Hackney Devolution Pilot: Outline Business Case

Delivering improvements to health and wellbeing through health and social care integration

Hackney Devolution Partners
November 2017
Version 6.0

Hackney Devolution Partners

Hackney's Devolution Pilot is steered by a board of clinical and executive leadership from across all of Hackney's Health and Social Care partners. These include:

- City and Hackney Clinical Commissioning Group
- City and Hackney GP Confederation
- City and Hackney Local Pharmaceutical Committee
- City and Hackney Urgent Healthcare Social Enterprise (Out of Hours)
- East London NHS Foundation Trust
- City & Hackney Health & Social Care Forum
- London Borough of Hackney
- Healthwatch Hackney
- Homerton University Hospital NHS Foundation Trust
- City of London Corporation (observer)

Common Introduction

Over the past 18 months, local and sub-regional areas have been working to make rapid improvements to health and care within existing powers and exploring how more local powers, resources and decision-making could accelerate the improvements that Londoners want to see at the most appropriate and local level. Different parts of London have diverse communities, health challenges and quality of health and care services. It is therefore entirely appropriate that different solutions are developed for different areas and that enabling tools, such as devolution, be adopted at different pace and scale based on local appetite.

In this spirit, the approach to London health and care devolution has been for five 'pilots' to develop shared local plans for health and care transformation and then identify opportunities to accelerate these plans through devolution. Each pilot business case aims to describe this local transformation vision, priorities, governance and delivery plans. The pilots have wide partnerships including local authorities, Clinical Commissioning Groups, providers of health and care services, clinical leaders, the voluntary sector and wider public sector partners. The visions and plans developed by the pilots aim to further this collaboration and accelerate health and care transformation, not just through devolution but also by accelerating progress within existing arrangements. These business cases have been developed locally and are owned by the individual pilots.

Over the past 18 months, the work of the pilots has demonstrated that the benefits of devolution are as much from indirect as direct effects. The potential of devolution has galvanised local plans, local ownership and local partnerships and made sure that the potential of existing arrangements has been fully explored and implemented. But it is also clear that devolution itself would provide significant benefits to enable the delivery of these local ambitions.

The pilots, London and national partners have worked together explore the proposals set out in these business cases. Where there was a clear case that proposals would assist, enable or accelerate improvements to the local health and care system, steps have been taken towards devolution, delegation or sharing of functions, powers and resources currently exercised by national partners. The London Health and Care Devolution MoU contains details of the specific devolution commitments made by Government and national partners.

Executive Summary

Introduction to Hackney Devolution Pilot
Through a focus on the wider determinants of health and inequalities, devolution provides all those working towards improved health and wellbeing for the population of Hackney with an opportunity to better address the challenges the borough faces; Hackney is a vibrant, diverse and deprived inner London Borough with specific health and wellbeing challenges. The partners in the borough have come together to initiate a collective and ambitious approach to delivering new models of care to support these challenges.

To tackle the problems we face, we want to really join up public services, make better use of our collective estates and take a new approach to prevention. Whilst we've achieved a lot and have ambitious plans for the next few years, devolution powers will really make a difference to what we can deliver for local people.

We see devolution as the means to help us do even more - deliver greater and deeper integration, further our local ambitions and those of the North East London Sustainability and Transformation Plan (NEL STP), and make more of a difference to the lives of local people.

Following the submission of the first draft of our business case and further discussion with London Devolution Board and colleagues the asks to secure our ambitions are outlined in the London Devolution MOU.

Our vision for a health and wellbeing system
The vision for Hackney is to work together with our patients and providers to deliver an integrated, effective and financially sustainable system that meets the population's health and wellbeing needs.

As a system we have the following collective ambition:

- Improve the health and wellbeing of local people with a focus on prevention and public health, providing care closer to home, outside institutional settings where appropriate, and meeting the aspirations and priorities of the 2 Health and Wellbeing strategies;
- Ensure we maintain financial balance as a system and can achieve our financial plans;
- Deliver a shift in focus and resource to prevention and proactive community based care;
- Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value;
- Ensure we deliver parity of esteem between physical and mental health;
- Ensure we have tailored offers to meet the different needs of our diverse communities;
- Promote the integration of health and social care through our local delivery system as a key component of public sector reform;
- Build partnerships between health and social care for the benefit of the population;
- Contribute to growth, in particular through early years services;
- Achieve the ambitions of the NEL STP.

Our Service Model
We will deliver our plans through six models of care:

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

Together we want to increase the independence and choices of local residents, improve the quality and timeliness of care, tackle mental health, impact as early as we can to help people stay healthy and independent at home for as long as possible, and use our collective estates infrastructure to deliver modern joined up and responsive services tailored to our communities. To achieve these ambitions we are redesigning our delivery architecture on both the commissioning and provision sides and we need devolution to help us achieve the integration we aspire to and give us the levers and tools to maximise the benefits we can deliver.

Our ambition as a devolution pilot:

- We need more public health powers to have a greater impact through our primary prevention work
- We need local powers to plan NHS and local authority estate together so buildings are delivering an integrated offer to the local communities
- We need the combined powers and levers of the local authority and CCG to tackle the wider determinants of health and use the Marmot principles to drive how we plan and deliver services together
- We can't plan for the NHS in isolation from either social care or in a Borough like ours without thinking about the wider Local Authority and all its powers and services

Only by working together can we have the greatest impact. Failing to redesign the way the system works would be a missed opportunity and a disservice to the residents we serve.

How this aligns to our STP ambitions
The Five Year Forward View has set out the ambition to provide new models of care to patients and to join up services between health and social care. The NEL STP has put this ambition into deliverable outcomes. These outcomes include, improved health and wellbeing outcomes for the people of north east London, sustainable services built around the needs of local people, and the development of new ways of working in partnership to deliver services and prevent ill health. We share the same ambitions and are committed to doing our bit to support the delivery of the NEL STP. Our devolution plan will direct the practical delivery of the Five Year Forward View and STP ambitions across Hackney. With our local plans we will now be able to go further in delivering the STP ambition, by empowering local solutions for our population.

Our Partnership
Our success will be built on strong and existing partnerships, both within Hackney and across the broader NE London health economy and on a history of collaboration which has resulted in some real improvements for local people and a sustainable health and care system. We recognise that we are part of a broader system but with specific responsibilities to those we serve in Hackney.

Our original submission considered the benefits of a single membership delivery organisation taking responsibility for Hackney's whole population, creating incentives for prevention, early intervention and proactive primary care with better access to community services and the creation of safe and high quality alternatives to higher cost hospital or residential care. This document goes further recognising the progress we have made and setting out our new collective delivery arrangements over the next few months.

How this impacts on populations beyond Hackney
The Hackney devolution pilot will have a positive impact on neighbouring populations, in particular the City of London which has a different population with different health needs and priorities and a different provider landscape from Hackney.

Historically Hackney and the City of London have always been overseen by one commissioning organisation - be it Health Authority PCG, PCT and now the CCG; such an arrangement does not effectively differentiate or address the distinct requirements of the residents and workers within the City of London nor take into consideration the different network of services offered within the footprint of the City. Through devolution, an independent integrated commissioning board will be established for the City creating opportunities for improved governance structures, separate budgets and tailored commissioning to meet the unique needs of the residents and workers in the City of London. This is an important side effect of the Hackney devolution pilot which has been embraced by the City of London Corporation and other local partners as a significant opportunity to deliver better integrated services for the City of London as well.

Strong Foundations and a track record of integration
The strong partnerships we have built have allowed us to work on improving health and social care across Hackney which has already proven successful in a number of areas.

- We have a unique and successful partnership with an active resident population who we work with to co-design services.
- We have some jointly commissioned services including, a learning disability service and an Integrated Independence Team (IIT) to support care closer to home (reducing emergency activity).

- We have experience of working together on the Better Care Fund, our Mental Health Alliances and our One Hackney & the City pilot and we have created joint health and wellbeing strategies.
- We have a strong GP Confederation delivering at scale extended primary care services with full population coverage and supporting general practice resilience.
- We successfully ran a two year pilot community-based care coordination service through collaboration between health and social care providers and the voluntary sector using an outcomes based alliance contract.
- We have a history of clinical and managerial collaboration with Homerton Hospital which has effectively managed planned and unplanned demand, maintaining a system in financial balance.
- We have a range of initiatives co-designed by the partners to support care closer to home and develop integrated services.

What we haven't been able to do within the current ways of working, is modernise our estate to deliver the services our residents need, really tackle prevention nor effectively jointly plan together and think about “the place” as a whole. What devolution provides therefore is a chance to unblock some of these barriers, so we can go further with our plans, build on these strong foundations and deliver greater benefits.

Our ambitious plans will improve the lives and wellbeing of Hackney residents.
Our programme will operate on Marmot principles to attempt to tackle deprivation and the wider determinants of health such as employment, education, housing and poverty with a strong emphasis on influencing and improving life chances in the early years, which is key given our population profile. This will inform everything we do. Devolution offers us the opportunity to integrate these goals and further our ambitions.
We are putting in place a single health and social care integrated commissioning board that will oversee a single pooled budget for the population of Hackney. This will drive integration of care, improved quality and better outcomes for Hackney residents.
The development of these arrangements for Hackney will require us to develop a similar model for the City which will then give for the first time a dedicated and distinct focus to commissioning for the city.

We will deliver our plans through six new models of care:

- **Practice-based family nursing teams** (incorporating community and mental health nurses) under the leadership of primary care
- **Quadrant-based voluntary sector organisations** delivering a range of social, wellbeing and public health services via social prescribing and integration with statutory services
- **A fully integrated community health and social care team in each of the four quadrants** building on the success of One Hackney and the City
- **A physically integrated single point of coordination (SPOC)** involving call operators, senior clinicians, paramedics, social workers, GP in and out-of-hours, community nursing leadership, mental health, pharmacy, key voluntary sector services and transport
- **Empowered patients** equipped with skills and information to help them self-manage, access the right services when needed, make informed decisions on the evidence and options for their care and who are active in the co-design of our service delivery arrangements and pathways
- **A strong safe local hospital** delivering:
    - High quality 7 day services, integrated with mental health resources and networked with other local hospitals where necessary.
    - Fewer face to face outpatients - replaced by digital solutions.

- Support and expert advice to primary and community care.
- Demand management of tertiary service.
- Reductions in variations between teams.
- Minimal length of stay, thanks to good primary and community services which command universal clinical confidence.
- Aligned clinical behaviours across primary community and secondary care, which see the community / home as the default and support the delivery of patient care plans.
- Public health interventions.

We want to make sure we have a strong provider landscape - working with our partners in relation to our high quality mental health provider (East London NHS Foundation Trust) to embed their mental health services in our local delivery model and ensuring our GP confederation and GP out of hours provider (CHUHSE) can continue to provide high quality local services, integrated within our clinical network. Our vision is primary and community services fully integrated with social care, acute and tertiary services.

In order to do this, we need to seek additional powers through devolution to:

- Pool NHS, public health and social care budgets to support joint planning and delivery, drive integration, improve outcomes and achieve clinical, environmental, social and financial sustainability.
- Use additional powers to promote prevention and to embed health and wellbeing as a decision making criterion within planning decisions, which will allow us to create a local environment that encourages healthy choices every day.
- Develop the most appropriate organisational form/system of care to maximise the outcomes from our integrated delivery model.
- Build community assets through devolved estates responsibilities to adapt our existing estate, making buildings more appropriate for the new care models we are creating and developing them to deliver a strong community benefit.

We are developing further plans for devolution opportunities over the coming months through our five year joint locality planning groups. These will identify other opportunities and we will want to explore other initiatives in the devolution menu to help us with our plans.

Ultimately we want to join up local public services with closer planning, working and decision making across the Local Authority and the CCG and ensure integration across our providers. Only with this delivery architecture in place can we tackle the problems we face and make the biggest impact for our residents. We need devolution to help us go further and faster.

This document sets out a clear case for integration of health and social care and devolution of powers to maximise the benefits and deliver a truly person-centred health and wellbeing system.

Contents

1. Our Vision

Local leaders and organisations in partnership with people across Hackney have developed a vision to deliver an integrated, high-quality, effective and financially sustainable service model that meets the whole population's health and wellbeing needs, reduces inequalities and improves outcomes.

We want to join up our planning and provision of public services in Hackney as that's how we firmly believe we can make a real difference to outcomes for local people - we must tackle the wider determinants of health and use the Marmot principles to address deprivation and the inequalities our residents face.

We need to change our approach to prevention using the powers we are seeking as part of devolution, and we want to use our collective estate so that buildings are delivering real benefit to the local communities through a wide range of local authority and health services.

Our vision for our services is to improve the quality and timeliness of care, increase the independence and choices for local residents, intervene "upstream" as much as possible, create an environment where residents know how to choose and access the services most appropriate to their needs, in settings appropriate for modern care delivery and reduce reliance on institutional care.

In line with the Five Year Forward View and the NEL STP our key aims and objectives are to work towards a system in which commissioners and providers of health and care services work together with our patients to put in place an effective and financially sustainable service that meets the population's needs across the borough, balancing health and social care needs. At a high level we aim to deliver this through the joint commissioning of all of our services to make the most of the Hackney pound, and jointly provide them in order to meet all the needs of each person we care for. We see this as a step towards developing a practical accountable care system that will ultimately deliver the outcomes for Hackney people in a financially sustainable way.

Our devolution pilot has galvanised us to think about how we could go further and faster with integration across the Local Authority and CCG as planners and across the provider delivery system. Whilst we have achieved a lot, we could do more once devolution helps us to unlock some of the barriers we face.

2. Responding to our local challenges

Delivering our vision is set against a context of existing health and wellbeing challenges within the borough, and financial challenges facing our system of health and social care. We are clear that the only solution for these current and emerging challenges is through a radically different system, continuing to build on our collaborative approach, coupled with devolution to unblock system barriers to transformation. We are in a relatively strong position financially, with high quality provider performance and a history of innovation and significant care and outcome improvements which have come about from our local partnership working. Therefore, we start from a relative position of strength which unifies the partners to do more.

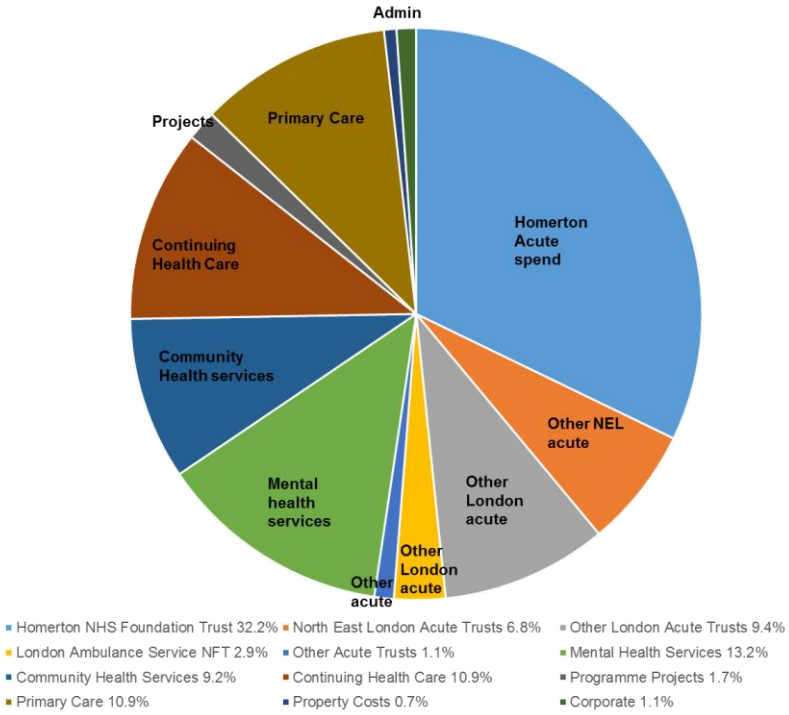
Whilst Hackney, as an inner London Borough, faces many challenges that are similar to the rest of the capital, it has particular challenges that are local and require a local response. Devolution enables us to develop a more tailored approach to our local challenges in Hackney and respond more closely and more quickly to the needs of our population.
Our health, wellbeing and organisational challenges are well understood across partners:

1. **Headlines**

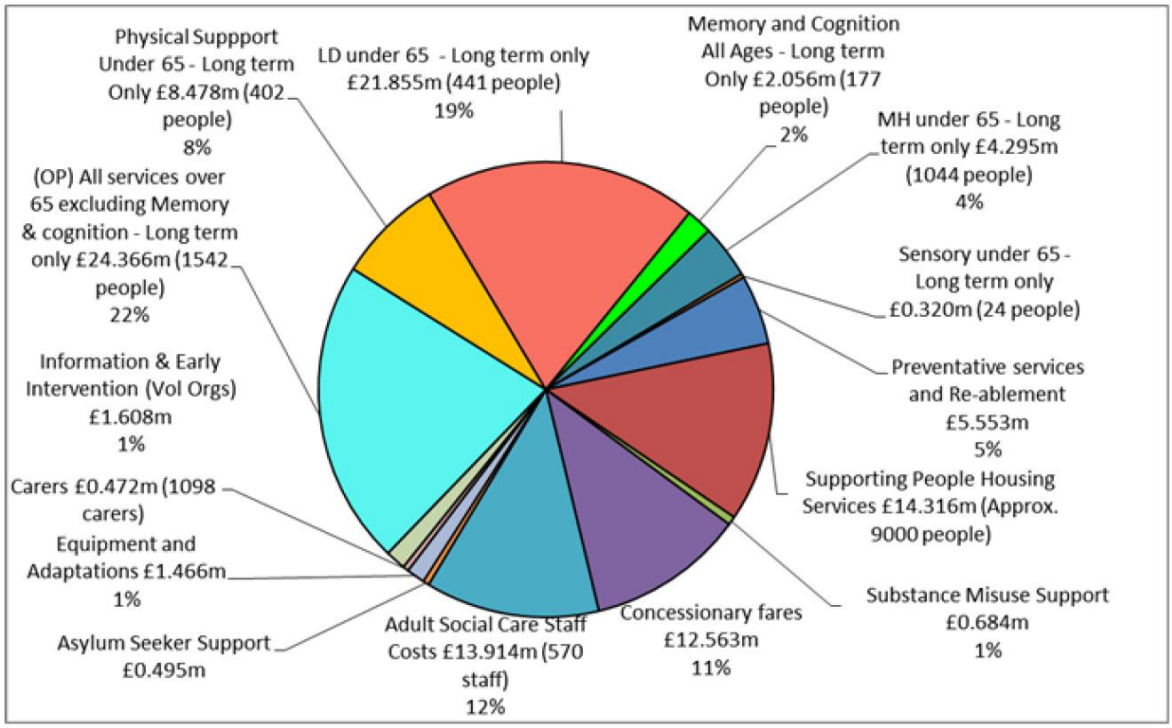
- Population of 309,163 registered patrients as at September 2016 across City and Hackney. Of which 300,017 of these are Hackney Residents.
- High levels of movement in and out of the borough, with 11% of the population being new to the borough each year and 9.3% leaving the borough in the past year.
- Hackney is the second poorest borough in London
- The joint largest rises in working-age population in London between the 2001 and 2011 Censuses and lowest percentage of over 65s in London[1].
- In Hackney we have 12,654 patients identified across the system as very high risk and high risk of hospital admission and 70% of these are under 70 years of age
- 94 properties across health and the Local Authority within Hackney with mixed public ownership. 29% owned by Hackney Council, 19% by NHS Property Services, 14% by GPs and 14% by the Church of England; only 17% of all properties have more than one usage at present.
- In 2014/15, 3,630 people in Hackney were eligible to receive ongoing long term service such as home/residential care and social worker support.
- CCG has a 1:1 relationship with Homerton that represents 86% of all acute and community health care spend.
- In 2014/15 the local authority spent £112.4m on adult social care in 2014/15 which represents 21% of total spend.
- £24.38m was spent on services for older people in 2014/15 by the local authority

[1] According to the most recent joint strategic needs assessment (JSNA) updated in 2014

The graph below provides a breakdown of CCG spend over 2015-2016.



