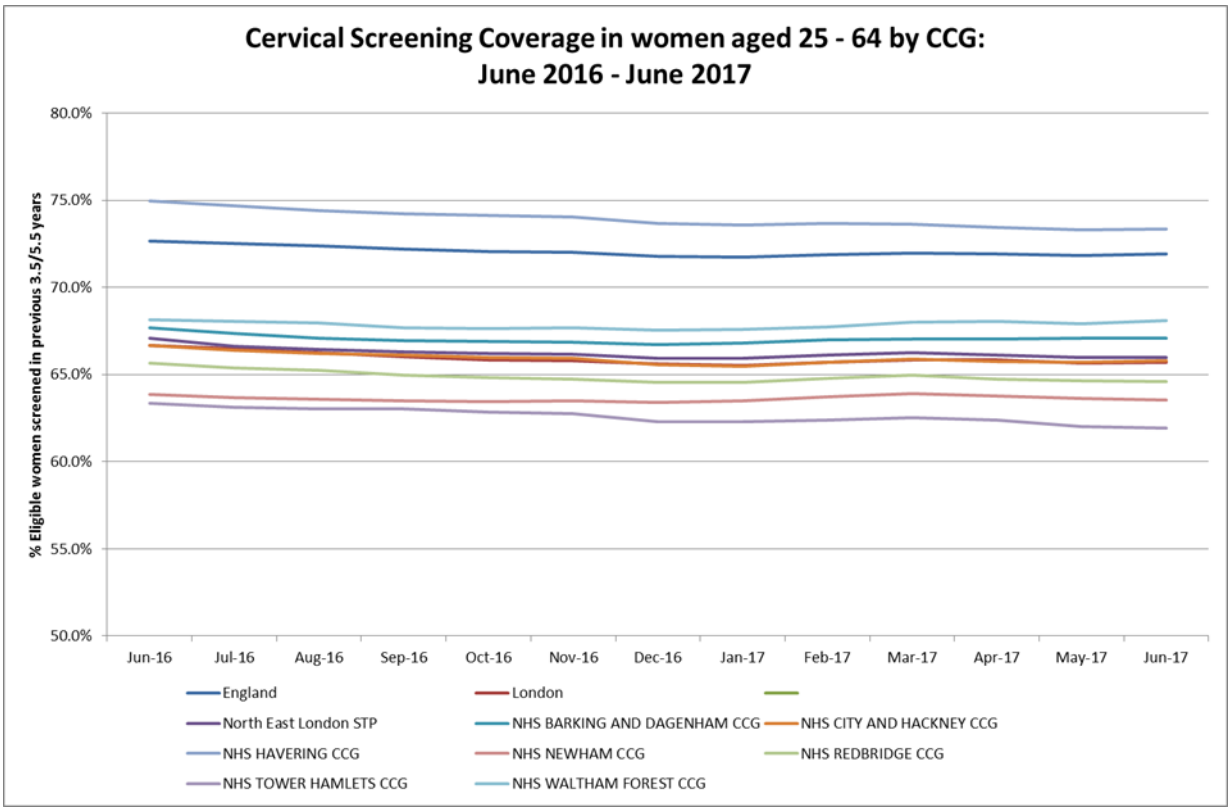
- Providing training and development to Community Links staff

- 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.

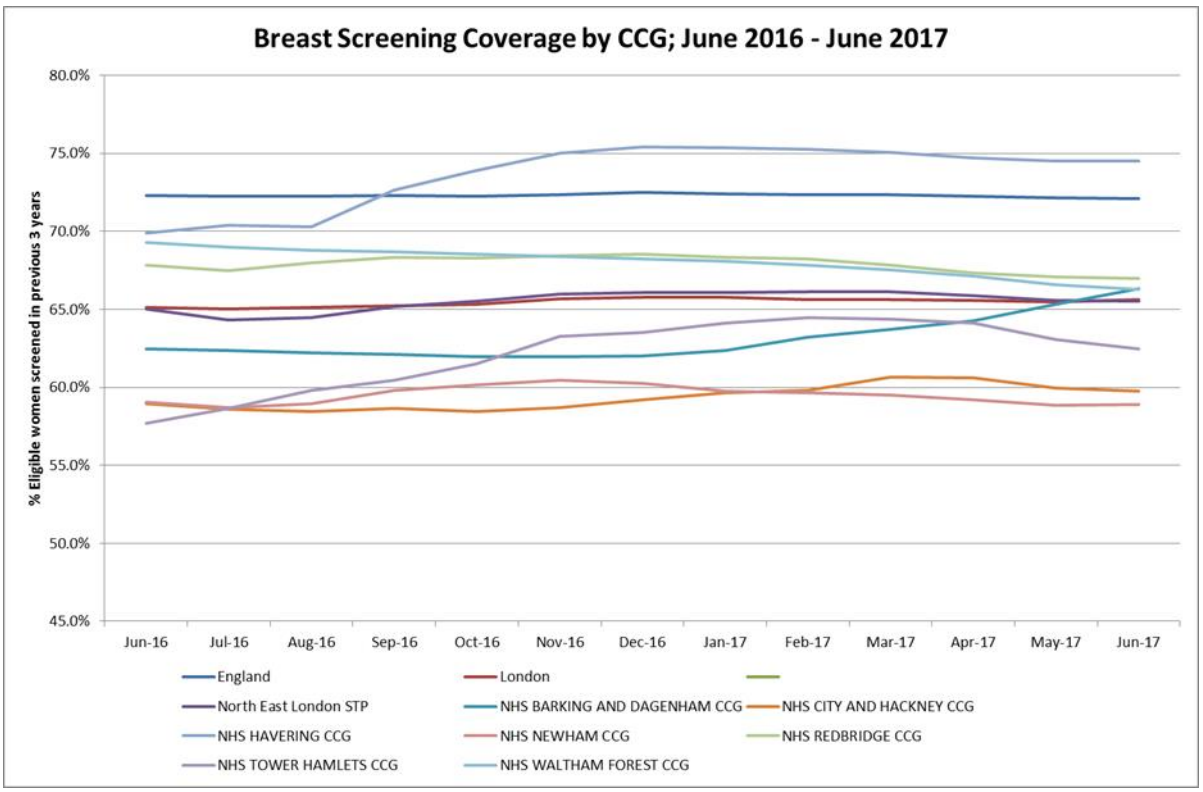
Cancer statistics



Cervical 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%	77.1%	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%	79.1%	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%	63.5%	63.5%	63.1%	63.0%	63.3%	63.5%	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%	62.1%	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%	60.9%	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

East London Health & Care Partnership

Appendix A

2017-18 QIPPs and CIPs-£m														
Org.	**STP Work Stream**	**B&D**	**BARTS**	**BHRUT**	**C&H**	**ELFT**	**Havering**	**HUH**	**NELFT**	**Newham CCG**	**Redbridge**	**TH CCG**	**Waltham Forest**	**Grand Total**
CCG QIPPS	Cancer											0		0
	Clinical Productivity	3,022			480		5,998				4,506	105		14,111
	Further info required	4,740			1,032		4,687			1,100	6,672	787	2,700	21,717
	Infrastructure	187					825			1,000			250	2,262
	LD											-100		-100
	Meds Optimisation	1,360			505		2,010			1,300	1,696	0	1,000	7,870
	Mental Health				1,435					1,100		-932	1,100	2,703
	None				650		250			2,200		4,580	1,690	9,370
	Planned Care	1,563			535		2,759			3,005	1,429	4,260	1,680	15,232
	Planned Care / Primary Care									700				700
	Prevention											-21		-21
	Primary Care				160							-9		151
	Primary Care / Infrastructure											220	300	520
	Productivity	63			213					900				1,176
	Spec Comms										273	63		336
	UEC	430					603			1,100	439	2,028	500	5,100
	UEC / Planned Care												1,400	1,400
	UEC / Primary Care												200	200
CCG Total		**11,364**			**5,010**		**17,132**			**12,405**	**15,014**	**10,982**	**10,820**	**82,728**
Trust CIPS	Total		66,658	28,000		9,050		10,106	16,000					129,814
Trust Total			**66,658**	**28,000**		**9,050**		**10,106**	**16,000**					**129,814**
Grand Total		**11,364**	**66,658**	**28,000**	**5,010**	**9,050**	**17,132**	**10,106**	**16,000**	**12,405**	**15,014**	**10,982**	**10,820**	**212,542**

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Thirteen principles of payment

In July 2017 the ELHCP published a consultation on payment development to support transformation in care and ways of working across East London. The consultation document provided an overview of different payment approaches, outlined benefits and risks of each and highlighted other 'enablers' of change that are needed to support system development.