The following graph provides a breakdown of 2014/15 Social Care spend



2. Demographic Challenges

Our population is young, mobile and diverse, and rapidly increasing in the next ten years. This poses a challenge to us to ensure co-ordinated and simplified access to our services and resilient services that can meet the rising needs.

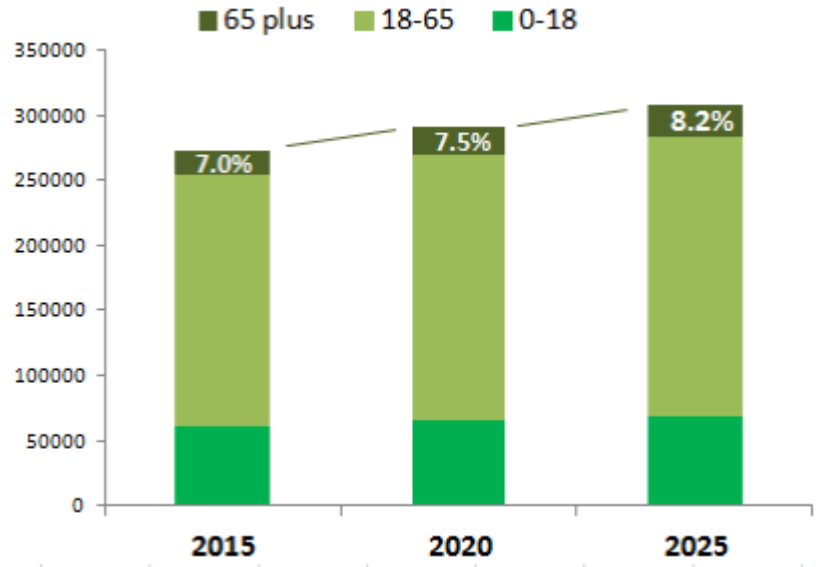
- Population of 309,163 registered patrients as at September 2016 across City and Hackney. Of which 300,017 of these are Hackney Residents.
- Population growth of 12% expected by 2025 – fastest in over 65s.
- 16,000 new homes are expected to be built in the next 10 years.
- A quarter of the population is under 20.
- High levels of movement in and out of the borough, with 11% of Hackney residents new to the Borough each year and 9.3% leaving the borough each year.
- The joint largest rises in working-age population in London between the 2001 and 2011 Censuses and lowest percentage of over 65s in London[2].
- In Hackney we have 12,654 patients identified across the system as very high risk and high risk of hospital admission and 70% of these were under 70 years old, reflecting the health impact of deprivation.
- A high percentage of singles. Hackney has a higher percentage of one person households than London average. In the 2011 census 35% of households were one person households against a London average of 32%.
- Cultural and religious diversity, including the largest Orthodox Jewish community outside Israel.
- Hackney's 2004 household survey indicated that more than 100 languages are spoken in the borough. Two thirds (66%) of households stated that English was the only language spoken in their household and 22% said that English was the main language spoken at home, leaving 12% for whom English was not the main language spoken at home (if spoken at all)[3].
- As well as an increasing working age population, the profile of Hackney is one of continued increasing diversity, with sizable White British (36.2%) and Black African communities (11.4%) but also a large and increasing group of residents from mixed ethnic backgrounds, emphasising the hyper-diversity of the borough. Although at 36.2% the White British population remains the single largest ethnic group in Hackney, this group has decreased significantly as a proportion of the borough from 44.1% in 2001 especially in the context of 20% growth[4].
- Risk factors in the area are shown to be linked to deprivation, age, gender and ethnicity.

This means our future plans must focus on:

- **Developing a system that tackles the wider determinants of health through adopting the Marmot principles and integrating services**
- **Targeting our services to meet our specific and changing population needs**
- **Ensuring community buildings provide an environment and services that enhance health and social wellbeing.**

[2] According to the most recent joint strategic needs assessment (JSNA) updated in 2014
[3] City and Hackney Health and Wellbeing profile 2011-12, p. 27. – forms part of JSNA
[4] Analysis of 2011 Census www.hackney.gov.uk/population

Population growth 2015-2025 by age in City and Hackney (GLA predictions)



Overall, growth is projected in all age groups. However, it is the working age population (16-64 year olds) who are projected to grow most significantly. The majority of the population growth over the period can be accounted for by this segment of the population. The young population (0-15s) is also predicted to grow over the next ten year period.

Managing the challenges in our population

We must focus on the needs of our young population and ensure children get the best possible start in life, where evidence is clear that we can have the biggest impact on future outcomes in the antenatal period and first 1000 days of life. Our growing population means we must support our local hospital by keeping people well, independent and providing care in the community. This emphasis on prevention and our demography mean we need to explore a uniquely tailored health and social care system.

1. **Deprivation and inequality**

Hackney's diverse population includes significant deprivation, and this is a known link to inequality of health and wellbeing outcomes. We must continue to work to ensure our services meet the needs of all our people, and that we reduce inequality in our borough.

- Hackney is the second poorest borough in London and most health outcomes are linked to deprivation.
- Hackney has higher rates of unemployment and families in temporary accommodation than the England average.
- Health inequality (measured as the difference in life expectancy between the richest and the poorest) is expected to rise.

2. **Health and wellbeing challenges**

A significant proportion of our residents' health and wellbeing outcomes are influenced by inequalities, an environment that is not conducive to healthy living, and a health and social care system that could do more to work together and support self-care. We want to promote and support healthy lifestyles and choice-making to help us

maintain health and wellbeing in our population, and ensure our services remain sustainable.

- 35% of deaths within Hackney are preventable.
- Reported sexually transmitted infections (STI) and HIV incidence remains high compared to England.
- Infant mortality is slightly higher than the London and England averages.
- 50% of the population have 1 or more long term conditions by the age of 60.
- The standardised rate of emergency admissions for under 65's was above the average for London.

Mental Health

- There are high levels of mental health need in the area – connected to deprivation.
- People with mental health issues are twice as likely as the local adult population to smoke or be obese.

Smoking

- Around 20% of our adults smoke which is higher than the London and England Average. This remains the single biggest preventable cause of death. Though smoking rates are declining, 20% of deaths among Hackney residents are still attributable to smoking. As such this is a significant priority for our local health and care system.

Alcohol

- Some evidence of decline in younger groups, but alcohol still causes 6% of deaths.
- It is estimated that almost 10,000 people in Hackney are dependent drinkers, and these numbers are expected to rise. 13% of adults binge drink, and 8% are higher risk drinkers.
- Alcohol-related health harms are more prevalent in Hackney than nationally - hospital admissions for alcohol-related problems and alcoholic liver disease are both more common in the local population
- Levels of alcohol-related violent crime and sexual assault are also higher locally than the London and England averages – linked to the night-economy as well as a relatively young population.

Inactivity

- A quarter of adults do under 30 minutes of moderate activity per week. This causes 5% of deaths and may be increasing.

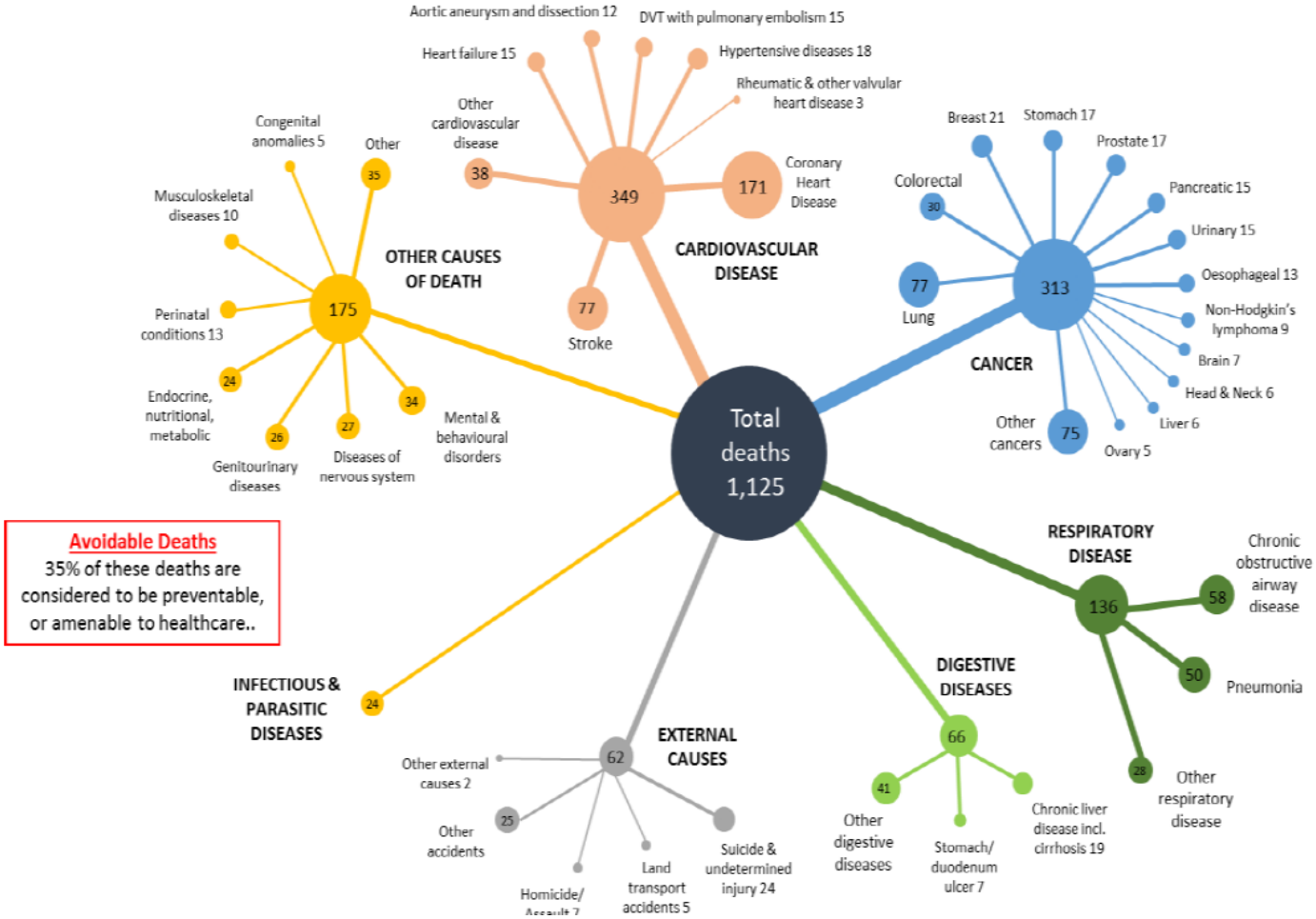
Healthy weight

- Around 40% of Year 6 pupils are overweight, and over 50% of adults.
- Adult obesity is higher than the London average and causes 10% of deaths.

Gambling

- There are 56 betting shops in Hackney, with the highest concentrations in Haggerston and Dalston

- Gambling exacerbates financial vulnerability and worsens mental health problems through addictive behaviour – problem gamblers have the poorest health outcomes and tend to live in more deprived areas



3. The financial challenge

We have been working through the NEL STP to understand our local five year affordability challenge across health and social care and achieving and maintaining financial balance across our system is a key driver for our local devolution plans. We want to ensure our new models of care are sustainable in the longer term and this can only be achieved through changes to the way we currently commission and deliver services. The financial challenge that Hackney could face across health and social care is between £20m and £78m by 2020/21 and there is considerable volatility within these estimates. Challenges include but are not limited to:

Uncertainty of external funding across health and social care

- Access to the historic CCG surplus
- Changes to the revenue allocation for Local Authorities

- Revised Better Care Fund allocations

Policy changes
- Impact of Brexit on economy and domestic policy
- Proposals to move Attendance Allowance responsibility to Local Authorities
- Introduction of system wide control totals within NHS
- Ongoing welfare reform
- Potential implementation of the Housing and Planning Act

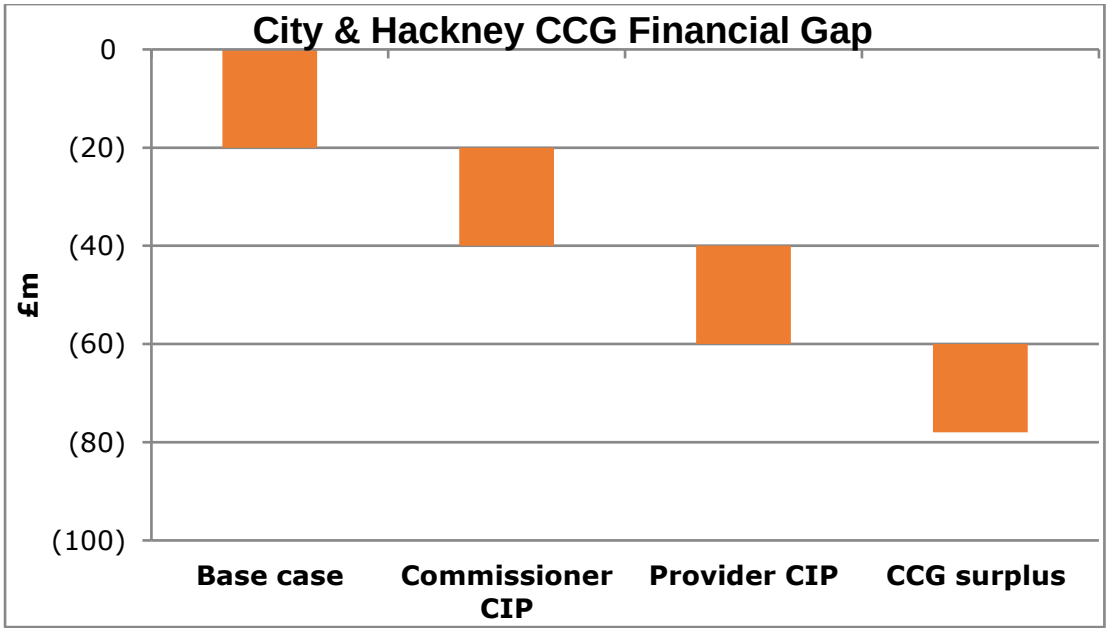
Successful management of existing pressures within the system
- Ongoing delivery of savings across health and social care
- Management of growth in demand and changes in acuity and complexity of need
- Impact of pressures on providers such as national minimum wage, recruitment and retention
- Continuing care market in distress

The Hackney partnership has developed baseline financial figures from the four main devolution partners as part of the work for the NEL STP. These include income and expenditure for health and social care services provided to Hackney residents and all patients registered with Hackney GPs, but exclude a number of services commissioned by NHS England such as specialised commissioning. The range of the challenge illustrates the high levels of uncertainty faced by both NHS and Local Authority partners on the future funding arrangements, the ability to meet recurrent savings requirements and the unknown impacts of legislative and policy change during the period of the model.

The assumptions within the model include:

- Growth in activity within healthcare services in line with North East London STP plans.
- Growth in social care activity net of demand management strategies.
- Planned service developments as per organisational plans and shifts of care.
- Maintaining current benchmarked performance despite population increases and stretching this where clinically supported as a safe strategy.
- Degrees of achievement of cost improvement plans (CIP) for 2016/17 and beyond across all organisations.

The financial bridge below illustrates how the financial gap develops based on assumptions relating to CIP delivery and access to the CCG surplus.



The analysis above presents the financial baseline for the next 5 years without devolution.

The above figures come from a mixture of sources but align with STP financial analysis. These are:

1. CCG figures – June STP submission adjusted to remove City activity and costs
2. Council figures – Estimated 5-year plan
3. Homerton Hospital figures - June STP submission adjusted to remove any non-Hackney activity and specialised commissioning
4. ELFT figures – Contractual value for Hackney patients only assuming breakeven position

We are committed to closing this financial gap through a radically new way of organizing our system, built on collaborative principles and experience. Devolution presents significant opportunities to achieve this. The anticipated financial impact of our proposals is described in section 13 – Financial impacts.

We believe that our new system architecture coupled with our requested devolution powers will not only improve outcomes but also maximise our efficiency and cost effectiveness.

3. Building on strong foundations: our opportunities

A locally-contained system

Hackney's health and care system and geography is well suited to borough level devolution so we can make a real impact. The boundaries of the Hackney partners are broadly co-terminus. The London Borough of Hackney's work is all within the Borough and over 80% of our acute work and all community health services are delivered by Homerton University Hospital Foundation Trust.

Locally we have an effective and well-functioning GP Confederation that has successfully taken on delivery of enhanced primary care services and supporting GP practices. Both the GP Confederation and City and Hackney Urgent Health Care Social Enterprise (CHUHSE - the GP out of hours social enterprise) work solely within City and Hackney and both deliver 100% population coverage, whilst East London Foundation Trust (ELFT) works across three inner NE London boroughs. We also have an active and well organized voluntary sector contracted to deliver a range of health and social care services who share our ambitions and are active delivery partners.

This local focus of all our organisations provides a common platform plus a shared vision and desire to really make a difference for local people.

A strong local partnership

The London Borough of Hackney, the City of London Corporation and City and Hackney CCG have a long history of joint work across health and social care. Leaders from health and the Local Authority have come together on a regular basis over the last two years, through a leader's summit to develop a systems leadership approach. Through this, we have agreed a collective ambition to work together to make real improvements for local people through how we commission, through integrating the delivery of services across organisations, and through exploring new delivery structures and mechanisms. The STP process has further galvanised and embedded our system approach to enhance our collective work to deliver the STP and tackle the challenges within City and Hackney, as part of a joined up effort within North East London.

A track record of delivery

We have worked together to date to develop integrated ways of working and through our system leadership have already put in place a range of new models to support system resilience and integration:

- An **Integrated Independence Team provided by Homerton Hospital** consisting of health and social care professionals that supports care closer to home, increases independence and reduces emergency activity. The team works intensively with people for up to six weeks and arranges on-going support services for those with longer term care needs.
- An alliance outcomes based contract **One Hackney and City**, which has piloted care coordination and the introduction of out-of-hospital health, social care and voluntary sector teams working alongside general practices.
- Alignment of our offer for **vulnerable families** through the health visiting service, children's centres and the contract with the local GP federation to identify vulnerable families and agree a co-ordinated response.

- **Mental health alliances** to support dementia, a key local health and wellbeing priority, and other mental health conditions in working-age adults.
- A **learning disability service** delivered via an alliance contract to pilot the development of out-of-hospital health, social care and voluntary sector teams working alongside general practices.
- System wide strategy for **tobacco control** incorporating prevention and smoking cessation to interventions within NHS providers and smoke free environments.
- A new model for GP input into two out of three of our nursing homes.
- The Paradoc model (our in hours GP visiting service working with local community professionals, London Ambulance Service and care homes) which avoids admissions/attendances for 50% of those referred, and only conveys 10% to hospital.
- Joint work on the **Better Care Fund** and **Joint Health and Wellbeing Strategies** overseen by our two Health and Wellbeing Boards.

We have also delivered significant improvements in outcomes over the last few years:

- Homerton Hospital has consistently delivered the 95% A&E target in 2015/16, and City and Hackney CCG perform consistently well against other key national targets.
- We are in the top quintile in England for the care of people with long term conditions[5]* Through effectively commissioning a contract for long term conditions care through our GP Confederation, in 2014-15 the CCG was in the top quintile for 21 QOF measures, and remain top in England against 27% of measures. These include long term conditions (LTC) care and blood pressure control for conditions including diabetes, coronary heart disease, stroke/transient ischaemic attack, chronic kidney disease, as well as asthma and COPD reviews. We have made significant progress given that in 2005 the Borough performed among the most poorest in the country on many of these indicators:
- The London Borough of Hackney Public Health department provided an estimate of morbidity and mortality reduction due to higher blood pressure control in people with LTCs in C&H, as delivered through the LTC Contract. In City and Hackney, currently 961 extra hypertension patients achieve the QOF BP to 150/90 mmHg target, above the number which would be expected if average London performance was achieved. Applying number needed to treat (NNT) estimates from a large US study to the local population at least 75 CVD events and at least 46 deaths in total are estimated to be prevented in this cohort over the next 10 years.

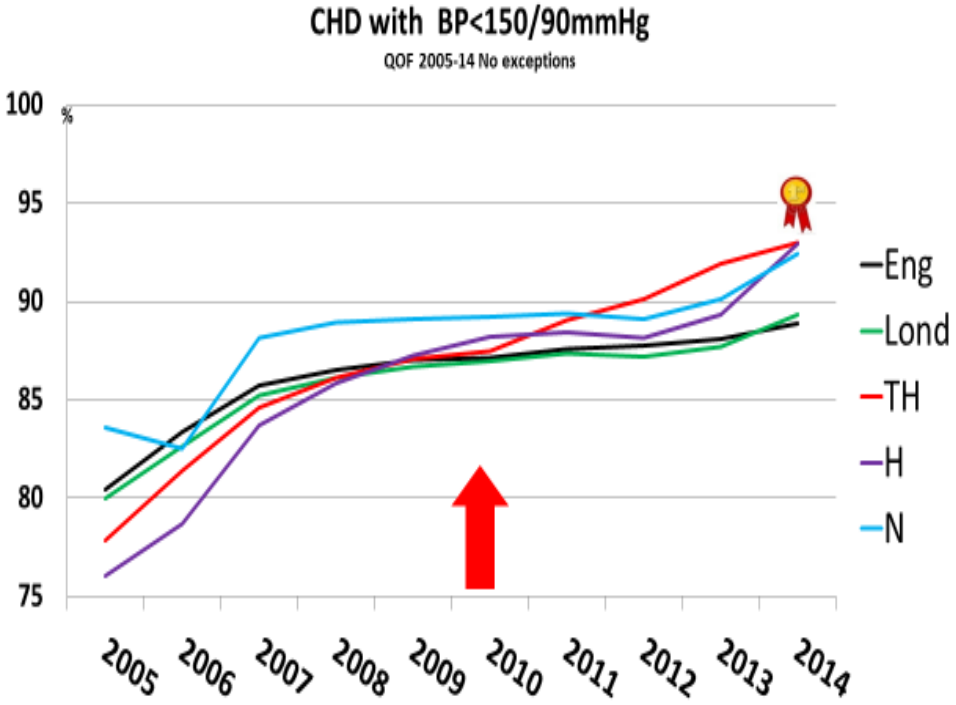
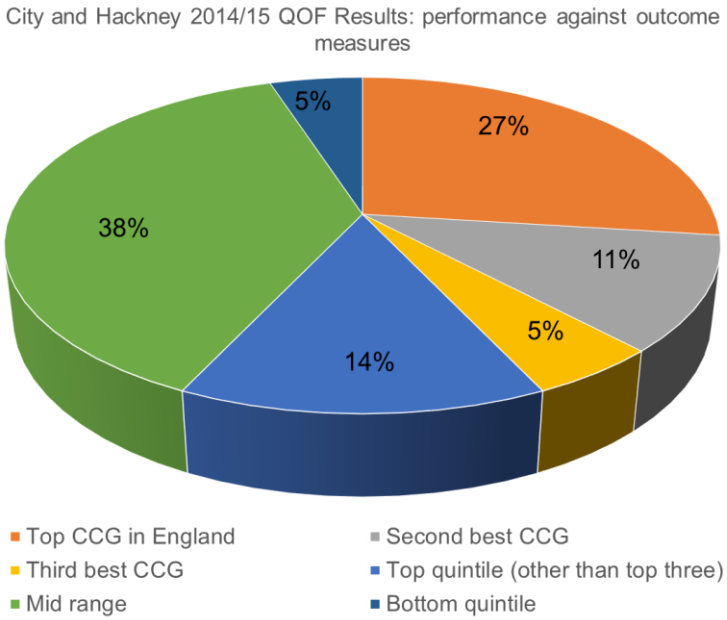


Figure 1: Over the past few years, the borough has moved from among the poorest performing areas for managing CHD to the best in the country, through initiatives in primary care including the LTC contract



- We have been working with GP practices and clinicians to develop effective pathways that mean our patients have significantly lower referral rates than the next lowest of our peer group and comparable London areas.
- We delivered the second lowest % increase in prescribing costs in London in 2015/16, and were ranked 9th best in the country for our reduction in the prescription of wide spectrum antibiotics.

- City and Hackney CCG has the flattest AGI (absolute gradient of inequality) in the country, meaning there is the least disparity between emergency admissions from the poorest and wealthiest neighbourhoods in our borough.
- We have increased our satisfaction ratings for social care services by nearly 7% since 2010, while making £12.8m of savings between 2012 and 2015 on our social care spend.
- We have very effective reablement services in the borough, where in 2014/15 91.3% of older people who received reablement services were still at home 91 days after discharge.
- We have a well-established social prescribing scheme from primary care for people to access health and wellbeing services.
- 950 patients have a Coordinate my Care (CMC) record with the highest number across London added to this system in the last 12 months.
- We have been piloting over the last two years community-based care coordination via a strong collaboration between health and social care providers alongside the voluntary sector using an outcomes based alliance contract.
- We have a high quality mental health provider, plus 4 alliance contracts with primary care and the voluntary sector for dementia, psychology children and enhanced primary care, delivering integrated services across statutory and voluntary sector organisations.
- All of this along with strong patient and public engagement is our foundation to achieving greater success.

With a shift in legislative arrangements and further devolved responsibilities, we are confident we can go even further.

Strong partnerships and engagement with patients and citizens

The work described above has been underpinned by engagement with communities and strong working relationships with our residents. We have done this through annual joint commissioning intentions events across health and care, in conjunction with both Local Authorities, to shape our plans and strategy along with continued conversations with the public on our plans. We are committed to continuing developing this engagement further and co-designing solutions that best meet the needs of our local population. This explored more fully in the next chapter.

4. Our approach to engagement: what we have been hearing

The Hackney Devolution Pilot is built around the vision set out in the "Five Year Forward View" to 'engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services', together with the Health and Wellbeing Board's stated ambition for citizens to be at the centre of service redesign and decision-making. We are committed to meeting policy and statutory requirements and best practice for consultation on service changes for local authorities and the NHS and working together to ensure:

- Co-design and implementation of best practice evidence-based models of care which ensure a productive health and social care economy, locally within Hackney and with surrounding areas.
- A local health and care system that offers choice and control to patients and service users, more self-care options and reduces or eliminates health inequalities and waste.
- Residents are fully engaged in designing all our plans and proposals and have had opportunities to ask questions, contribute ideas, and be part of the planning and decision-making process.
- People of Hackney are more engaged in their health and care and feel more confident about their role in managing their own health and wellbeing.

The governance structure for integrated commissioning includes an Engagement Enabler Group co-chaired by the Director of Healthwatch Hackney and the CCG's Lay Member for Patient and Public Involvement and additional support for public events and for our engagement work has been fully funded. The Enabler Workstream acts as a 'critical friend' to the programme and supports the driving principles for public involvement, including: open and informed debate; opportunity and time to form, inform and consider proposals; deepening the partnership between residents and those delivering services; co-design through effective resident and service user involvement.

We have recruited public representatives to sit on all of the Transformation Programme work streams, their role is to raise issues important to local residents, comment on issues from a public perspective, challenging and providing an impartial and independent view. We will also provide opportunities for patients and service users to contribute to the service-redesign work through a "design lab" approach. Our clear ambition is to embed these principles in the new model of healthcare delivery that emerges from the project.

The work programme includes the development of a detailed engagement and communications plan based on a comprehensive stakeholder mapping exercise that identifies all stakeholders and how they wish to be involved and informed. In addition to patients, service users and residents, this includes political stakeholders, voluntary/community sector, GPs and other clinical leaders, staff whose roles/services are affected by the proposals and Trade Unions and other staff groups and representatives.

On 28th June 2016 we held our first public engagement event "City and Hackney Health and Care goes Local: a community conversation" attended by 140 people, about 90 residents and the rest staff from partner organisations and the voluntary sector. We debated together the current situation and the challenges we face, what is meant by devolution and the opportunities it may provide.

Participants were able to discuss and challenge our specific transformation plans for health and care services for City and Hackney for next 5 years as set out in our devolution proposal

and the STP at themed stalls and via a Question Time-style panel involving all Transformation Board partners. Prior to the event, we also ran a programme of “road-show” events catering for people who might not be able to attend the main event. A total of 181 local people were involved in these meetings, including young people, people with mental health issues, carers, people with disabilities including learning disabilities, older men, and refugees and migrants.

At this meeting we heard:

- A clear plea to focus more attention on young people and services for those in their early years.
    - Children and young people are concerned about their mental wellbeing and lack of access to appropriate to support.
    - There are concerns about smoking in young people
    - The access and cost of healthy foods and sports facilities prevent healthy choice-making.
    - There is currently poor information and signposting for children and young people.
- We can do more to enable access and information about self-help, and support carers who look after people outside their more direct interaction with our services
    - Unpaid carers feel increasingly isolated and unsupported, and those in full time work require more support
    - Patients and their carers lack confidence in the services currently available to support them
    - There are opportunities to use e-solutions and social media to help people self-help and self-manage their conditions
    - People are looking for more support on how to spot early signs of illness, and prevent existing conditions getting worse
- There is inequality between access to mental health and physical health services, and between the way that different groups of people in the borough access care
    - Housing is a challenge for vulnerable people
    - Opportunities and support for people with learning disabilities are limited
    - Migrant and refugee concerns about the quality and access of interpretation and translation services

This feedback has been used to shape the priorities for the programme, which are described in the following section and underlines the importance for us to tackle the wider determinants of health as much as health and care services

The overall conclusion from the event was that in spite of the challenges, people could see a real opportunity to build a better local health and social care system with local organisations working more effectively together and services being co-designed with the public.

We engaged with our local people at a series of four engagement events in November 2016, organised by the 4 quadrant geographic areas, to work through ideas for the models of care being developed for each quadrant.

Continuing to work with local people:

We have strong patient and public involvement in all our workstreams. - providing a leadership triumvirate of public/patient, manager and clinician/practitioner to work together and challenge each other. There is public representation on our Transformation Board and on the Integrated Commissioning Board.

Over the next 12 months:

- We will continue a debate with local people about our ambitions and workplans, ensuring they are equal partners in thinking about and designing services, as well as providing feedback on delivery and what more we could do. We have signed up as partners to a co-production charter and will build co-production principles into our work over the coming months.
- We are planning a systems commissioning intentions event for March 2018
- We will continue to work with our patients to explore how our public sector can support the use of wider community assets and ensure our plans are socially sustainability. We understand the value of local and culturally relevant access points to support for our residents. Our vibrant voluntary sector providers are a key part of our plans for utilising existing community assets to ensure our services are: targeted and effective, culturally appropriate, and they maximise the increased social value of our plans. As an example, our Psychological Therapies Alliance are working with faith groups to co-locate therapists in local places of worship.

5. Our Priorities

Based on the key health and wellbeing, system and financial challenges that we face, we have identified four service transformation priorities which we believe will have the greatest impact, all of which can happen faster through devolution:

Early intervention

Early intervention to give children a healthy and happy start to life.

Through devolution we will seek to increase the speed of service integration and align the interventions needed to improve outcomes for vulnerable families and in the first 1000 days.

Self-Care

Encouraging self-care and promoting independence for those who do not yet need long term services.

Through devolution we will create a new model of care designed to support independence and self-care.

Single point of Co-ordination

Coordinating community based services around GP practices at a quadrant level and creating a single point of coordination across providers to reduce the need for hospital or residential care admission.

Through devolution we will seek to create an accountable care system with shared priorities and a focus on providing care closer to home.

Equality of Access

Providing equality of access and support to those with mental health conditions and physical health conditions to reduce mortality.

Through devolution we will ensure the financial and system architectures are aligned in order to improve access to health and care services and reduce inequalities.

How devolution can help us deliver against these priorities:

While working together to design and develop our delivery architecture to take our plans forward, we have identified a number of restrictions in the current arrangements. Unblocking these through devolution would really enable us to go further and faster in making a difference for our residents. These are:

1) A fully integrated commissioning and planning model for health and social care
2) Effective local estates management across health and the local authority and retention of receipts to transform the care infrastructure and deliver wider social value for the community
3) Enhanced local powers to enable planning and licensing decisions to improve residents' health and wellbeing and deepen our work on primary prevention
4) Development of a truly integrated health and social care workforce
5) Ability as a devolution pilot to engage with and learn from the vanguards and new models of care pilots to help our journey and exploration of new ways of organizing our services and contracting for outcomes

In order to deliver our ambition, integrate health and social care and deliver the full set of benefits, we require changes to policy, legislation and regulation. In many cases the specific details of changes required are not yet known and will emerge through the planning process and through working closely with national partners. This document focusses on the changes we require to create a fully integrated commissioning architecture. Aspirations relating to public health and estates are contained within appendix 3 and 4.

6. How we will work together:

Based on the key health and wellbeing, system and financial challenges that we face, along with what we are hearing from our patients public and staff, the partners have agreed a number principles which define how we will work together in order to achieve our vision.
In order to deliver improvements to the lives of people in Hackney we will:

Our Service Model
We will deliver our plans through six models of care:

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

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

Working to these principles will enable us to plan and deliver services together, with collective responsibility to improve outcomes for the local population.

7. New models of integrated care

Building on integrated pathways that keep people well and out of hospital

Local work is continuing building on the strong foundations already in place in Hackney in a number of areas. Through working across acute, community and primary care and work in partnership with patients, we have already made progress designing pathways that keep care closer to home. Hackney has low referral rates for outpatients as a result of established high quality joint care pathway development across primary and secondary care. Rather than fundamental changes, it is this work and patient focus that will enable us to develop care models that meet our aspirations. Examples of how the proposed out of hospital care model and devolution pilot will build on these pathways include:

- **Children's health:** Strengthened liaison between GP's and Children's Centres, health visitors and School nursing with pathways to ensure the early identification of struggling families, tacking mental health issues and impacting on early years.
- **Neighbourhoods** Develop our model of neighbourhood care
- **Discharge to Assess**: We have developed our discharge to assess model in both City and Hackney.
- Development of a local **Single Point of Coordination** to ensure rapid access through integrated clinical response, as well as fully utilise the Integrated Independence Team (IIT) and ambulatory care to ensure safe care at home rather than hospital when appropriate.
- **Long term conditions**: Implement the renal pathway of proactive patient identification of AKI (acute kidney infection) across primary and secondary care with an e-referral service. This should delay the need for future renal dialysis. We will roll out the proactive case finding and e-referral model across other services.
- **Maternity**: Early identification of psychological, social and physical risk to improve outcomes, an obesity in pregnancy pathway and further work to improve patient experience.
- **Mental health**: More effective management of the individual needs through tailored action plans including promoting mental wellbeing and '5 To Thrive' initiative using our four alliance contracts.
- **Prescribing practice**: Maintain our position in London for high quality low cost prescribing.
- **Primary Care**: Continue to commission a range of enhanced primary care services, such as home visiting, extended access, duty doctor and enhanced community services, from our GP Confederation.
- **Planned care**: Continue to develop and audit our referral pathways and commission practices to deliver our demand management contract. Introduce more community based services (e.g. Minor eye service) and focus on better patient decision aids where interventions with a limited evidence base are being considered.

How we will go further

Starting from the platform of good, well-organised primary care, we have 6 building blocks and transformation projects to deliver new models of care. Each of these is an essential component of our delivery model and each builds on what we have put in place over the last few years:

The NHS Five Year Forward View said:

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

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

Aims and Objectives

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

- Improve the health and wellbeing of local people with a focus on prevention and public health, providing care closer to home, outside institutional settings where appropriate, and meeting the aspirations and priorities of the 2 Health and Wellbeing strategies;
- Ensure we maintain financial balance as a system and can achieve our financial plans;
- Deliver a shift in focus and resource to prevention and proactive community based care;
- Address health inequalities and improve outcomes, using the Marmot principles in relation to the wider determinants of health and focusing on social value;
- Ensure we deliver parity of esteem between physical and mental health;
- Ensure we have tailored offers to meet the different needs of our diverse communities;
- Promote the integration of health and social care through our local delivery system as a key component of public sector reform;
- Build partnerships between health and social care for the benefit of the population;
- Contribute to growth, in particular through early years services;
- Achieve the ambitions of the NEL STP.

Our Service Model

We will deliver our plans through six models of care:

- **Enhanced primary care –** practices working together within each of the 4 quadrants and delivering population health
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- **Quadrant-based voluntary sector organisations** delivering a range of social, wellbeing and public health services via social prescribing and integration with statutory services
- **A physically integrated single point of coordination (SPOC)** for crisis care
- **Empowered patients** equipped with skills and information to help them self-manage, access the right services when needed, make informed decisions on the evidence and

options for their care and who are active in the co-design of our service delivery arrangements and pathways

- **Strong safe local hospital care** delivering:
    - High quality 7 day services, integrated with mental health resources and networked with other local hospitals where necessary.
    - Fewer face to face outpatients - replaced by digital solutions.
    - Support and expert advice to primary and community care.
    - Demand management of tertiary service.
    - Reductions in variations between teams.
    - Minimal length of stay, thanks to good primary and community services which command universal clinical confidence.
    - Aligned clinical behaviours across primary community and secondary care, which see the community / home as the default and support the delivery of patient care plans.
    - Public health interventions.

Our delivery plans are being developed by our four care workstreams:

- Unplanned care
- Planned Care
- Prevention
- Children and Young People

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

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

Next steps

Over the course of 2017/18 each workstream will contribute to the establishment of an accountable care system across Hackney and the City by April 2018 which demonstrably achieves and will continue to achieve our system aims and objectives. As part of our devolution ambitions, we will work to integrate the following principles into our delivery model

- All providers and community based teams working in collaboration at a locality level, using standard operating systems and sharing back office functions to achieve economies of scale and deliver savings in line with the vision of the STP.
- All providers working together to deliver a range of outcomes for which they take collective responsibility – these will be about making significant improvement against patient, health and performance outcomes. Providers will work together via an alliance contractual arrangement in the first instance to achieve this.
- The move to a contractual arrangement based on capitation, aligned levers and outcome delivery. As the model develops we will continuously review how much we could transition our current commissioning function into the new delivery model with

the potential to be built around capitation. Our local definition of the term capitation relates to a system where payments are based on pathways of care, delivery of capacity over a number of organisations, an expenditure limit, and is measured on shared outcomes and quality standards. We have more work to do on this and the risks and benefits for both the individual organisations and the system. We are also keen to move to a regulation model which measures these system impacts rather than individual provider performance.

- We will continue as active partners in the NEL STP process to understand where some commissioning is better delivered at scale.

8. Delivering improvements through integrated commissioning

As an integration pilot, Hackney has focused on pursuing areas of work where the fastest and greatest impact is likely to be seen. Commissioning has been a key focus for us because it provides an important lever to rapidly align partner incentives and demonstrate our commitment to our shared vision.

We believe that the role of commissioning is to:

- Define the desired outcomes and service model, underpinned by a clear vision and strategy owned by clinicians, practitioners and patients
- Ensure that efficiencies are generated, that value for money is achieved and that the most cost effective and high quality service models are delivered
- Create the environment for change
- Ensure we base our plans on evidence based best practice
- Ensure standards are met and improvements are made
- Provide an effective means of integrating commissioned services to achieve our plans and align our dealings with our providers
- Support our providers to take collective responsibility for improving outcomes

Therefore, it is through commissioning that we are able to achieve our shared vision of an integrated system delivering improvements in health outcomes.

Integrated commissioning will also help facilitate the development of new delivery arrangements and models across the local provider landscape, the rapid integration of services, generate savings through increased efficiencies and a reduction in transaction costs and support the emergence of an accountable care system which may, subject to compliance with legislation, ultimately take greater responsibility for the health of the population.