The consultation process sought and received views on what individuals and organisations within East London wanted to achieve with the payment system and what payment reform should deliver for the health and care system as a whole. There was wide involvement in the consultation process and rich feedback was received in both written and verbal forms. The ELHCP held six workshops for payment development for ELHCP stakeholders including nearly 100 health and care representatives covering all 20 ELHCP partner organisations as well as other providers within East London. 54 members of the public attended the first workshop, representing a mix of individuals, health conditions and backgrounds across the ELHCP footprint. ELHCP colleagues also attended local authority governance and scrutiny committees. This process also enabled ELHCP partners to kick off a discussion across ELHCP about how they can work together differently to serve our population better.

Feedback from the Consultation suggested a number of 'principles for payment'. The ELHCP Board agreed this set of principles, and that they should apply to payment approaches developed within East London. If a single approach to payment was not taken across East London, local authorities or integrated care systems within this footprint could still adhere to a common set of principles.

Principles are not presented in a specific hierarchy.

Payment should:

1. enable and incentivise providers and commissioners to focus on achieving good quality care and the right outcomes for patients and our population;
2. include metrics that allow agreed outcomes to be linked to transactional payments;
3. allocate resources to get the balance of services right for our population, and to achieve value for money in regard to the location, model and method of care delivery;
4. support early intervention, prevention and condition management;
5. align organisational and system objectives, including measurements and targets;
6. ensure that payment within the system supports, and works within, the system-wide control total;
7. incentivise providers and commissioners to cooperate and provide coordinated care;
8. facilitate innovation and transformation at all levels within system, including making the most of the ideas and energy of clinicians, care professionals and front line staff;
9. facilitate, and create incentives for, delivery of the clinical strategy agreed for East London;
10. share risk in a way that is fair and creates incentives that support ELHCP objectives - ensure that overall system risk is lowered and financial risk is aligned to those parts most able to able to influence/manage the risk;
11. offer longer contract cycles to provide stability and incentivise investment;
12. ensure an approach that is transparent and simple for all in the system to understand
13. minimise administrative burdens and transaction costs associated with payment, including streamlining 'key performance indicators' and targets.

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East London Health & Care Partnership

Infrastructure Work Stream

JHOSC update February 2018

London Devolution

East London Health & Care Partnership

Memorandum of Understanding (MoU)

Since the London Devolution MoU was signed mid-November 2017, the estates work stream has moved to the next gateway requiring London partners to complete a robust London Capital Plan by end of March 2018. This requires STPs to:

1. Establish a governance structure and set up an Estates Board
2. Complete an STP wide Strategic Estates Plan (SEP)
3. Produce a detailed, prioritised pipeline of projects
4. Compile an STP Capital plan to feed into the London Capital Plan

The completion of this work requires each ACS to produce local level information to feed into the STP Plan. This document forms the BHR Integrated Care Partnership contribution to the ELCHP STP Plan.

Devolution Opportunities

A new national £2.6bn capital fund was announced in the budget with the first 10% being given to the most mature STP plans.

Future access to this fund will be via a single STP estates strategy and capital plan. Individual organisations will not be allowed to bid for money for individual schemes.

The STP capital plan must demonstrate an outline clinical strategy and outline all available disposal opportunities.

Devolution offers the opportunity to argue for capital receipts to be recycled locally, noting that London will expect all receipts to be recycled within London as part of the agreement.