Integrated commissioning governance

Our current governance arrangements and journey so far

Our current integrated governance structure has developed out of our system leadership development, conducted over the last three years supported by the Office of Public Management. Key senior stakeholders from the London Borough of Hackney, CCG, Homerton Hospital, East London NHS Foundation Trust, City and Hackney Urgent Healthcare Social Enterprise (CHUHSE) and the GP Confederation began meeting to discuss the problems in Hackney and how we could better work together to improve services and outcomes. Through these meetings and the formalisation of Hackney as a devolution pilot we formally established a Transformation Board, made up of the local leaders with the addition of a CCG lay member, the voluntary sector and Healthwatch, to oversee the further development of our plans, break down traditional barriers and work for a common goal. The collective focus of the transformation over the last two years has enabled a large number of successful integration programmes. These are detailed in full on page 18 in the section on ‘our track record of delivery’.

Our integrated governance structure

We have formalised our integrated working and commissioning through use of existing legislation.

In April 2017, we established two Integrated Commissioning Boards (ICB), one for Hackney and the other for the City of London that uses the current s75 legislation to control a single pooled budget between CCG and each local authority.

The Integrated Commissioning Board members have delegated decision making from the statutory organisations to make decisions together on behalf of the organisations and operating within a scheme of delegation agreed by the three organisations.

This ICB represents the interests of both the Local Authority and CCG in improving the local health and social care system – we are proposing that ICB members will have equal voting rights and an equal stake in securing better outcomes (Please see appendix one for the terms of reference for the Hackney ICB board).

The Hackney ICB is currently made up of:

- 3 Cabinet members
- The chair of the CCG (GP)
- 1 CCG lay member
- CCG Chief Officer

- Others in attendance (e.g. Director of Finance Chief Officer of LA, CCG CFO)

- Hackney Healthwatch, and a voluntary sector rep also regularly attend.

The proposed arrangements is underpinned by a financial framework outlining how the statutory bodies set and manage the pooled budget each year. Under current legislation, not all budgets can be pooled and the statutory organisations will still retain decision making responsibility for a number of services but we expect these decisions to be made on the advice in the Integrated Commissioning Boards.

We set up a similar model with the City of London Corporation as well as with the London Borough of Hackney in April 2017. For the City of London this brought an immediate benefit and change with the dedicated focus for the first time on commissioning for City of London residents and being able to really lever services to focus on their distinct needs. This approach has the full backing of the Health and Wellbeing Boards and in principle local political and partner support in the City of London. Work is already underway to disaggregate the necessary contracts and budgets.

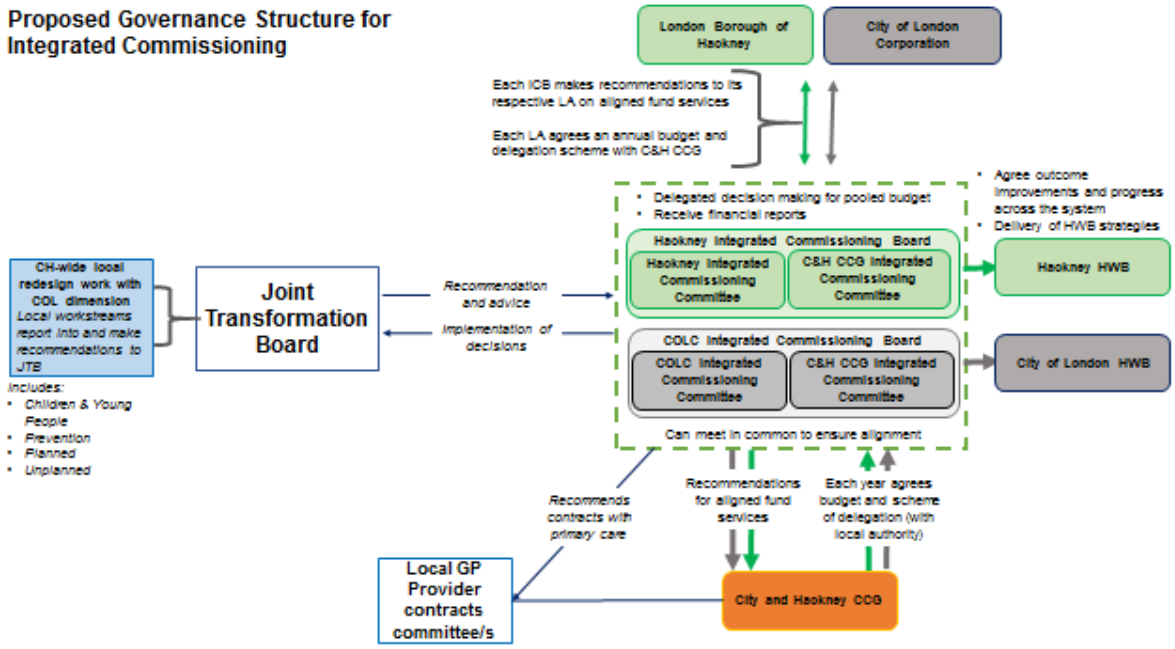
The two statutory Health and Wellbeing Boards continue to oversee local workplans that improve local services and outcomes. The statutory organisations ensure that the Integrated Commissioning Boards are commissioning the providers to achieve the improvements in outcomes and deliver the joint health and wellbeing strategy ambitions, local plans and the STP.

With the development of the Integrated Commissioning Boards the Transformation Board changed from April 2017, to become a more formal anchor and ‘engine room’ to ensure our local plans deliver improvements and achieve the STP, as well as make recommendations to the two Integrated Commissioning Boards. In line with the STP and national direction of travel this will formally bring local clinical and managerial leaders - both commissioners and providers - together to plan for the system and focus on the place.

Reporting to the Transformation Board are our four transformation workstreams (focused on integrated health and social care planning) and our enabler workstreams. Local leaders from the Transformation Board will represent the local system in the STP governance. The CCG

Governing Body and the Local Authorities will continue to be statutorily responsible for all services as the Integrated Commissioning Boards will operate under a scheme of delegation to the individual Board members - the statutory organisations will ensure the Integrated Commissioning Boards are operating within the agreed scheme of delegation and are meeting statutory responsibilities and will be supported by the Audit Committees in this assurance.

To avoid potential conflict of interest that may arise due to the membership of the Integrated Commissioning Boards, the CCG Governing Body will retain a Local GP provider Contracts Committee. This Sub-committee has been active for the last three years, has a lay chair, an independent GP advisor, meets in public and has no local GP involvement and provides a detailed scrutiny function for all contractual proposals involving local GP providers. The Committee will therefore consider all proposals involving local GP providers which emerge from the Transformation Board and recommend contractual arrangements to the Integrated Commissioning Board. This Committee will also transact primary care commissioning and make recommendations to the CCG Governing Body should the locality decide, to take on the formal delegation of primary care commissioning functions from NHSE.



As described in the diagram above, the joint commissioning boards for the City of London and for Hackney will meet in common as required.

How we can go further through devolution

Whilst we can use current legislation to support joint commissioning there are limitations in what we can do and how flexible our governance structure can be to allow full partnership working and the level of joint commitment we aspire to.

Currently, the ability for CCGs and Local Authorities to form Joint Committees in relation to functions that are commissioned under a section 75 framework is restricted to the formation of a “management” joint committee (regulation 10). This would not normally be interpreted to enable decision-making joint committees and so requires the use of work-around solutions

(e.g. Delegation to individuals who meet in common as we are introducing). This is not consistent with the wider objectives of integrated working and efficient, transparent decision-making, nor of a collective body working together for the greater good.

This also means that in absence of legislative chance to the S.75 regulation or NHS Act, our future integrated model would require the CCG to double run some commissioning elements with some decisions reserved for the CCG Governing Body increasing commissioning and transaction burden and restricting the ability to think about integrated pathways. For example, because of the restriction in services under s75 legislation we would have the joint commissioning board making decisions about commissioning community based demand management services (to reduce demand for surgical services). Under current S75 legislation, these surgical services, will remain commissioned by the CCG. This could prohibit a common pathway and a single contractual arrangement based on outcomes.

The other limitation includes section 14Z3 (as amended by the Devolution Act 2016) which does not currently allow for London CCGs and London local authorities to commission jointly through the establishment of a formal Joint Committee. This prevents a full integrated model being established and prevents the step change in commissioning behaviour required to focus on health and wellbeing and collective local responsibility. Critical to the success of this approach and ensuring a change in mindsets is board members working together as a unified governance arrangement, rather than as a sum of individuals from two organisations who meet in common.

Delivering integration: Pooled budgets

What we are doing now

The Section 75 agreement for Hackney is made up of a pooled budget of £49.9 million that incorporates the BCF, Learning Disabilities Services and the budget for the Integrated Independent Team. We are planning further pooling for 2018/19 subject to approval of business cases.

We have a clear financial framework in place outlining how the partners develop and manage the pooled fund each year.

The Integrated Commissioning Board determine how best to use the fund to secure local improvements and deliver the locality plan and Board members will have delegated authority for the use of the fund.

The four care workstream have an overview of all existing contractual arrangements in their areas including the achievement of outcomes and metrics. In looking at these together leaders hold all the necessary levers to align system incentives and empower clinical behavior change in order to change how services work together and ensure financial balance.

This is an important building block to exploring a future capitation based arrangement. Whilst we will start this model using current contractual arrangements - e.g. Block and full payment by results - it will allow the system to decide how to change contractual arrangements to better deliver integration and outcomes and in doing so help us understand the levers and risk/gain share we will need to have in place to maintain financial balance as we explore when we may want to move to a more outcome based capitation arrangement.

Our proposed financial arrangements moving forwards and why we need devolution

We want to move towards further pooling of budgets.

The current legislative restriction prevents a fully pooled budget across health and social care requiring us to continue to use the statutory organisations to manage these "excluded" services, pending changes to legislation.

We would ask that there is an expansion of the s.75 regulations (the NHS Bodies and Local Authority Partnership Arrangements Regulations 2000) to include the current list of excluded services:

- Surgery
- Radiotherapy
- Termination of Pregnancies
- Endoscopy
- Laser Treatment
- Emergency Ambulance Services

Doing this would allow for integrated commissioning from a single budget that will reduce duplication and join up services along pathways. This will enable improvements in care and service integration and maximum benefit to be gained from the Hackney pound. For example excluding Local Ambulance services from the section 75 agreement would mean commissioning these services outside of the rest of the integrated crisis system and so prevent a whole pathway approach being taken in commissioning decisions. Without this, any trade-offs and interrelationships between services cannot be fully taken into account. Similarly it will be difficult to develop pathways to demand manage surgery through commissioning out of hospital services.

Fully pooling local social care and public health budgets with local NHS budgets would also support coordinated commissioning for service integration and provide a platform for future delegation of other commissioning functions. Integrated commissioning will also ensure that the transaction costs of commissioning are kept to a minimum.

Delivering integration: Primary care commissioning

We successfully moved to level 3 primary care commissioning from April 2017. This is a key building block of our devolution pilot.

Delivering integration: Positive impact on the City

With a standalone s75 agreement with the City of London and a separate board, we would ensure a complete focus on meeting the needs of both City residents and City workers. As a consequence of the Hackney devolution pilot, the CCG and Corporation of City of London determined that the best way to ensure the pilot had a positive outcome on the City and City residents was to develop a similar integrated model. Separate City of London commissioning plans will continue to be developed from those for the London Borough of Hackney to take account of the different networks and provider landscape for the 8000 City residents who have a very different profile of health and care needs to those residents of Hackney.

For example, the City receives over 400,000 commuters each day requiring specific services to meet their needs and positively impact on their health. Providers of care to City of London residents are also different from Hackney and are focused more on North Central London

with University College London Hospital in particular delivering the majority of local acute services.

Currently, the City of London Health and Wellbeing Board is the only body which has a pure City of London focus and the Corporation has its own commissioning arrangements for social care and public health. By setting up integrated commissioning for the City of London with a separate health budget we can unify and align our plans and contracts and begin to deliver the ambitions that address their distinct needs. Members and officers in the Corporation and other partners in the City (e.g. Healthwatch, community and voluntary sector providers, GPs) are very enthusiastic about this approach and the opportunity to take an approach to our joint work based on Marmot principles.

We will use the collective leadership of the City of London Health and Wellbeing Board to ensure alignment and joint work with the arrangements with Hackney in areas that are appropriate. We have agreed that for 2017 we are going to review individual plans against joint objectives. This will mean exploring the opportunities for better alignment, and will include reviewing the community health services offer in the City and how it is supporting care closer to home and service integration across the provider landscape.

Should devolution be agreed and legislative changes put in place to extend the range of services that can be included in a s75 pooled budget and to allow the establishment of a full Joint committee we plan to move to a new governance arrangement to reflect this as soon as we are able to (subject to national timetable on legislative change)

9. Joint planning of local services and accountable care

Our current work arrangements
With the robust governance structure in place and to support the implementation of integrated commissioning as described in the previous section Hackney (and the City) has been working to develop integrated plans between the Local Authorities and CCG to transform local services. Whilst responsibility has remained with the statutory bodies, the Transformation Board with its partnership members has continued to debate local issues and has taken on the role of supporting the development of and reviewing our local five year integrated plans that address both local issues and the NEL STP challenges.

To further our ambitions and support the delivery of the STP, this year we have embarked on a significant integrated planning programme across the CCG, the two local authority adult and children's social care commissioners and the two public health commissioners to:

- Review our local performance against all metrics and outcomes
- Review our local priorities for change in the context of the STP base case and our own plans which are supporting the delivery of the STP priorities and local priorities
- Review the action plans in place across the 3 statutory commissioning organisations to support performance improvements
- Review the local delivery arrangements and contractual agreements currently in place which will form year 1 of both the STP and our own plan

We are currently finalising the review of individual commissioner workplans, undertaking peer challenge of what we are doing and exploring the scope for where we could do more by working together and aligning our approaches and contracts so that we can make a greater contribution to improving outcomes for our patients and delivering the STP ambitions.

Our delivery plans are being developed by our four care workstreams:

- Unplanned care
- Planned Care
- Prevention
- Children and Young People

The ‘asks’ of the unplanned care, planned care and prevention workstreams are attached at Appendix 3. The children and young people’s workstreams began its work in October 2017 and the workstreams asks will be finalised by December 2017.

These workstreams are establishing where we now need to focus our efforts; what the transformation initiatives we need to deliver are, the year on year improvements we will aspire to make and the system responsibilities and milestones for measuring progress and success.

Supporting the workstreams are our enabler workstreams: workforce, estates, digital/IT and primary care quality.

This joint planning work aims to create an environment that focusses on integrated working, provider collaboration and whole system productivity. It will also allow us to align budgets to our plans and understand how our individual contracts are supporting delivery. We believe this focus will also help our Integrated Commissioning Boards to identify where we could do more. We are also framing our work in the context of the Marmot principles so we explore how to lever the benefit of integrating the wider range of local authority services. We believe

this work is the prerequisite condition for moving rapidly towards an accountable care system.

Towards an accountable care system

Accountable care systems have been cited as new models that overcome fragmented responsibility for commissioning and the provision of care; something that Hackney has been working towards via our work to date and our devolution pilot. Hackney has taken steps and demonstrated a strong ability to work collaboratively with local partners and overcome organisational and professional silos and as detailed in the previous section has extensive patient and clinical collaborative planning and delivery of locally based services.

Devolution is important in ensuring Hackney is able to successfully continue integration and move closer towards becoming recognised as an accountable care system. We would explore how we could provide much better local signposting and advice to local people, promote self-help and management and have a unified digital platform. Including looking at creating a range of premises that deliver social value to the local community through health, wellbeing and social care services as well as those impacting on the wider determinants of health.

As we move towards an Accountable care system across City and Hackney and, in doing so, explore taking on a capitated budget, this would have implications for the model of commissioning and it is likely that a number of current commissioning functions would merge into the integrated organisation.

With devolution and legislative change to s75 and the ability to fully pool budgets we look forward to using our collective levers to align incentives and budgets and to have fully aligned contracts during 2018 whereby single contracts could be granted to each provider, assuming the landscape remains unchanged.

The statutory commissioners, (the CCG and local authorities) would still carry ultimate responsibility for commissioning and setting the outcomes, but would review what the residual local integrated commissioning function would look like within the STP footprint. We recognise some services will be better commissioned at scale at an STP level but still with a wide range of integrated community and out of hospital health and care services commissioned locally given the local focus of our providers, what we need to do locally to achieve the STP and the local ambitions of our residents and the two Health and Wellbeing Boards.

10. Our journey so far with future models of care

With integrated planning and governance and pooled budgets we can move faster on making the future models of care a reality.

Turning the plans into reality will require the development of new delivery models which the Board has been working on collectively. Our fundamental principle is the best use of the Hackney pound by services working together and taking collective responsibility to improve outcomes across organisational boundaries.

This focus on social value and 'additionality[6]' puts our patients and local communities at the centre of our model in order to working alongside local organisations using a co-production approach.

Service users and citizens of Hackney, together with other stakeholders will continue to be involved in the redesign of local health and care services. This will ensures that patients will be empowered to manage their conditions, supported by a range of voluntary and community based services to promote health and wellbeing.

This chapter describes the progress we have made in developing new models of care under the banner of integration and how devolution will help us accelerate the progress against these.

Neighbourhoods

We are currently exploring our neighbourhood model that will be organised in distinct and discreet geographical areas.

By formalising these, the aim is that the delivery model will improve outcomes and better integrate services and care for local people. GPs will act as the main coordinator of care, supported by a range of community based services working together to meet the needs of our population.

In the proposed neighbourhood model GPs will work collaboratively as a network in each of the neighbourhoods to:

- Deliver high quality care and extended services to uniform and consistent standards.
- Deliver extended opening hours and a stepped increase in digital access.
- Achieve 100% population coverage for all services within each quadrant through collaborative working.
- Support people to access the range of prevention and wellbeing services in each quadrant through social prescribing and closer work with our voluntary sector.
- Deliver improved outcomes and evidence based secondary prevention for people with long term conditions.
- Identify and provide proactive care and support to our most vulnerable patients and those with mental health problems.

[6] "Additionality is the extent to which something happens as a result of an intervention that would not have happened in absence of the intervention".
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191511/Additionality_Guide_0.pdf

- Reduce emergency admissions and support the achievement of our better care fund metrics.
- Align interventions and efforts during the critical first 1000 days of life.
- Continue their work on demand management through referral discussions, audit and peer challenge and review.

Single point of coordination

The second major delivery plank of integration is the single point of coordination. Starting by bringing the integrated independence team (hospital and social care combined assessment early intervention and rehabilitation team) together with paradoc (our in hours GP visiting service working with the London Ambulance Service and local nursing and care homes) with a common offer and assessment process this will become the main access point to all crisis care services and link with nhs111. It will ensure people can stay at home by rapidly putting in place an intervention and care package backed up by our quadrant and primary care model; a process which we expect to make a real difference in reducing hospital activity and hospital length of stay as well.

Organisational development and enablers

These are both significant integration projects; bringing practitioners from different disciplines and providers together to streamline assessment and care management systems and align inputs around each patient. Close links with our enabler groups will facilitate efficient and effective programme development and execution.

Our Community Education Provider Network was funded with £1.4m initially via the workforce enabler group to support our delivery plans with initiatives including:

- The piloting of a new care assistant role (This role will work across the practitioners to free them up to concentrate on specialist input),
- The new quadrant team leader role,
- Extension of our long established practice based prescribing advisers,
- Piloting the development of our integrated nursing model,
- A new medical assistant role for primary care.

Further funding is being made available for additional work in 2017-18.
We are also making progress with developing new roles that work across traditional organisational boundaries. For example, we already commission a duty doctor scheme from the confederation to ensure GP availability for urgent requests from patients and local practitioners, Homerton staff and LAS and the GP Confederation have also developed a salaried GP model to support primary care resilience and free up valuable GP time so that they can concentrate on the high risk patients.

The CEPN is also working with Homerton A&E, CHUHSE and the GP Confederation to explore rotations and initiatives to increase resilience in the emergency care workforce.

However we recognise that we need to work together and with HEE to tackle the increasing workforce problems we face in primary care (GPs) and in acute services (A&E, Anaesthesia and Obstetrics) as this could destabilise our plans. We are keen to work with the vanguards and other pilots to explore work elsewhere on new workforce roles and initiatives to address recruitment and retention - and understand how any offers on the London devolution menu could support us. We are also keen to use our estates strategy to look at key worker housing in line with London priorities.