Phase 2 Devolution functions and what this means for NEL

Phase 2 Functions	Phase 3 Gateway Criteria	Requirements of NEL to enable progress to Phase 3
Continue to provide **single forum for NHS estates** discussions and enable whole system strategic estates planning, building a London view from local and sub-regional estates strategies		
Support local and sub-regional areas **to develop clear estates strategies** aligned to clear commissioning strategies.	**Established business case support function**	
Develop a **clear capital plan for London**, drawing from local and sub-regional estates strategies and ETTF bids. Supported by a clear list and status **of prioritised capital cases** under development.	**Clear local and sub-regional estates strategies aligned to commissioning strategies**	The LEDU is working with STPs to assess the resourcing need to support business plan development. As part of this, practitioner training has been proposed for all Steering Group members. NEL to continue to support this work as required, and commit relevant NEL representatives to attend training.
Develop a prioritisation framework for decisions.	**Clear capital plan for London**	NEL to review local estates strategies holistically to ensure that they are in alignment relevant commissioning strategies.
Develop a **robust and professional business case support function** within the LEDU to support local and sub-regional areas.	**Pipeline of sites and agreed prioritisation framework**	NEL to continue to work to produce a strategic estates plan, built up from a clear clinical strategy, which will feed into the London capital plan.
Support sub-regional and pilot estates boards to take on **robust governance and accountability** functions to a sufficient standard to enable delegations and devolutions from national partners to be made to sub-regional level.	**Agreement from national partners for the LEB to commence shadow running.**	NEL working to prepare a complete prioritised pipeline of sites, using a standardised prioritisation methodology as agreed with the LEDU.
Consider **the recommendations of a London report on NHS estate utilisation.**	**Evidenced collaborative working**	NEL continuing to work collaboratively with the LEDU, LEB and London and national partners on estates matters, to focus on how they can work together to unlock site-related issues and deliver progress.
Work with **national partners** to explore how **incentives** for the health and care system to release surplus land can be optimised.	**Agreed governance and key appointments**	NEL agreeing a strong and established governance structure which brings together CCGs as well as Trusts, iNELuding the appointment of key roles.
Work with DH, NHSPS and CHP to develop an approach for NHSPS and CHP investments and sales, which balances national and London needs and priorities.	**Signed MoU relating to internal delegations.**	
Work with DH and sub-regional areas to ensure that when **surplus NHS sites are released**, this is done with due consideration of wider local health economy and public sector opportunities.	**LEB membership review**	