The IT enabler group has plans to increase digital access to primary care. We already have some of our health information systems talking to each other which will again see a step change improvement when 'Coordinate My Care (CMC)' becomes the Hackney care plan in April 2017.

We are considering how best to contract for the services which encourages collaboration but also binds the providers together to focus on reducing avoidable hospital activity and achieving the metrics and outcomes we have set. Integrating commissioning across the CCG and LAs will also be used to align incentives and clinical behaviours and will allow us to do more and have a greater impact on both outcomes and the provider landscape than we can as separate commissioners.

We all recognise that further new organisational arrangements may emerge from this model as it is embedded and as the organisational development work moves forward – it is the building block for our accountable care system and for any potential accountable care organisation.

We have put in place a large organisation development programme to support practitioners to work together using common assessment processes and common operational policies, trusting each other's assessments and judgements to deliver an integrated offer. This needs alignment across organisations and is building on the two year One Hackney and the City pilot of integrated community based teams. We expect this work to identify changes in working practices, better alignment of services, new workforce roles and ultimately new organisational delivery arrangements which wrap integrated services around patient needs and support them in community settings as much as possible. It should deliver savings through integrated delivery as well as through continuing to reduce emergency admissions.

We are committed across the partnership to reviewing progress and considering our strategic direction every 3 months as this model is implemented – from February 2018, we plan to roll out our neighbourhood model, subject to learning and capacity, to focus on how the wider community teams can support practice work with patients with long term conditions. This will link with both our self-care work which offers extended GP consultations for people with multiple Long Term Conditions and cancer and our social prescribing service, a sign posting service aimed at enabling individuals to feel more in control and reduce social isolation. We are also keen to make better links with housing associations recognizing the important role they can play in both admission avoidance and prevention as well as supporting discharge. We already commission a home from hospital service from Age UK which has the potential to make much wider links with housing and other community based services.

Our estates strategy:

We are determined to think about community value as we plan our estate - working with local people in each quadrant to get their views about local needs and assets - and thinking about how buildings can deliver wider community gain beyond traditional health and social care services.

There are 94 properties across health and the Local Authority within Hackney with mixed public ownership. 29% are owned by Hackney Council, 19% by NHS Property Services,

14% by GPs and 14% by the Church of England; only 17% of all properties have more than one usage at present.

Our estates strategy aims to ensure:

- Sufficient capacity to support our quadrant model - gains will come from team co-location. We have agreed a campus or network approach in each quadrant, rather than one central building as we need to be realistic about what can be achieved.
- That we capitalise on the One Public Estate programme which is focused on delivering more integrated and customer focused services, creating economic growth, reducing running costs and generating capital receipts.
- We have fit for purpose general practice buildings. This could in some cases, lead to the consolidation of some practices as we explore the opportunities from the current estates footprint and look at the creation of new premises. Whilst 40% of primary care premises need investment, our patients tell us they value local provision over centralisation. Our plans will also need to ensure we have capacity for our increasing population.
- We plan our estate across health and local authority and move to much more shared use and collocation of health wellbeing and wider Local Authority services.
- A strong focus on housing - both to ensure affordable housing for a local workforce and ensuring that we can impact on health through housing, particularly for those from vulnerable groups.
- Link with the Community Wholecare Project - a programme conceived by the Church of England to develop local community centres providing health social and spiritual care on land adjacent to Church of England churches. There are 13 potential sites within Hackney including one submitted through the Estates and Technology Transformation fund. More detailed of our estates aspirations are in appendix 4.

GP Confederation

We are continuing to encourage the development of our GP confederation - it is a crucial building block for local high quality and sustainable general practice delivery and has well tried methods to improve standards across practices, share best practice and ensure uniform quality in service offers.

It holds a number of two year contracts for enhanced services and has been instrumental in achieving population coverage for all services. Through its salaried GP scheme it is supporting practice capacity and resilience and we will be consolidating this role through commissioning them to deliver a range of quality improvements in individual practices against our primary care dashboard.
The confederation currently delivers a range of services including: smoking cessation from the Local Authority, dressings, wound management and phlebotomy, which have all resulted in a shift into the community to meet the expressed wishes of our residents. The confederation works closely with the provider of the GP out of hours services CHUHSE, to mitigate manpower issues and is implementing a digital offer across practices.

The confederation is also working closely with Homerton and East London NHS Foundation Trust to develop more integrated services ensure high quality senior clinical input in the community to support and enhance the work of practices and runs a significant clinical education and skills development programme for GPs, Practice Nurses and the wider practice team.

Integrated pathways

To support our early years offer we have undertaken significant work with Homerton Hospital on developing pathways for vulnerable women. We have commissioned a preconception and antenatal offer from GP practices via our confederation along with an integrated pathway for obese women and those with medical risk factors. We commission a mental health service in schools and have commissioned a service via the confederation focusing on the identification of vulnerable families and children, working with Health Visitors to develop care plans, as well as the identification and review of children with long term conditions. This is aligned with the early years' service commissioned by public health from Homerton and the services commissioned from children's centres. Whilst we have a wide range of services which are important building blocks for an early years offer, we have more to do to integrate these into a combined offer which brings in mental health needs and which appropriately targets services on the vulnerable population and specially impacts on the critical first 1000 days, where there is a strong evidence base for effective intervention. We plan to do this via integrated commissioning and focusing providers on collective responsibility for outcome improvement.

We are developing integrated offers around obesity and smoking. These are significant health issues and areas where through integrated commissioning and aligned service delivery we can do more to really make an impact and deepen the reach of our commissioned services. These will be complemented by our proposed devo powers relating to public health as per the London Devo MOU. Which will have a particular impact on our primary prevention strategy.

All of our initiatives are gradually aligning the range of different practitioners, services and organisations we have in Hackney in the pursuit of common aims and outcome improvement, where residents needs take precedent over organisational loyalties. We recognise that efforts will be required to align operational arrangements, remove duplication and waste, and ensure different services are working together with a consistent and unified focus and plan to learn from our pilot work on One Hackney and the City and on the development of the Integrated Independence Team as we move forward.

Integration of back office functions

Our other development initiative is building on the NHSI and STP initiatives relating to back office where we have agreed to explore a range of local integrated solutions to achieve financial savings including: A common interpreting, advocacy and translation service; a common transport system across providers and the consolidation of individual primary care back office functions into the GP confederation. This complements the wider STP work on more traditional back office functions such as IT, HR and financial systems.

How devolution will help us go further

The Transformation Board partners have agreed a set of monthly gateways to drive the embedding of the two most developed delivery models (quadrants and single point of coordination). This will drive delivery and at each stage deepen the integration and expected impact.

As legislation changes and Hackney's new models of care mature and lessons are learnt from these initiatives and new models elsewhere we plan to formalise and create a more coordinated system of delivery and we want to begin to explore the options for this. We don't want to change organisational arrangements unless and until we are convinced it would have a positive effect on our residents and on outcomes.

Similarly, whilst we are committed to exploring different contractual arrangements, there is more work needed to finalise the preferred option. We want to understand the impact of our pilot in crisis care, emerging models across the STP and how local integrated commissioning develops and explore what others are doing in order to ensure the new contracting arrangement delivers the biggest positive impact on our residents and on outcomes.

We are also keen to access other available devolution powers to support our work be they in relation to workforce planning, education and role design. We will also work closely with other pilots moving to new delivery models and contractual arrangements to ensure best practice is shared and learn from each other. We are keen to work with the vanguards and new models of care programme - we have much to learn and much to contribute.

Areas requiring further work:

The following section summarises the areas where we know there will be future proposals around new ways of working. We request collaboration with national partners in taking forward these elements of work.

a. Integrated commissioning: New payment model

Current context and limitations:
Current payment models do not always necessitate collaboration across the system to improve care for Hackney residents and some payment models do not help drive costs out of the system or promote prevention and early intervention.

This is because traditional payment models, such as episodic or block payments, incentivise a focus on individual aspects of an overall care pathway. Developing an integrated care system therefore requires a new payment model to support the overall objectives of integration and ensure that the system as a whole is incentivised to address identified issues and improve the overall care pathway within an expenditure limit. The recent focus on developing outcomes-based contracting and capitated payment systems illustrates the desire to move towards new payment models.

We also know that current payment models do not always facilitate or support integrated working, demand management initiatives or shifts of care into community settings.

Our requests:
We welcome the invitation by NHS Improvement and NSH England to explore new contractual payment models which will maintain financial balance and support delivery of control totals. We would seek a commitment by NHS England, NHS Improvement to support us to co-develop and adopt innovative models of payment within the emerging new funding model which recognises our level of integrated commissioning and provision.

The benefits this will deliver:
Moving to outcomes-based commissioning and capitated payment models will help address some of the current issues and help shift focus to ‘upstream’ activities that promote health, wellbeing and staying well. As integration proposals develop, new payment models may also emerge to address specific local needs/arrangements and the focus on control totals and expenditure limits. What we would like to see around the development of new payment models are linked to those relating to governance (including greater ability for CCGs and

local authorities to develop joint working) and the pooling of budgets, both of which are important in enabling truly capitated payment systems and joined up planning

b. Integrated commissioning: system based regulation

Current context and limitations:
Current regulatory frameworks can mean that there is a lack of formal coordination across health and social care. With different elements of patient pathways being inspected separately and at different times. This can result in uncertainty, duplication and inconsistency in approach. This can increase the administrative burden on providers and commissioners in terms of demonstrating compliance and reporting. For instance, CQC inspections focus on individual provider organisations and will reflect feedback received as part of that process in terms of how well the provider works with its partners but will not have inspected the services related to the partnership at the same time.

This can mean that issues involving multiple organisations (e.g. delayed discharge or pan organisation pathways) are not fully tested /or explored.

Our requests:
Commitment by NHS England, NHS Improvement and CQC to explore new ways of inspecting and regulating health and social care. This would focus on developing a model that means regulation is flexible and responsive enough to adapt with the sectors as they change. For example looking at regulation that encourages improvement and learning in health and social care systems through focus on:

- **Place** – assessing how well organisations are working together to provide health and care services for specific populations and in specific local areas (for example in the way CQC safeguarding inspections look at place based pathways across organisations)
- **Pathways** – improving information about the quality of care that specific populations experience as they move between services and organisations

Approaches could include:

- The ability for an integrated / single delivery system to be regulated as a whole, despite underlying distinct organisational operating units (e.g. CCG, LA, NHS FT, NHS Trust, other providers).

- Assurance and regulation of individual units operating as part of an integrated delivery system to be managed by the overall system, adopting a similar approach to that used in Greater Manchester in relation to CCG assurance and building on the proposed approach for integrated care vanguard sites.

The benefits this will deliver:
A regulatory approach that crosses organisational boundaries and ensures linkage between what the respective regulators are assessing would support the objectives of integration. This would allow regulators to join up and present an aligned approach to address issues which span a number of organisations. This would mean enable:

- A reduction in administrative burden across organisations.
- An aligned, system approach to address issues which span a number of organisations.
- Focus on patient journeys rather than organisational boundaries.

11. Links to the North East London Sustainability and Transformation Plan

The Five Year Forward View has set out the ambition to provide new models of care to patients and to join up services between health and social care. The North East London Sustainability and Transformation Plan (NEL STP) has put this ambition into deliverable outcomes. These outcomes include, improved health and wellbeing outcomes for the people of north east London, sustainable services built around the needs of local people, the development of new ways of working in partnership to deliver services and prevent ill health. Our devolution plan will direct the practical delivery of the Five Year Forward View and STP ambitions across Hackney. We have been active partners in the STP process with both provider and CCG representatives leading specific workstreams, and our devolution pilot and integration plans are a critical part of the system delivery architecture and new models across NEL STP. We will now be able to go further in delivering the STP ambition, by empowering local solutions for our population.

We are working as part of our STP area to:	**How integration and devolution will help us go further:**	**Local examples of delivery**
Ensure that we channel demand with appropriate capacity: We have a fast growing, mobile and diverse population and this is putting pressure on all our services. We need to change to channel the demand for services through: • Maximising prevention • Supporting self-care • Innovating the way we deliver services	Legislative permissions to regulate gambling, smoking, unhealthy eating will enable us to develop a local environment that is better able to encourage people to lead healthier lifestyles, reducing instances of illness and poor health and in turn the growing demand on health and social care services.	• Increasing our work on primary prevention – linked to premature mortality • Continued focus on secondary prevention • Continued demand management work via the CCG commissioning and engagement contract with practices and planned care work (workstream on pathways/new models, diagnostics) • Early years work • Work to reduce procedures of limited clinical value and medicines management

Transform our delivery models to support self-care, deliver better care close to home, and high quality secondary care: Transforming our delivery models to empower our residents, and tackle variations in quality, access and outcomes. Leverage community assets and ensure residents are proactive in managing their own health, and receive co-ordinated, quality care in the right setting.	Joint governance and planning will enable us to commission services that span the health and social care divide and focus on wellbeing and wider local authority services as well as health. Further decision making powers over our estates will enable us to determine how best to utilise our existing assets, and retention of capital receipts will allow us to invest more in modernising our health and social care settings to make them fit for purpose and provide opportunities for greater community assets.	• Development of our quadrant model of care across the borough • Enhanced primary care provision through the GP Confederation • Developing single point of coordination • City of London -specific models taking into account their unique needs

Ensure health and social care providers remain sustainable: Our hospitals have made significant progress in productivity and improvement programmes, but cannot succeed in isolation. They need to collaborate on improving the costs of workforce, support services/back office and diagnostics.	Through enabling pooling of resources over and above that currently permitted in s75 and similar agreements, we can minimise the transaction costs between health and social care organisations, and more freely joint plan services to enable joint service delivery. We are exploring local opportunities for shared services.	We have begun exploring opportunities for consolidating back office functions across health and social care organisations. Through an integrated commissioning model we can support joint planning, and keep transaction costs to a minimum.

12. Financial impact

It is anticipated that the devolution programme will deliver a minimum of £15m[7] NHS commissioning savings, support providers in delivering their cost improvement plans and bridge the local funding gap within social care.

Savings will be delivered across our new models of care through:

- Fully integrated health and social care teams working with primary care.
- Utilising digital technology to improve our services.
- Developing the most appropriate organisational form/system of care to maximise the outcomes from our out-of-hospital model of care and to seek to increase the speed of service integration.
- Developing capitated budgets for new care models that provide financial freedoms to support the development of an integrated place- and outcome-based system. Merging the distinction between commissioner and provider functions will create the potential to reduce the transactional costs involved in the delivery of health and care services.
- A prevention strategy facilitated by devolution status that is directed towards population health.
- Prioritising encouragement of self-care and promoting independence for those who do not yet need long term services.
- Consolidation of back office functions between partners.

We will be further refining the financial model in Q4 of 2017/18. Savings will continue to be identified as work on new models of care, and enabler groups' progress, and will be further worked up during.18/19.

Examples of how we will deliver savings specific to the new models of care include the following:

Neighbourhood Model

Building on the concept of One Hackney and the City, a non-recurrently funded project running for two years using alliance contract and outcomes model, we will establish a fully integrated community health and social care team operating in each neighbourhood.

Single Point of Coordination

Coordinating community based services around GP practices at a quadrant level and creating a physically integrated single point of coordination (SPOC) across providers will:

[7] As identified within the North East London STP

- Reduce the need for hospital or residential care admission.
- Support community based responses to urgent needs from health and social care practitioners, care homes and London Ambulance Service and reduce conveyances to hospital.
- Enable rapid decisions and activate a service response at quadrant or practice level to make sure individuals don't fall through the gaps and are directed to the right place in order to avoid admission to A&E.
- Reduce the length of hospital stays and delayed transfers of care through supporting earlier discharge and joint work with secondary care.

Pathways

Hackney has a long track record of high-quality shared clinical design of pathways that keep care closer to home that have resulted in low referral rates for outpatients. We will build on the trust and confidence of successfully working together with committed patient involvement to enable further care models that meet our aspirations to optimise care and maintain financial stability.

Changes to these pathways through the out-of-hospital care model and devolution pilot include:

- Children's health: Strengthening liaison between GPs and Children's Centres, health visitors and school nursing with pathways to ensure the early identification of struggling families, a focus on mental health and on antenatal care, timely, more appropriate and more cost-effective intervention particularly to impact on the first 1000 days of life.
- Integrated Care: Use One Hackney and the City alliance approach to further reduce length of stay and continue to develop continuity of care and patient led care plans with enhanced choice of preferred place at end of life and continue the use of Co-ordinate My Care (CMC) by all providers. It has been agreed that all care plans will be transferred to CMC by 1/4/17.
- Urgent Care: Develop a local Single Point of Coordination to ensure rapid access through integrated clinical response, as above.
- Long term conditions: Implement the renal pathway of proactive patient identification of AKI (acute kidney infection) across primary and secondary care with an e-referral service which should delay the need for future renal dialysis.
- A roll out of the proactive case finding and e-referral model which can now be efficiently deployed to other services using the work done on renal as the approach.

A Strong Safe Local Hospital

Underpinned by a contractual arrangement based on capitation, aligned levers and outcome delivery, a strong safe local hospital will deliver:

- High quality 7 day services, integrated with mental health resources and networked with other local hospitals where necessary.
- Fewer face to face outpatients - replaced by digital solutions.

- Support and expert advice to primary and community care.
- Demand management of tertiary service.
- Reductions in variations between teams.
- Minimal length of stay, thanks to good primary and community services which command universal clinical confidence, delivered by the quadrant model.

Workforce

We will implement new workforce models and take a more radical look at skill mix across teams. Workforce was identified in 2015 as a major risk to delivery of future models and pilots project have been pump primed with £1.4m from the CCG via the CEPN for 2016/17, such as:

- Salaried GPs working across core and extended primary care, emergency care and out of hours care
- Interchange of hospital and primary care based doctors and nurses
- Practice based pharmacists
- Combined community nursing teams including MH practitioners based around primary care
- Health care assistants working across primary and community/social care
- Combined health and social care practitioner roles
- Medical assistant role in primary care
- Team leaders
- Care navigators and coordinator roles

Integrated Commissioning

The parties have pooled NHS and social care budgets to support joint planning and achieve clinical and financial sustainability. A section 75 agreement has been agreed for 2017/18 with further pooling planned, subject to the approval of business cases, in 2018-19.

Integrated commissioning will:

- Enable maximum benefit to be gained from the ‘Hackney pound’, while keeping the transaction costs of commissioning to a minimum.
- Maximise the two parties’ existing financial flexibilities and identify areas of further integration and devolution
- Facilitate greater opportunity for back office savings on a borough-wide basis as well as creating estate opportunities once the model has bedded down.

As the model develops we will continuously review how much we could transition our current commissioning function into the new delivery model. This will need to take into account how much commissioning could be better be transacted at scale via the STP footprint.

Digital Roadmap

The CCG has invested £5m over two years to accelerated the delivery of integrated IT and the digital roadmap which will underpin the integration model. This is key to:

- Ensure greater efficiency by enabling patients to have greater self-management and to crossing organisational boundaries.
- Joint working and care delivery systems will be underpinned by information to improve patient outcomes.

Back Office Functions

The devolution programme is committed to minimizing costs for back office functions within the locality and has completed a review of all back office functions provided by devolution partners. With an estimated total of £43m spent per annum on back office functions for partners, we will build on some of the lean principles which have enabled the CCG to have the lowest running costs in London, being £4per head cheaper than the next lowest and more than £9 per head cheaper than the most expensive. This programme of work will also complement the work on consolidation of back office functions being led by North East London STP for NHS providers. We are keen to focus on opportunities across our local system on transport, interpreting and translation as well as GP practice back office functions delivered by the GP Confederation.

Savings from estates

The devolution programme considers NHS and Local Authority estates in tandem and fully supports the need for cost savings to be delivered through sweating the existing asset base and looking at co-delivery of projects and services. It has identified a number of local opportunities to support both the clinical strategy and the need to reduce estates costs.

Devolution of powers and local ownership would accelerate the potential to release savings.