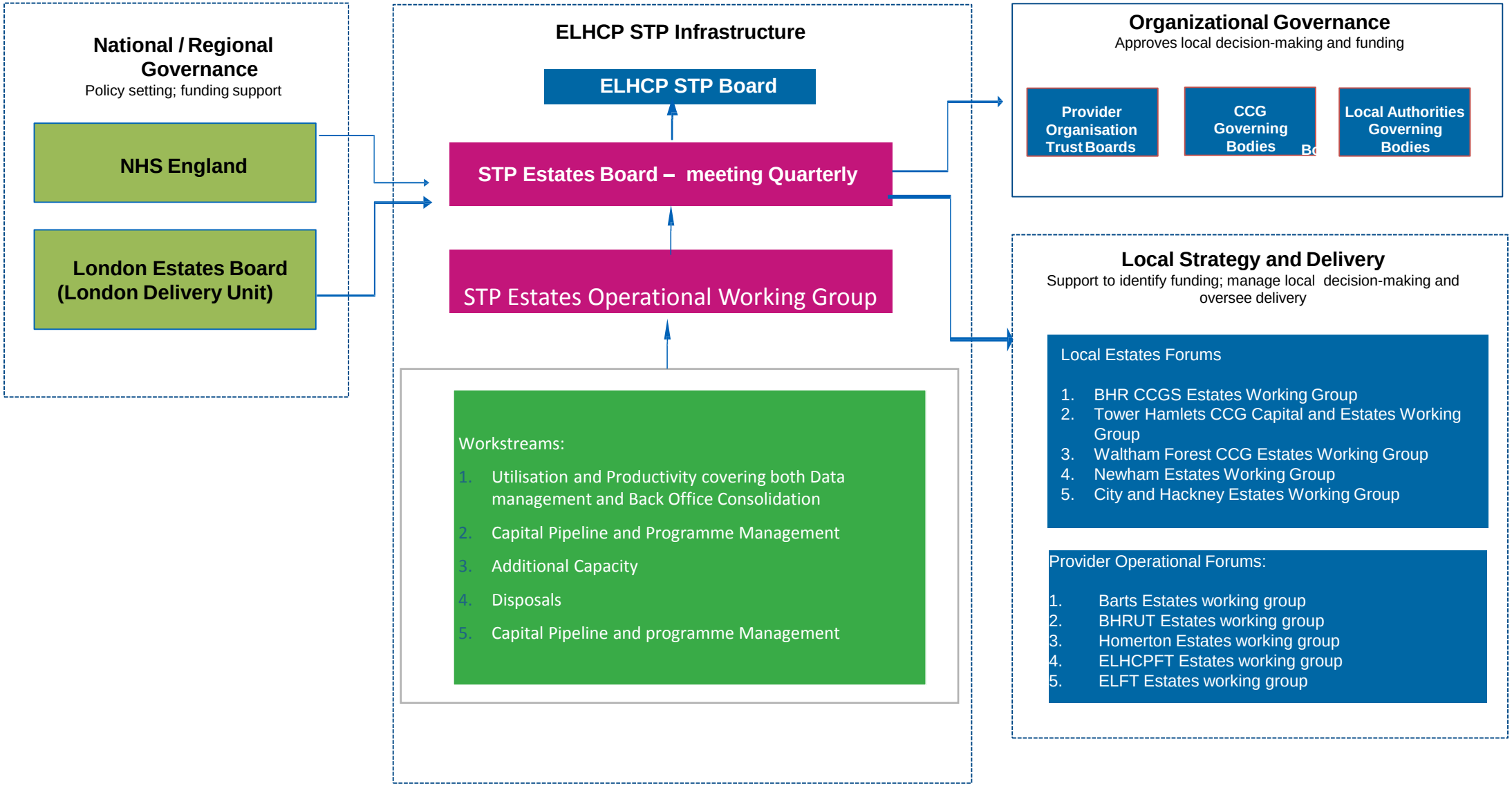
Governance Model

ELHCP Infrastructure

- MoU requires specific governance arrangements to be put in place for each STP to ensure appropriate, transparent and robust decision-making authority within ELHCP.
- We need to establish an **ELHCP Estates Board** to link to London Estates Board and STP governance arrangements.
- The Estates Board aims to facilitate more joined-up strategic decision-making for NEL and to enhance effectiveness, efficiency, quality and transparency of process and decisions
- ELHCP Estates board will work alongside ACS local estate forums to ensure adherence with the principles of subsidiarity fulfilling the below functions:
    - **Strategic** – in relation to oversight of the STP strategy for estates. We have already developed a set of principles setting out what activities should be considered at what level
    - **Bringing partners together** – to provide greater co-ordination and easier escalation to tackle barriers which can be addressed through improved local joint working
- Project delivery and day to day operational management will remain at an ACS level.
- Trusts and Local Authorities will continue to make decisions through their own governance structures.
- Core Members may be asked to delegate responsibility to individuals to allow decisions to be made '**in the room**' for example in relation to prioritisation within an agreed framework.