13.Risk, mitigation and exit strategy

Risks to the proposed approach

Devolution is a new approach that requires CCGs, Local Authorities and providers to work together more closely than ever before to plan and deliver health care collaboratively. The STP Programme supports the same ambition. There are inherent strategic and operational risks to the proposed programme of work and we are setting up robust monitoring and governance arrangements to ensure potential risks are identified, captured and managed effectively and comprehensively.

Key risk areas include:

- **Culture:** Fostering constructive joint working in order to develop, agree and implement transformational plans across health and social care at both strategic and operational level – achieving consensus on common goals and trust amongst the partners whilst maintaining pace in implementing our transformation plans realising the patient benefits and supporting and inspiring our front line staff to work in the same way as leaders.
- **Governance:** Agreement and implementation of necessary underpinning financial and commissioning architecture.
- **Transparency:** Lack of transparency and visibility around co-dependencies within care and enabling workstreams.
- **Accuracy:** Access to timely and accurate system data to support timely management remedial action across the system.
- **Outcomes:** Tracking progress against improvement in clinical outcomes.
- **Risk Sharing:** Agreeing how risks are shared by different partner organisations
- **Data:** getting specific data for the City of London separate from Hackney data.
- **Stakeholders**: Gaining the necessary support and buy in for the work across health and social care – this includes staff, patients and our citizens and ensuring we work with them as equal partners at a time when the health and social care system is under pressure and there are concerns about impact of reducing money on local service provision.

Our financial framework sets out the initial terms by which we will pool budgets and manage financial risks.

Mitigation

We have a robust governance structure established with members/partners who have defined roles and responsibilities. This will allow risks and issues that are to be monitored in line with project management best practice, as detailed below, to be escalated rapidly and mitigated through collective involvement at the transformation board as required.

Low level risks will be monitored and managed by care and enabler workstream project managers and escalated to the PMO. Programme-level risks and mitigations will be informed by the PMO and escalated to the Transformation Board.

Clinical and financial risks will continue to be managed through the statutory organisations until partners are comfortable to transition responsibilities to the new arrangements.

During 2017/18, a full assessment of risk arising from further devolution, and a robust mitigation plan, will be developed to ensure that quality, safety and finances are protected within the revised accountability arrangements. This will include of clinical risk, financial risk and performance is managed across the new structures.

We are committed to continuing to engage local people both in co-design and in an honest dialogue about what we are doing and why – we have a history of involvement and of transparent decision making and these values will continue to underpin our approach.

We have a very stable leadership community in Hackney which we believe is critical to enabling us to deliver our plans as a result of the history of joint working and trust between partners and individuals. Without this trust and set of senior relationships we recognise that as financial pressures start to bite and integration meets some challenges, it could become easy for partners to go back to working in organisational silos. We as a group of senior leaders across the partnership are committed to working together to ensure this doesn't happen and that the needs of our residents and the success of Hackney will always come first.

The project support (PMO) and infrastructure to support our plans is fully funded and we also have extensive political support for our plans across both Hackney and the City of London.

Exit strategy

Where there is a risk to delivery or a change in the context, partners will need to make a decision on whether to continue the programme of work. This will be managed through agreed gateways and oversight of delivery plans and performance.

These gateways will be designed to mitigate risks and protect quality, safety and finances in the case of failure.

In such circumstances where the programme is viewed as unviable or a sub optimal solution and stopped, powers will revert back to City & Hackney CCG, City of London Corporation and London Borough of Hackney as statutory bodies. This will be captured in the detailed terms of any formal legal delegation and devolution agreements.

14. Programme Timeline and next steps

Overarching strands of work and core workstreams

Our programme activity was organised around four sequential strands of work facilitating full coverage of our population under the new model by 2020-21. These are:

1. Negotiation of devolution by national partners
2. Development of new working arrangements within current powers
3. Implementation of joint commissioning arrangements
4. Implementation of new arrangements in light of proposed legislative change

At the core of this work will be continued development and elucidation of joint commissioning arrangements across the four care workstreams: prevention, planned care, early years and crisis/quadrant working.

Enabler workstreams

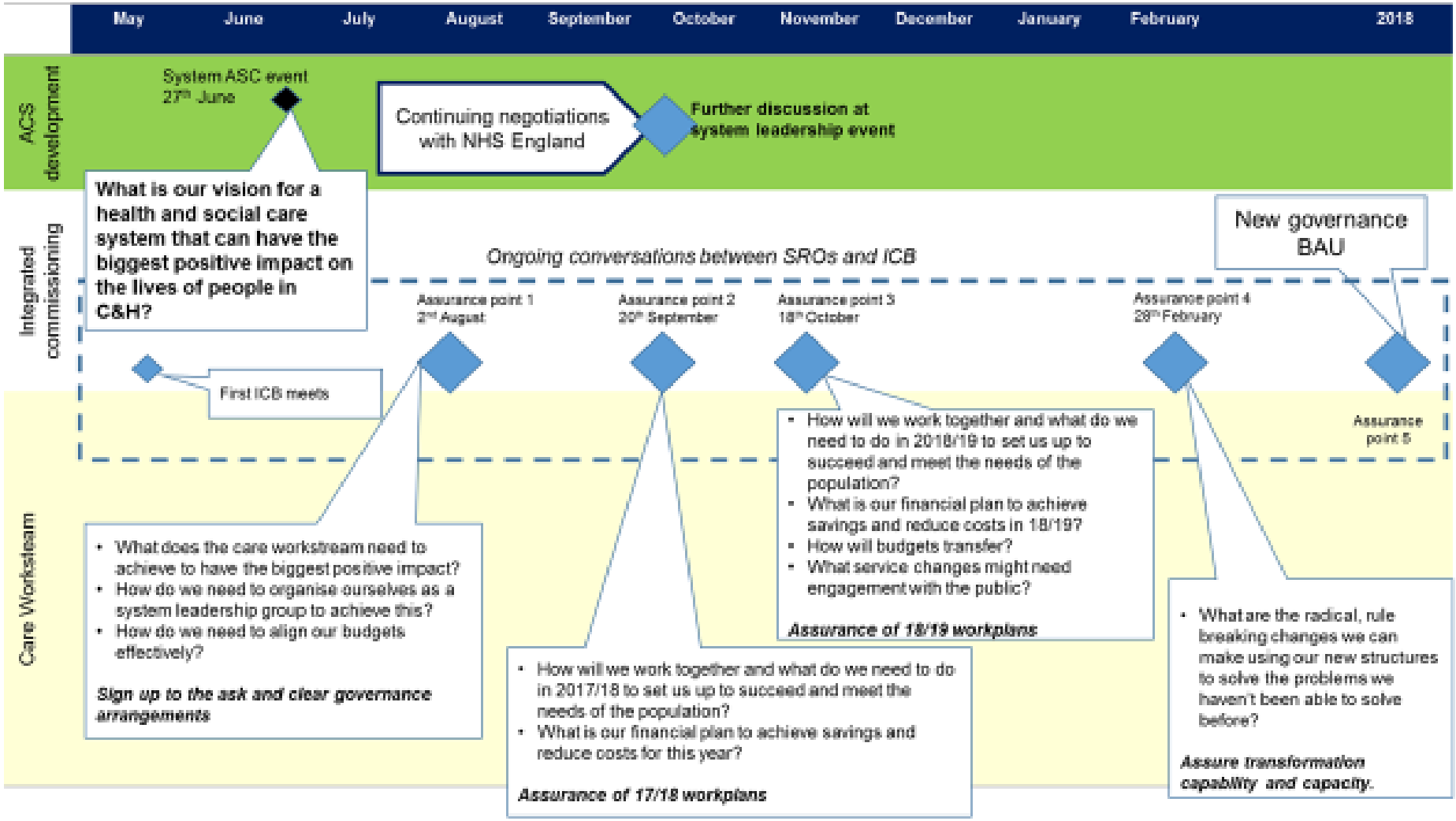
Particularly in the development phases, work to understand, map and proactively manage dependencies and co-dependencies within the enabler workstreams will be vital. Key focus areas will include:

- Estates: mapping to quadrant model, STP planning and feasibility study across the public estate
- IT: roadmap for information improvements, information access and architecture
- Workforce: implementing the workforce initiatives to deliver the new models
- Primary care quality

Effective communications and engagement, designed in line with work underway in the care workstreams, will support the activity through to implementation of devolved arrangements and we have funded specific support for engagement and communications.

Programme delivery

As part of the programme delivery we funded both a Programme director and programme management office to ensure delivery against our deliberately ambitious timeline.


May
June
July
August
September
October
November
December
January
February
2018
ACS development
System ASC event
27th June
Continuing negotiations with NHS England
Further discussion at system leadership event
What is our vision for a health and social care system that can have the biggest positive impact on the lives of people in C&H?
Integrated commissioning
Ongoing conversations between SROs and ICB
New governance BAU
Assurance point 1
2nd August
Assurance point 2
20th September
Assurance point 3
18th October
Assurance point 4
28th February
Assurance point 5
First ICB meets
Care Workstream
• What does the care workstream need to achieve to have the biggest positive impact?
• How do we need to organise ourselves as a system leadership group to achieve this?
• How do we need to align our budgets effectively?
Sign up to the ask and clear governance arrangements
• How will we work together and what do we need to do in 2017/18 to set us up to succeed and meet the needs of the population?
• What is our financial plan to achieve savings and reduce costs for this year?
Assurance of 17/18 workplans
• How will we work together and what do we need to do in 2018/19 to set us up to succeed and meet the needs of the population?
• What is our financial plan to achieve savings and reduce costs in 18/19?
• How will budgets transfer?
• What service changes might need engagement with the public?
Assurance of 18/19 workplans
• What are the radical, rule breaking changes we can make using our new structures to solve the problems we haven't been able to solve before?
Assure transformation capability and capacity.

Appendix 1: Terms of reference for the Integrated Commissioning Board

NHS CITY & HACKNEY CLINICAL COMMISSIONING GROUP ANDTHE LONDON BOROUGH OF HACKNEY

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

The London Borough of Hackney (LBH) has established an Integrated Commissioning Committee and NHS City & Hackney Clinical Commissioning Group (the CCG) has also established an Integrated Commissioning Committee. Those two committees shall meet in common and shall be known together as the Integrated Commissioning Board ("the Board").

LBH's Integrated Commissioning Committee has authority to make decisions on behalf of LBH, which shall be binding on the authority, in accordance with these terms of reference and the scheme of delegation and reservation.

The CCG's Integrated Commissioning Committee has authority to make decisions on behalf of the CGG, which shall be binding on the authority, in accordance with these terms of reference and the scheme of delegation and reservation.

Except where stated otherwise (in which case the term "committees" is used), all references in this document to the "Board" refer collectively to the two committees described above. The Role and Responsibilities of the Board, as described below, are the roles and responsibilities of the individual committees insofar as they relate to the individual committee's authority.

The CCG and LBH committees (i.e. "the Board") will manage the Pooled Fund element of the Integrated Commissioning Fund in the delivery of the Locality Plan. For Aligned Fund services the Committees act as an advisory group making recommendations to the CCG Governing Body or the LBH Cabinet.

Role and Responsibilities of the Board

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

The Board's remit is in respect of services that are Pooled Funds (including the Better Care Fund budgets) within the Integrated Commissioning Fund (ICF). The Board also has a remit with regard to Aligned Funds, whereby it is an advisory group making recommendations to the CCG Governing Body or the LBH Cabinet.

The CCG and LBH shall determine the funds, and therefore the services, that are to be pooled or aligned at any time (and shall include requirements in respect of Better Care Fund budgets). Once defined, the remit will be stated in these Terms of Reference or in another appropriate document that is provided to the Board.

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

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

The duties of the Board defined below are subject to its Scheme of Delegation and subject to the financial framework which outlines which budgets are pooled and which are aligned and the role of the Board in relation to each.

Specifically, the Board will:

Commissioning strategies and plans

- Lead the commissioning agenda of the locality, including inputs from, and relationships with, all partners
- Ensure financial sustainability and drive local transformation programmes and initiatives
- Determine and advise on the local impacts of commissioning recommendations and decisions taken at a NEL level
- Ensure that the Locality plan is delivering the local contribution to the ambitions of the NEL STP
- Lead the development and scrutiny of annual commissioning intentions as set out in the Integrated Commissioning Strategy, including the monitoring, review, commissioning and decommissioning of activities
- Provide advice to the CCG about core primary care and make recommendation to the CCG's Local GP Provider Contracts Committee
- Ensure that the locality plan delivers constitutional requirements, financial balance, and supports the improvement in performance and outcomes established by the Health and Wellbeing Board
- Promote health and wellbeing, reduce health inequalities, and address the public health and health improvement agendas in making commissioning recommendations
- Ensure commissioning decisions are made by the ICB in a timely manner that address financial challenges of both the in-year and longer term plans
- Ensure that local plans can demonstrate their impact on Hackney residents.

Service re-design

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

Contracting and performance

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

Stakeholder engagement

- Ensure adequate structures are in place to support patient, public, service user, and carer involvement at all levels and that the equalities agenda is delivered,
- Ensure that arrangements are in place to support collaboration with other localities when it has been identified that such collaborative arrangements would be in the best interests of local patients, public, service users, and carers

- Ensure and monitor on-going discussion between the ICB and provider organisations about long-term strategy and plans

Programme management

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

Safeguarding

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

Geographical Coverage
The responsibilities for the Board will cover the geographical area of LBH.

It is noted that there will need to be decisions made about how to address the issues of resident and registered populations across the CCG and LBH.

Membership
The membership of the LBH Committee shall be as follows:

- LBH Lead Member for Health, Social Care and Devolution
- LBH Lead Member for Children's Services
- LBH Lead Member of Finance and Corporate Services

The membership of the CCG Committee shall be as follows:

- Chair of the CCG
- CCG Governing Body Lay Member
- CCG Chief Officer

As the two committees shall meet in common, the members of the LBH Committee shall be in attendance at the meeting of the CCG Committee, and the members of the CCG Committee shall be in attendance at the meeting of the LBH Committee.

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

- CCG Governing Body GP
- CCG Chief Financial Officer
- LBH Group Director – Finance and Corporate Services
- LBH Group Director – Adults and Children's Services

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

- LBH Director of Public Health
- A person nominated by the Chief Financial Officers of the CCG and LBH
- Representative of London Borough of Hackney Healthwatch
- Representative of Hackney Voluntary and Community Services.

Meetings of the Board shall be chaired by either (1) the Chair of the CCG or (2) the cabinet member for health, social care and devolution / the cabinet member for Children's services. The Chair shall rotate between CCG and LBH every six months, with whoever isn't Chair becoming the Deputy Chair of the Board.

In the event of the Chair being unavailable for a meeting or when the Chair is conflicted regarding an agenda item and is required to leave the meeting, the Deputy Chair will assume the chairing of the meeting. Where the Deputy Chair is unavailable or is conflicted, a quorum of the members of each Committee will by consensus select a chair for the whole or part of the meeting concerned. Where the Board is making a decision to award a contract or funding to a local GP provider organisation or considering a recommendation to the CCG about core primary care services, that item will be chaired by the Deputy Chair if the CCG Chair is the Chair of the Board.

The membership will be kept under review and through approval from the CCG's Governing Board and LBH's elected Mayor. Other parties may be invited to send representatives to attend the Board's meetings in a non-decision making capacity.

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

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

It is anticipated that the Board will routinely meet monthly. When the Chair and Deputy Chair of the Board deem it necessary in light of urgent circumstances to call a meeting at short notice this notice period shall be such as s/he shall specify.

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

There may be occasions where an Integrated Commissioning Board established by the City of London Corporation meets in common with the Board for Hackney to consider the same items of business. The terms of reference for the respective Boards still apply in such circumstances.

Secretarial support will be provided to the Board and minutes shall be taken of all of the Board's meetings, with one set being prepared for each of the committees in common and submitted to the relevant forum as determined by the CCG and LBH. Agenda, decisions and minutes shall be published in accordance with partners' access to Information procedures rules.

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

Decision making
Each committee must reach its own decision on any matter under consideration, and must do so by consensus.

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

Quorum
For the CCG committee the quorum will be two of the three members.

For the LBH committee the quorum will be two of the three Council members.

Conflicts of interests
The partner organisations represented in the Board are committed to conducting business and delivering services in a fair, transparent, accountable and impartial manner. Board members will comply with the Conflicts of Interest policy statement developed for the ICBs, as well as the arrangements established by the organisations that they represent.
A declaration of interest will be completed by all members and attendees of the Board and will be kept up to date in line with the policy. Before each meeting each member or attendee will examine the agenda to identify any matters in which he/she has (or may be perceived to have) an interest. Such interests may be in addition to those declared previously. Any such conflicts should be raised with the chair and the secretariat at the earliest possible time.

The Chair will acknowledge the register of interests at the start of the meeting as an item of business. There will be the opportunity for any potential conflicts of interests to be debated and the chair (on the basis of advice where necessary) shall determine whether any conflicts of interests exist and, if so, the arrangements through which they shall be addressed.
In some cases it may be possible for a person with a conflict of interest to participate in a discussion but not the decision that results from it. In other cases, it may be necessary for a person to withdraw from the meeting for the duration of the discussion and decision. When the chair has a conflict of interests relating to an agenda item which obliges them to withdraw, the members of the board will select from among their number a chair for the whole or part of the meeting.
When considering any proposals relating to actual or potential contractual arrangements with local GP providers the Board will seek independent advice from the CCG Local GP Provider Contracts Committee who provide a scrutiny function for all such matters, particularly that the contract is in the best interests of local people, represents value for money and is being recommended without any conflict of interest from GPs.

All declarations and discussions relating to them will be minuted.

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

The Board must operate within the schemes of delegation and financial framework agreed by the CCG and LBH, who remain responsible for their statutory functions and for ensuring that these are met and that the Board is operating within all relevant requirements.

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

Reporting and relationships

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

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

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

Review
These terms of reference will apply for the year from 1 April 2017 to 31 March 2018, subject to their agreement by the 2 statutory organisations.

The terms of reference will be reviewed not later than six months from initial approval and then annually thereafter, such annual reviews to coincide with reviews of the s75 agreements.

Appendix 2: Workstream asks

Ask of the Planned Care workstream

The Planned Care Workstream is asked to establish an accountable care system approach to planned care for the people of Hackney and the City within the overall strategic framework. The Planned Care workstream will need to work closely with the other three care workstreams in order to ensure a system-wide approach is taken across the workstreams:

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

This will involve:

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

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

Most efficient use of resources across the system

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

- Implement the Cancer Plan improvements with a focus on achievement of waiting times standards and earlier diagnosis, alongside other areas of focus from cancer dashboard/CCG rating (including delivery of the Quality Premium target for early diagnosis)
- Deliver the medicines management/optimization plans
- Deliver the agreed QIPP plans
- Develop a new cost effective operating model for Continuing Healthcare which delivers 17/18 QIPP and achieves national plan to deliver 85% of CHC assessments in the community (in line with national guidance in relation to Fast Track Continuing HealthCare and as per Quality Premium target)
- Implement the anticoagulation service once agreed by the Integrated Commissioning Boards
- Deliver national CQUIN measures and targets on:
    - Antibiotic prescribing (in addition to Quality Premium targets on antibiotic prescribing)
    - Advice and guidance services to GPs
    - E-referrals
    - Improving assessment of wounds
- Support the RightCare Programme relating to Neurology (pathway design meeting held, logic model/business case developed and implementation started by September, as per NHS England requirements – more detail in information pack)

- The current NHS, Social Care and Public Health metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories for 2017/18. In particular during 2017/18 the system will be expected to:
    - Maintain or improve admissions to residential and nursing care homes
    - Maintain or improve user satisfaction with social care services
- Institute a review programme for all current outpatient pathways and ensure that mental health is on each pathway
- Initiate a programme to increase use of diagnostics to support primary care based management and reduce duplication of unnecessary diagnostics
- Deliver mandated targets on IAPT (access, recovery, 6wk and 18wk waiting times, Quality Premium target on improving recovery for BAME groups and access for over 65s), QIPP targets and deliver maintenance of waiting list backlog at zero and first appointment to second appointment waiting times, along with initiatives on employment

advisor workstream with DWP, IAPT provision for pts with LTC, new service for mild to moderate perinatal patients, interface with psychosexual Health Service, e-CBT

- Review available capacity and service model for bereavement support services most appropriate to meet need of local population
- Improve the Community Health Services (including children's and maternity services) offer to City resident/registered populations (referral routes/pathways appropriate and accessible for CoL population, including working with Unplanned Care workstream on integration of different services e.g. CHS and Integrated Independence team and Paradoc)

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

- Manage the planned care budget and agree remedial action to be implemented on 1 April 2018 to bring the budget back into balance should PbR spend increase during 17/18
- Review the current contract portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, reduce avoidable unplanned care spend, maximize quality and efficiency from services and improve value
- Reduce avoidable demand for elective care by maintaining or improving referral rates (increasing e-referrals) and reducing outpatient follow (including actively managing medically unexplained symptoms) – develop a plan which will implement a radical approach to the current outpatient model and reduce face to face contact
- The workstream will need to develop a system action plan to take forward the 'big ticket' item relating to housing
- Support STP plans around improving elective surgical outcomes and North East London model
- Develop a plan to address clinical practice variation across primary and secondary care
- Review the support offer to local care and nursing homes (working with the Unplanned Care workstream)
- Develop a plan for future management of medicines management support
- Linked with the above service delivery changes and/or transformation initiatives, model and agree improvement trajectories for mandated NHS and Social Care outcomes along with agreement on any additional decided local population health outcomes and trajectories attached for 2018/19 onwards
- Improve care for those Learning Disabilities (improved screening uptake including cancer screening, increase employment and training opportunities, increase uptake of annual health reviews and health action plans, plan to address any areas of poor performance/gaps identified in latest SAF, deliver Transforming Care Partnership's local objectives to better support local people with challenging behaviour, input to strategic review of the current integrated Learning Disabilities service)

Objectives for 2018/19:

- Deliver system action plans agreed above, alongside improvement in outcomes as per agreed trajectories (including NHS Constitution standards: Referral to Treatment and IAPT)
- Evidence impact of new delivery models implemented in 2017/18 on agreed metrics
- Manage the planned care budget within plan
- Agree remedial action if any deviation from plans/trajectories
- QIPP
- RightCare
- Achieve nationally mandated CQUINs for 2018/19

Ask of the Prevention workstream

The Prevention Workstream is asked to establish an accountable care system approach to prevention for the people of Hackney and the City within the overall strategic framework. The Prevention workstream will need to work closely with the other three care workstreams in order to ensure a system-wide approach to prevention and early intervention is taken across the workstreams:

- Establish a robust governance arrangement to support collective delivery
- Ensure a system wide approach to the delivery of prevention initiatives
- Provide support (as needed and agreed) to the other three workstreams to help embed prevention principles in their plans
- Manage service delivery within the prevention budget
    - Redirect funding within the workstream that either improves service delivery or reduces cost (or both)
    - Develop service delivery proposals across workstreams that reduce overall system costs
    - Ensure most effective use of existing resources including CCG and local authority staff including support teams, clinical input and existing clinical leads to support the work programme of the workstream
- Make suggestions to the statutory commissioners on changes to current contractual arrangements which would improve service delivery and secure performance and value for money
- Ensure the achievement of all performance standards and key performance indicators (KPIs) within existing contracts
- Deliver improvements in outcomes (both nationally mandated outcomes and additional locally relevant outcomes)
- Engage in organisational development offer to develop system leadership

This will involve:

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

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

Working with wider services across the two local authorities and beyond to influence the social and economic determinants of health and wellbeing (including housing, planning, transport, regulatory services, employment, education, etc.)

- Advocating for health and wellbeing to influence relevant local policies and plans

- Working in partnership with relevant service leads on joint projects of relevance to the health and wellbeing of local residents and workers

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

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

- The current NHS, Social Care and Public Health metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories for 2017/18. In particular during 2017/18 the system will be expected to:

    - Secure improvements in the CCG Improvement and Assessment Framework measures relating to diabetes and ensure a system wide approach to reduce the risk of Type 2 diabetes

    - Deliver Quality Premium target on smoking quitters

- Use the Right Care programme to support the local focus on Circulation (CVD) and Respiratory – improving prevention programmes in place, management of existing conditions and preventing avoidable admissions (RightCare requirements: pathway design meeting held, logic model/business case developed and implementation started by September, as per NHS England directives – more detail in information pack)
- Ensure an integrated approach to national plans to increase NHS Health Checks
- Work with providers to ensure that plans are implemented to secure delivery of national CQUIN measures and targets on:
    - Screening, brief advice and referral for people who smoke and/or have high alcohol consumption (ELFT only in 2017/18, Homerton in 2018/19)
    - Personalised care and support planning
    - Staff flu immunisations
- Support the local delivery of STP ambitions relating to workplace health, supporting healthy workplaces and giving healthy messages to workers (alongside delivering national CQUIN on staff health and wellbeing – for both ELFT and Homerton)
- Ensure progress towards making Homerton and ELFT smoke free
- Implementation of new sexual health service models (including GUM integrated tariff, London STI testing e-service)

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

- Review the current contract portfolio, performance within these and drivers of acute activity and make recommendations for any consolidation/alignment to services/contracts – to improve patient outcomes, reduce inequalities, maximize quality and efficiency from services and improve value
- Develop system wide plans to reduce smoking prevalence and inequalities in smoking prevalence across the local population (and worker populations)
- Develop system wide plans to reduce obesity in the local population
- In addition to the above, review current services and develop integrated plans to drive primary and secondary prevention (including risk factor management and early detection) of long term conditions in the local population
- Review current initiatives and recommend changes needed to secure a system wide approach to improving the management of long term conditions (LTCs; sickle cell, CVD/AF, Diabetes, COPD/asthma, hypertension, renal) including potential to apply the renal model to other LTC
- Develop plans to increase self-management, access to self-care/advice and link social prescribing to other community based prevention initiatives to support primary prevention initiatives and those with LTC to manage their own health care and wellbeing
- The workstream will need to develop a plan during 2017 to take forward by April 2018 the 'big ticket' items relating to:
    - Employment (working with the Central London Forward Work and Health Programme) and specifically improving employment rates for those with Learning Disabilities and Mental Health problems
    - Self-care, including access to advice and social prescribing
    - Making every contact count
- Work with Planned Care workstream to improve uptake of all screening programmes and adult immunisations
- Develop system wide plans for health and social care organisations to work in a more integrated way to identify and support carers
- Build on existing wellbeing network/'5 to Thrive' work and suicide prevention plans to improve Mental Wellbeing and reduce rates of suicide
- Work across organisations, including voluntary sector, to reduce social isolation and the impact of this on health and wellbeing
- Increase the number of disabled people and those with complex health needs to benefit from a personal health budget
- Improve the accommodation pathway/care provided to rough sleepers
- Agree, and develop recommendations to implement, the local strategy for a whole systems approach to tackle alcohol-related harm.
- Ensure the substance misuse shared care model with primary care continues to deliver positive outcomes, and improve the support available for young drug and alcohol users

to quit by strengthening links with the criminal justice system and mental health services.

- Implement required improvements to the support available to substance misusers with complex needs, informed by the results of an evaluation of the Multiple Needs Service.
- Develop and implement system wide plans to reduce STI prevalence and improve the sexual health of the local population, including in high risk groups

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

Objectives for 2018/19:

- o Deliver system action plans agreed above, alongside improvement in outcomes as per agreed trajectories
- o Evidence impact of new delivery models implemented in 2017/18 on agreed metrics
- o Agree remedial action if any deviation from plans
- o QIPP
- o RightCare
- o Achieve nationally mandated CQUINs for 2018/19

Ask of the Unplanned Care workstream

The Unplanned Care Workstream is asked to establish an accountable care system for the delivery of unplanned care services for the people of Hackney and the City within the overall strategic framework. The Unplanned Care workstream will need to work closely with the other three care workstreams in order to ensure a system-wide approach is taken across the workstreams:

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

This will involve:

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

- Establish a strong collective delivery arrangement across the providers which fully integrates service provision, including mental health, and minimises duplication and overlap
- Ensure that the delivery arrangement works for both the Hackney health and social care system and City of London health and social care system
- Ensure that the health and social care system achieves high quality, patient led services which also secure best practice, reduce unwarranted variations and demonstrates value for money

- Demonstrate the local contribution to the delivery of the North East London STP plans and delivery of the NHS Five Year Forward View (FYFV)

Objectives for 2017/18

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

- Develop a proposition for the local face to face/home visiting service to complement the 111 clinical assessment service and local primary care, consult on this and prepare for mobilization once agreed by the Integrated Commissioning Boards
- Implement the local ambulatory care model to achieve an increase in ambulatory care admissions with a corresponding reduction in emergency/non-elective admissions, reduction in length of stay and develop an integrated delivery model with primary and community services
- Develop plans to improve management of Mental Health patients:
    - Management of mental health beds (management of mental health needs to include appropriate levels of bed occupancy and efficient use of inpatient beds and support the review of Continuing Care beds)
    - Deliver local measures and targets for CQUIN for ELFT on reducing use of Mental Health Act for BAME communities
    - Work with ELFT on having 24/7 community-based mental health crisis response
    - Ensure continued achievement of psychosis waiting times target
    - Elimination of out of area placements
- Deliver a £500k QIPP against the baseline budget by working as a whole system (adhering to the principle of ensuring that QIPP proposals deliver cost savings across the system and do not increase costs for other organisations in the City and Hackney system)
- Deliver further QIPP via a focus on any/all of the following areas:
    - Reducing spend on emergency activity at UCL and Barts (areas of savings could be from reducing A&E attends and admissions, length of stay/excess bed day costs)
    - Using a Data/evidence based patient profile design interventions that improve access and services available to City residents (An example could be how Paradoc and the Integrated Independence Team interface with City re-ablement services to make more of an impact on admission avoidance and on LOS/discharge and improving the Community Health Services offer to City residents)
- Develop and deliver a series of proposals that maximise the use of primary care to reduce any unnecessary A&E attendances, including strengthening the duty doctor model and ensuring consistent delivery.
- Ensure compliance with East London Health and Care Partnership Urgent and Emergency Care plan

- Implementation of high impact changes
- Achievement of 4hr target as per ELHCP trajectory
- Implementation of other services/targets outlined in UEC plan

- The current NHS and Social Care metrics associated with this workstream are attached and the commissioners will want to agree with the system the improvements which will be achieved and the improvement trajectories for 2017/18. In particular during 2017/18 the system will be expected to:
  - Maintain or reduce the emergency admission rate for the 19-59 year old group (ensuring activity levels stay within activity trajectory for total non-elective admissions submitted to NHS England)
  - Reduce levels of Delayed Transfers of Care
  - Maintain or reduce in the A&E attendance rate and in particular "minor" cases presenting to A&E (ensuring activity levels stay within trajectory for total A&E attendances submitted to NHS England)
  - Achieve the Better Care Fund metric targets

- Deliver national CQUIN measures and targets on:
  - Proactive discharge
  - Sepsis screening
  - Improving services for people with mental health needs who present to A&E

- Take forward the RightCare programme relating to Falls (pathway design meeting held, logic model/business case developed and implementation started by September, as per NHS England requirements – more detail in information pack)

- Work with partners to support relevant actions within City of London Health and Wellbeing Strategy (on mental health and effective health and social care integration)

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

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

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

- Review the plans to ensure adequate Mental Health care in A&E by March 2018 (ensure that liaison services are 'core 24' compliant and delivery of national CQUIN)

- Agree system action plans to take forward the local 'big ticket items' linked to this workstream:
  - End of life care (including improving access and provision of individualised care, quality and coordination of care, improvement in management of symptoms/pain, reducing unnecessary hospital admissions, increasing the number of people who die in their preferred place and support to care homes and care workers)

- Dementia (continue to delivery diagnosis standards and robust care planning support)

- Agree system action plans to take forward local transformation initiatives:
  - Enhanced Primary Care (“Quadrants”)
  - Single point of co-ordination
  - Discharge from hospital model, delivering national FYFV expectations

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

Objectives for 2018/19:

- Deliver system action plans agreed above, alongside improvement in outcomes as per agreed trajectories
- Evidence impact of new delivery models implemented in 2017/18 on agreed metrics
- Manage the unplanned care budget within plan
- Agree remedial action if any deviation from plans
- QIPP
- RightCare
- Achieve nationally mandated CQUINs for 2018/19

Appendix 3. Devolution of Public Health: How we will improve the lives of Hackney residents through greater local decision making

Purpose of this document:

This document describes the aspiration that Hackney partners are hoping to deliver in terms of public health and should be read in conjunction with the Hackney devolution outline business case.

Hackney partners will be assisted in achieving the specific aspirations in this document by the commitments of other organisations contained in the London Devolution MOU. This business case provides clear rationale for why proposed changes would enable Hackney to improve the lives of local people, and explains how the commitments in the MOU will support this work.

It is recommended that local decisions on implementation of Hackney 'public health' initiatives are taken once the outcomes of a more detailed analysis of insight and evidence, alongside the deep dive exercise being undertaken by Haringey, are known.

Our vision for Hackney:

Together with organisations, partners and people across Hackney we have developed a vision to deliver an integrated, effective and financially sustainable service that meets the whole population's health and wellbeing needs.

Our vision for our services is to increase the independence and choices for local residents, improve the quality and timeliness of care, where residents know how to choose and access the services most appropriate to their needs, in settings appropriate for modern care.

We will work towards a system in which commissioners and providers of health and care services work together to deliver an effective and financially sustainable service that meets the population's needs across the borough. We want to jointly commission all of our services to make the most of the Hackney pound, and jointly provide them in order to meet all the needs of each person we care for.

What we want to see in the future

Partner organisations across Hackney have agreed the following potential opportunities to improve the health and wellbeing of people living in the borough:

1) Exploring the interaction between planning policy and health and wellbeing objectives
2) Tackling illicit tobacco
3) Tackling problem gambling

The following sections outline the rationale behind why these would help us improve the wellbeing of our population.

1) Health and planning policy

Current context

- It is estimated that almost 10,000 people in Hackney are dependent drinkers, and these numbers are expected to rise

- Alcohol-related health harms are more prevalent in Hackney than nationally - hospital admissions for alcohol-related problems and alcoholic liver disease are both more common in the local population

- Levels of alcohol-related violent crime and sexual assault are also higher locally than the

London and England averages – linked to the night-economy as well as a relatively young population.

What is being done

- Proactive alcohol identification and brief advice in General Practice
- A new drug and alcohol treatment service has been commissioned, responsive to the needs of the local community
- Public Health input to licensing conditions and decisions using 'bulls-eye' tool to help identify high areas of crime and where there are numerous licensed premises, primarily focused on off-licenses.

We feel that the above actions could be improved on because the current system of Public Health input into licensing conditions/decision (on case by case basis) is onerous and there is a risk that some applications with serious potential health consequences may be approved.

To support our transformation work, it would be helpful to:

Further explore the interaction between health and planning policy.

The council's Public Health currently input into licensing decisions on a case-by-case basis. Licensing objectives are set by central government – the four current objectives relate to public safety, protection of children from harm, prevention of crime and disorder, preventing public nuisance.
Hackney partners would be keen to see health being routinely considered as part of license decisions, ensuring a consistent and more efficient process. This would minimise the risk of decisions being taken which could create serious potential health risks through the proliferation of licensed premises.

This could be operationalised by considering health as a 5th licensing objective through existing licensing committee processes. We will learn from the results of the research programme being undertaken by Haringey and the London School of Hygiene and Tropical Medicine.

Reducing emergency hospital attendances and admissions is a key local objective as part of integrated commissioning plans. Restricting the number of new premises selling alcohol (where there is evidence of related health problems) could have a significant impact on the NHS, both in terms of A&E attendances and emergency admissions.

Impacts

Including health as a routine consideration in licensing decisions will contribute to the reduction of alcohol-related health problems in areas with a high concentration of licensed premises – reducing harms to individuals and their families.

It will help to reduce the higher than average alcohol-related hospital admissions in Hackney – relieving pressure on the local NHS.

It will also help to address higher than average levels of alcohol-related violent crime and sexual assault in the local area – improving the safety of all residents.

Estimates of RoI will be informed by the detailed work being undertaken as part of the Haringey devolution (prevention) pilot - the NICE RoI tool for alcohol licensing interventions will be used to model local savings for Hackney following the completion of this work.

2) Tobacco

Current context

- Smoking contributes to almost 1 in 5 deaths in Hackney; and is a major cause of health inequalities – it accounts for half the difference in mortality between rich and poor areas
- Local smoking prevalence (20.5%) is significantly higher than the national average – over 40,000 adults in Hackney currently smoke
- Smoking is costly to Hackney's public services (annual cost to the NHS=£7.4m; annual social care costs=£2.9m) and to society as a whole (total annual costs=£65.1m)
- Availability of cheap/illegal tobacco makes it harder for smokers to quit and easier for young people to start. Cheap/illegal tobacco is also strongly linked to serious and organised crime.
- Half of Hackney smokers in a recent survey had been offered cheap tobacco - almost 2/3 of these took up the offer

What is being done

- A comprehensive multi-agency tobacco control action plan has been developed in partnership with a broad spectrum of local stakeholders - responsibility for delivery of the action plan lies with Hackney Public Health, accountable directly to Hackney HWB Board
- Relevant actions in the plan include: a collaborative arrangement with neighbouring NE/NC London boroughs to improve reporting and reduce the supply of cheap/illegal tobacco across the patch. Intelligence-led enforcement is carried-out in collaboration with colleagues in trading standards, the Met Police and HMRC.
- Demonstrating Hackney's integrated approach, at a recent Health & Wellbeing Board meeting, all partners signed up to the aspiration for the entire public service estate to become smokefree.

Retailers do not need a license to sell tobacco, a product which causes significant harm to the local economy and health systems – there is currently no local (or national) mechanism for this.

HMRC recently consulted on the licensing of the tobacco supply chain – the outcomes of this consultation are not yet known. To support our transformation work, it would be helpful to:

- Be involved in HM Revenue and Custom's (HMRC) review of sanctions to tackle illicit tobacco and in DH's complementary review of the sanctions for businesses that break tobacco laws, including looking at further use of civil penalties where appropriate.
- Explore the evidence base for establishing a borough-led London-wide illegal tobacco and counterfeit alcohol enforcement team.

This would contribute to resolving our problems as restricting or eliminating the supply of cheap tobacco will make smoking more expensive and is expected to have the biggest impact (in terms of reducing purchases) amongst more deprived communities (with the highest rates of smoking and smoking related harm) and younger people (80% of smokers start before the age of 19 and the longer someone smokes, the greater the longer-term health harms).[2]

Options for extending smokefree spaces are possible (e.g. inclusion as a condition of licenses, or through local by-laws). The pros and cons of these different approaches in optimising local authority would need to be worked through. Extending smokefree spaces would help to reinforce longer-term progress made in reducing tobacco use by helping to 'denormalise' smoking further, and will extend benefits to non-smokers by protecting them from second hand smoke.

Impacts

The direct benefits to the target population, and the population as a whole include:

- Tackling illicit tobacco: Supply of cheap tobacco is reduced, affordability of smoking is reduced which will affect the amount of tobacco purchased in Hackney; expected to affect heavy smoking communities and younger smokers disproportionately with associated benefits in terms of reducing health inequalities; and
- Smokefree outdoor spaces: protect non-smokers from the harms of second-hand smoke; reinforce existing smokefree legislation for indoor spaces to 'de-normalise' smoking in Hackney.

Indirect benefits include:

- Tackling illicit tobacco: Will help to 'denormalise' smoking in communities where use of cheap tobacco is prevalent; by discouraging purchases amongst young people may act to reduce uptake of smoking and therefore reduce population prevalence.
- Smokefree outdoor spaces: as smoking becomes less visible in Hackney, smoking uptake is likely to fall and (successful) quit attempts to increase.

The risk exists that smokers will purchase their cheap tobacco in neighbouring boroughs and is to be mitigated through continued cross-borough working to control supply of illicit tobacco as well as support for London ADsPH business case for pan-London enforcement.