East London Health & Care Partnership

Proposed Governance for Estates



Infrastructure Workstream Structure

East London Health & Care Partnership

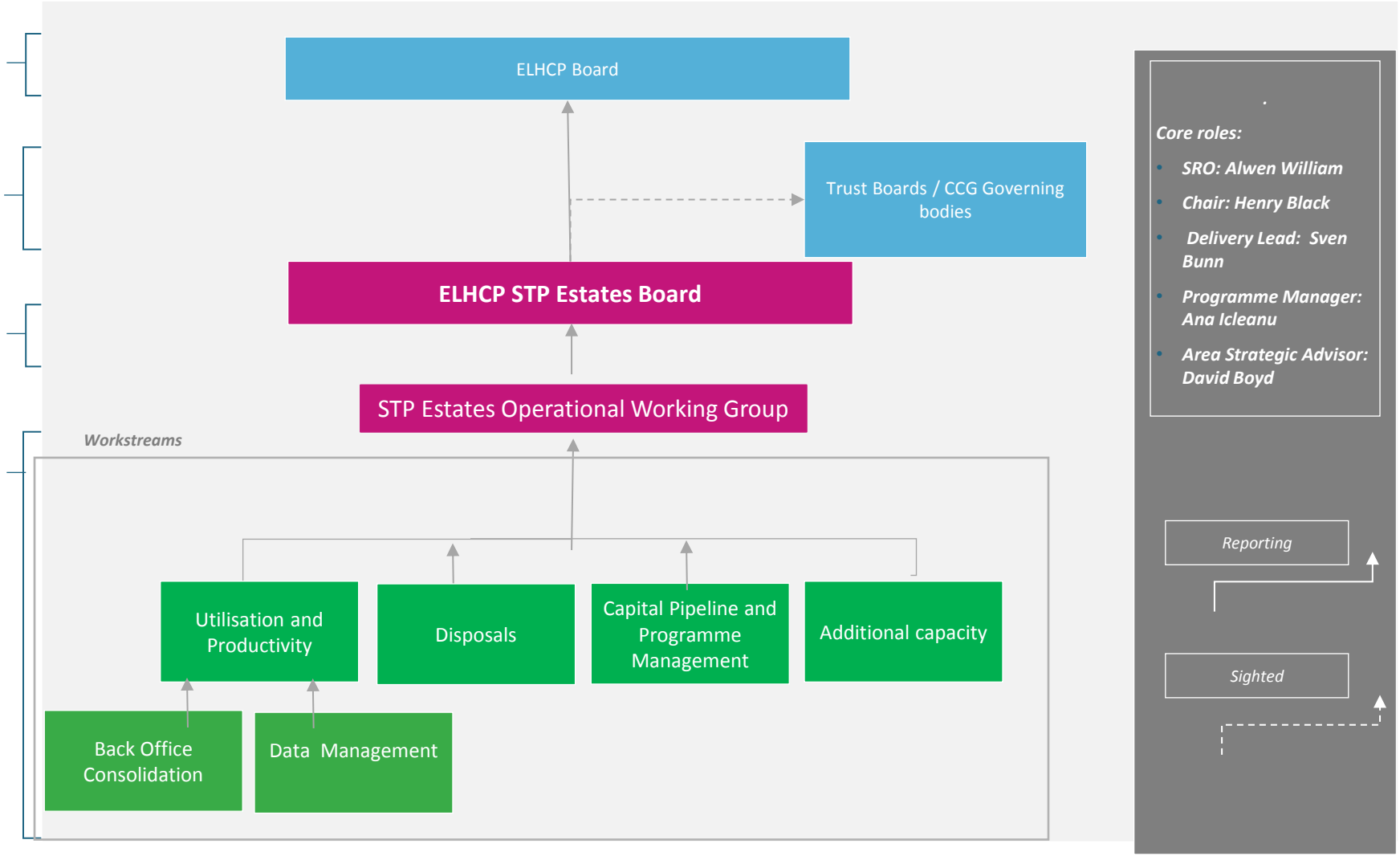
Trust boards will sign off ultimate proposals and plans recommended to them by their representatives on the Infrastructure Steering Group, with additional support as needed

The ELHCP STP Board is sighted on plans, making sure they are coherent with the overall plans across the STP

A ELHCP Estates Board with:

1. *Formal oversight and approval of ELHCP System Estates strategy and delivery*
2. *Make recommendations on the use of capital receipts*
3. *Make other delegated decisions (e.g. changes to increase utilisation).*

Workstreams do the detailed work and make recommendations to the Productivity Steering Group. Workstreams include wider group of stakeholders, including Directors of Estates, Strategy Directors etc.



Next Steps

East London Health & Care Partnership

January to March 2018

January

- Set up STP Estates Board and associated governance
- Set up STP Estates Team
- Detailed Delivery Plan and resources to complete work by end of March
- Prioritised list of projects to feed into London capital pipeline
- Each ACS to update local Strategic Estates Plans

February

- Summarise clinical model
- Finalise STP wide Strategic Estates Plan
- Develop detailed by year programme for delivery of strategic estates plan
- Produce capital investment plan with detailed requirements for years 1-3
- Start working on OPE Phase 7 bids due in April

March

- Detailed delivery plan and associated resources for 18/19
- Confirm resources required at STP vs local level
- OPE Phase 7 bids to be finalised for April

High Level Plan

East London Health & Care Partnership