Optimity/NICE RoI tools are available to model the impact of different levels of reduction in smoking prevalence as a result of wider tobacco control activity.

[2] http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2013-03-22-more-than- 200000-uk-children-start-smoking-every-year

3) Tackling problem gambling

Current context

- Around one in 10 people in the UK participate in over-the-counter betting in bookmakers – a small % of these are 'problem' gamblers
- Gambling exacerbates financial vulnerability and worsens mental health problems through addictive behaviour – problem gamblers have the poorest health outcomes and tend to live in more deprived areas
- Fixed Odds Betting Terminal (FOBT) use by young people is a growing problem
- There is a strong link between the availability of venues and the number of regular/problem gamblers in a local area
- There are 56 betting shops in Hackney, with the highest concentrations in Haggerston and Dalston

What is being done

- Local licensing decisions for betting shops are decided on the basis of principles set out in Hackney council's Gambling Policy, including a requirement to protect children and other vulnerable persons from being harmed or exploited by gambling
- Hackney Council has lobbied successive governments calling for councils to have more powers over betting shops, including a proposal to give betting shops their own planning class
- Following a public consultation in 2014, the Government amended the General Permitted Development Order to give bookmakers their own planning use class, giving greater control to licensing authorities to control their proliferation

We believe the above actions could be improved upon as the Gambling Act 2005 removed the controls limiting access and availability to many forms of gambling and requires local authorities and the Gambling Commission to 'aim to permit gambling'. Current licensing and planning restrictions do not allow local authorities to influence either the location, hours or number of FOBTs or FOBT maximum stakes.

To support our transformation work, it would be helpful to:

Work closely with DCMS as they undertake their review of gaming machines and social responsibility measures[8]. DCMS aims to publish its findings and any resulting proposals in 2017 and has committed to liaising closely with all stakeholders, including London's devolution pilots, as the review progresses.

Changes which would give us greater local control over the licensing of betting shops would make it possible to limit the concentration of such premises in deprived areas and the risks associated with FOBTs for some of the most vulnerable communities in Hackney.

Further work is required to determine exactly how changes could be implemented in practice within Hackney council's existing planning and licensing systems. The Local Plan is currently being refreshed which creates an opportunity to influence the development of policies to support greater control of the proliferation of FOBTs/betting shops within the local planning system (no devolved powers required).

[8] The review will consider robust evidence on the appropriate maximum stakes and prizes for gaming machines across all premises licensed under the Gambling Act 2005; the number and location of gaming machines across all licensed premises; and social responsibility measures to protect players from gambling-related harm. It will also close look at the issue of B2 gaming machines (more commonly known as Fixed Odds Betting Terminals or FOBTs) and specific concerns about the harm they cause, be that to the player or the communities in which they are located. The review aims to ensure that legislation strikes the right balance between allowing the industry to grow and contribute to the economy whilst ensuring consumers and communities are protected.

Joint working with betting shop proprietors to address problem gambling (funding by locally retained gambling levy) would provide opportunities for earlier identification of vulnerable residents and appropriate signposting to relevant health and related services.

Impacts

Direct benefits to the target population would be a reduction in the number of problem gamblers in Hackney, especially in the most deprived communities.

Indirect benefits would also result as tackling problem gambling behaviour will help to address some of the causes and consequences of poverty and deprivation, and associated health and wellbeing impacts. Potential exists to have a significant impact in reducing inequalities in health and other outcomes.

Next steps

As indicated throughout this submission, much hinges on the outcome of research and intelligence gathering in Haringey (prevention devolution pilot) to test out the principles of changes to existing legislation. As described at the start of this document, it is recommended that local decisions on the detail of the Hackney 'public health' context are taken once the outcomes of a more local detailed analysis of insight and evidence, informed by the deep dive exercise being undertaken by Haringey, are known. At that point, a detailed return on investment analysis of the various options will be undertaken.

Appendix 4: Hackney Estates Focus

The Hackney devolution partners recognise significant opportunities to enable greater social and community value for Hackney residents from the current estates. This supports the overall aim of the devolution programme to drive greater integration across health and social care in Hackney. Estates development will be achieved by managing the health and social care estates together, using the One Public Estates principles and providing a local forum to decide the future plans that will enable new models of care to become a reality, supported by fully integrated commissioning of services.

We want to use our estates to tackle the wider determinants of health, recognising that health improvement is not solely within the gift of the NHS. We want to work with the local authority to think about the how we can lever the full range of their services, alongside those delivered by the voluntary sector, to maximise health and wellbeing gain and tackle the wider determinants of health through integrated provision out of our estate. It is noted that a number of buildings within Hackney that deliver health services are not owned by Hackney devolution partners.

The London Borough of Hackney has an excellent record of recent investment in public infrastructure and the development of new housing. In contrast, over the last 5 years, there has been little investment in NHS estates which has stagnated; a report commissioned by the CCG in 2015 identified a 'time bomb' of premises issues in primary care. The lack of alignment of NHS property ownership, with capital investment decisions and commissioning responsibility has created a dysfunctional system. The NHS system by its design has constrained investment and has not enabled alternative investment opportunities to be pursued. For transformational change Hackney believes that we need a model that ensures NHS property ownership, commissioning responsibility and investment decisions are fully aligned and full integration through the inclusion of the existing local authority system, which will enable the combined system to function as one system. It is envisaged that the sum of the combined system under an estates board would produce better infrastructure outcomes for local people, innovative property and investment solutions, which are greater than the two systems operating separately could achieve. It would also facilitate greater housing investment than would otherwise be possible.

An initial mapping exercise of the current Hackney estate has been undertaken. This included properties owned and leased by devolution health partners and the London Borough of Hackney. In addition, 13 properties owned by the Church of England have been included in the exercise. The property data has been validated with the exception of properties used by the third sector, which will be completed over the coming weeks. We have identified a total of **94** properties that could better serve our community through more joined up ownership and investment decision-making.

- 29% of the properties are owned by LBH. Other key owners are NHS Property Services (19%), GP surgeries (14%) and Church of England (14%).
- 17% of the properties have more than one usage (i.e. both primary and secondary care or children's services and secondary care), however the majority are used for one type of service only: 37% are used for primary care delivery and 14% for children's services.

We have gone further to map the estates into quadrants within the borough. Each quadrant has been developed by health and social care partners to support effective management of integrated community health services across the area and are based on geographical clustering of GP practices in the borough. It should be noted that the quadrant model is not currently used universally (e.g. community mental health services split the area between north and south areas and the Learning Trust use 5 areas based on locations of local children's centres) but the vision is for quadrant working to be rolled out to all relevant services, and any estates plan must respond to this challenge either through opportunities from existing estates footprint or by the creation of new premises.

To ensure public engagement we are taking into account future consultations that must be done on a quadrant basis so local residents can understand what may be in the pipeline for them locally. We will also be broadening our scope to ensure housing features as an integral part of our local estates work, focusing on 2 particular areas: Establishing what can be done to ensure there is affordable housing for a local workforce, and understanding the link between the quality of housing and healthcare needs, particularly for vulnerable groups e.g. older people and those with mental health issues

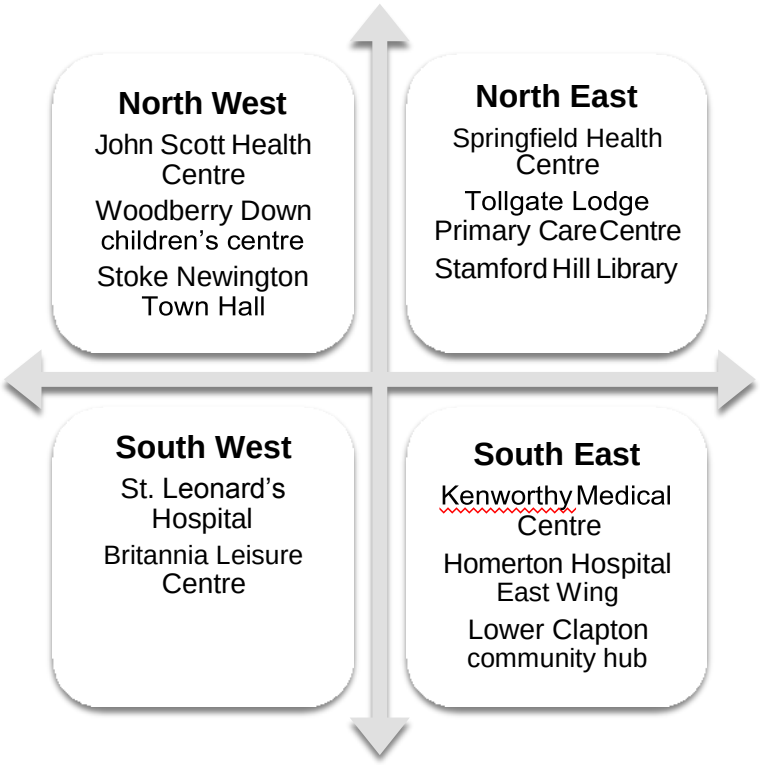
Examples of our estates aspirations that support transformation include:

- Building community assets through to adapt our existing estate, making buildings more appropriate for the new care models we are creating and developing them to deliver a strong community benefit
- Sufficient capacity to support our quadrant model - gains will come from team co-location. We have agreed a campus or network approach in each quadrant, rather than one central building as we need to be realistic about what can be achieved
- That we capitalise on the One Public Estate programme which is focused on delivering more integrated and customer focused services, creating economic growth, reducing running costs and generating capital receipts.
- We have fit-for-purpose general practice buildings. This could in some cases, lead to the consolidation of some practices as we explore the opportunities from the current estates footprint and look at the creation of new premises. Whilst 40% of primary care premises need investment, our patients tell us they value local provision over centralisation. Our plans will also need to ensure we have capacity for our increasing population.
- We plan our estate across health and local authority and move to much more shared use and colocation of health, wellbeing, and wider Local Authority services
- A strong focus on housing - both to ensure affordable housing for a local workforce and ensuring that we can impact on health through housing, particularly for those from vulnerable groups.
- We continue to work with our residents to explore how our public sector can support the use of wider community assets and ensure our plans are socially sustainable. We understand the value of local and culturally relevant access points to support for our residents. Our voluntary sector providers are a key part of our plans for utilising existing community assets to ensure our services are: targeted and effective, culturally appropriate, and they maximise the increased social value of our plans. As an example, our Psychological Therapies Alliance is working with faith groups to co-locate therapists in local places of worship.
- Link with the Community Wholecare Project - a programme conceived by the Church of England to develop local community centres providing health social and spiritual care on land adjacent to Church of England churches. There are 13 potential sites within Hackney including one submitted through the Estates and Technology Transformation fund

Overview of local estates priorities

A review of the existing estates has identified **11** programmes that are a high priority within the area. These are categorized below in terms of their current status and by quadrant. In addition to the work on the Hackney estate, the City of London have also identified 3 premises that are vital to the delivery of healthcare for their population, namely the Neaman Practice, St. Leonards Hospital and Barts and the London Minor Injuries unit.

Urgent	• Springfield Health Centre • Tollgate Lodge Primary Care Centre • Woodberry Down Children's Centre
Planned Developments	• Britannia Leisure Centre • Lower Clapton community hub • Kenworthy Medical Centre
Future Opportunities	• St. Leonard's Hospital • Homerton Hospital East Wing • John Scott Health Centre • Stoke Newington Town Hall • Stamford Hill Library



Examples of our priority schemes and the issues we are facing are listed below:

Primary care estate

The recent re-assessment of the current baseline primary care GP estate within City and Hackney has indicated that, whilst there has been a number of positive changes and consolidation there is a huge amount of work still to do. The report noted the following findings:

- A number 'planned' schemes for St Leonards (two practices), Somerford Grove (two practices), Woodberry Down, North East Resource Centre (two practice), London Fields, Lower Clapton Road and Lea Surgery **have not advanced in any significant way over the last 7 years**.
- Since 2010 responsibility for the development of primary care estate has become more confused with the traditional roles and responsibilities being clouded by the creation of initially larger estates regions and then the creation of two different estate entities and funding and responsibilities moving to NHS England.
- **The result of the above and a lack of identified estate funding has meant that until recently very few schemes have been developed or approved.**
- The recent introduction of the PCIF initiative has encouraged a small number of schemes to attract funding.
- **The initial assessment of site utilisation suggests that about 50%of the practices are fully or over utilised**, and that whilst there is capacity within the remaining estate, depending on their location, some localities are likely to struggle to grow services and match the capacity of a growing population.
- However, we believe that utilisation requires a more detailed analysis during the next stage of the project to assess the full extent of this, and whether or not practices could or are using their space as effectively as possible.
- The assessment of the functional suitability of existing practices suggests that about **58% of City and Hackney's GP practices, with minor investment, are functionally acceptable.**The remaining require either significant investment or relocation. This implies therefore that over **40% require substantial investment or new sites**, which will require significant financial input from both practices and the NHS.
- In the current financial climate, the cost impact of addressing the existing premises issues will need to be carefully managed and programmed, with local needs and value for money as key criteria in supporting investment.
- The CCG may wish to investigate how it can best leverage its position and that of its practices to ensure that any disposals of NHS Estate within City and Hackney are matched by the provision of new facilities and this may require some innovative approaches.

The work recommended urgent action to find urgent and permanent solutions to ensure that the estate was fit for purpose and able to meet future demand.

Through devolution we hope to ensure decision making is better aligned in order that the projects can proceed in partnership and mitigate any risk that opportunities are not realised because of delays.

Woodberry Down

The Children's centre operates out of a wing of the John Scott Health Centre and a temporary adjacent building due to be demolished as part of Phase of the Woodberry down Regeneration Programme. A new children's centre must be completed by end of 2017 to avoid detrimental effect on a house building programme encompassing 850 new homes. An extension to the existing nursery is the preferred option to replace the temporary building that houses the children's centre, but it is on land currently owned by NHS Property Services. A land swap between the LBH and NHSPS is

proposed (as the council own a car park adjacent to the John Scott Health Centre). The council has been seeking a solution to this with NHS PS since 2014, however ongoing dispute regarding the differential between the land value of the NHSPS land and the council car park has resulted in no progress. A number of independent valuations have been sought, however no agreement can be reached with the situation now becoming urgent due to the interdependencies with the wider regeneration project. The John Scott Health Centre is owned by NHSPS and earmarked as significant for the provision of future health and social care services for the north west quadrant. NHSPS are currently stymying the development potential here as incentives are not aligned.

Britannia Leisure Centre

Based in the south west quadrant, the facilities at the leisure centre are outdated and costly to maintain. A feasibility study has been commissioned by the Council to consider options of develop- ing new leisure facilities, a new secondary school, and private housing (to support scheme funding) on the site. There is ongoing work with Crossrail 2 involving initial proposals to use the land for a worksite and permanent vent shaft. This is an ideal opportunity to consider whether new facilities could support the new models of care proposed through the devolution pilot.

St Leonard's Hospital

St Leonard's is seen as the most important strategic site in Hackney for devolution. Currently primary care, community health services and offices occupy the premises which is dated and not ide- ally suited for modern healthcare provision. Buildings are c85% occupied with a wide range of uses and tenancies.

Redevelopment of the site has been proposed for a number of years, with full planning permission for redevelopment of the site granted in 2011. Since this time there have been significant changes to the NHS leading to different ownership arrangements (the majority is now owned by NHSPS, with a number of adjoining owners). Redevelopment plans previously produced included the development of healthcare facilities and new housing on the site which could continue to be the long term vision. There is now potential to include adjoining CoE premises to the development opportunity and a desire to ensure any facilities encompass health and social care facilities

Depending on the development of the quadrant model and other services, there could be potential for housing redevelopment/land sale, thus generating capital receipts in an area of high property values. The CCG in conjunction with CHP undertook a feasibility study in 2015, which was inconclusive as future service models were unclear and local decant opportunities problematic.

Under current rules, the property is owned NHSPS, the CCG pays any void costs and funds business case development, but receipts return to Treasury. Devolution would see ownership transfer and incentives to redevelop the site would align. An indicative timeframe for the project has been developed by the devolution estates group, with a view to any capital build work commencing at the end of 2020/21 which allows time for full business case proposals, funding, planning and de- tailed decant arrangements to be in place. Should there be a capital receipt it would emerge in 2021/22.

Given our challenges the partners have developed an exciting vision and identified how local planning and decision making across the London Borough of Hackney and health partners coupled with devolution could help us realize our vision.

Making better use of Stoke Newington Town Hall and Library

Hackney Council wants to find out how it can make better use of the historic Stoke Newington Town Hall and Library, and the under-used space at the rear of the Town Hall, to ensure that the buildings have a vibrant and sustainable long-term future.

It is expensive for the Council to maintain these buildings and their community functions. In recent years the Council has spent over £5 million refurbishing these buildings, and more maintenance

work is needed. Over the coming years it is estimated that the Council will need to spend a further £10 million on additional work to protect and maintain these important historic buildings and community functions.

Stoke Newington Library is a popular and well-used library and will be retained.

Likewise the Town Hall's assembly hall and council chamber are valued local venues, and will be retained. However parts of the building are under-used or not used at all. The Council believes this under-used space should be used to help pay to maintain and refurbish these buildings.

Though this will require significant investment from the Council, new uses could generate the income necessary to pay for refurbishment and ongoing maintenance – protecting these community facilities for future generations.

For example, there is potential to refurbish and create some business space in some parts of the building around the council chamber, the assembly hall and the library. The space could be used for creative studios or commercial workspaces and offices, as well as a range of other uses that support these including facilities such as GP Surgeries and Health Centres. There is also the potential to introduce some new housing to the rear of the site, behind the Town Hall building.

We are in the initial stages of developing a new Planning and Design Guidance document which, once drafted, will outline how the Council plans to shape and improve the Town Hall and Library and secure a more sustainable future for these important community and heritage assets.

There are 3 practices near to the Town Hall which are all at capacity and in poor accommodation – they do not therefore have scope to offer extended primary care or quadrant services at present. Registration with primary care is a challenge in the area due to physical capacity constraints (the area is quite close to the Islington border and there are flows in from Islington residents) and a new building could allow some potential consolidation of primary care as well as offer a wider range of community service alongside primary care – at present most of the wider community based services are located some distance away and residents have raised access issues

if the freedoms and flexibilities set out could be achieved it would be possible to consolidate the Barton House Health Centre (Currently owned by the NHS) and the Statham Grove Practice (Currently Practice Owned) and provide enhanced modernized facilities into one location alongside the provision of additional housing units and other uses whilst protecting a loved community asset.

Stamford Hill Library Site

The library site is within the North East quadrant of Hackney and is in close proximity to two GP practices (Springfield and Tollgate) who currently operate out of premises that are no longer fit for purpose. Both practices are in the process of agreeing moves to temporary accommodation to cover the next 3 year period, however a longer term solution is sought and inclusion of primary care facilities within the existing library site is a preferred option. This would allow us to explore what other Local Authority services could be situated alongside the 2 practices and what quadrant services could operate out of the building. Stamford Hill is where our large Orthodox Jewish population live and there are particular issues around ensuring tailored services and ensuring there is physical and practitioner capacity to deal with the significant young and growing population in this part of Hackney

The site extends to approximately 0.11 hectare (0.3 acre) and consists of a Council owned library with two voluntary sector occupiers on the first floor. The building first opened as a public library in 1968 and was identified in the mid- 2000s as being dated, in poor condition, and suitable for redevelopment, however, the requirement for a library function on this site remains. The building is

arranged over two storeys with a small extension to the rear at first floor only which provides vehicular access to the car park. There is a small basement which houses the boiler room and gas meter room. There are a number of existing trees at the boundaries of the site, and directly adjacent.

There is a small car park to the south eastern boundary which we understand is used for staff and visitor parking and to allow a daily van delivery of books to the library.

The floor plans show that the Property extends to approximately 1,291 sq m Gross Internal Area (13,896 sq ft). The ground floor consists of the main library space with toilets and storage, with the first floor consisting of toilets, kitchen areas and office space. The topography of the site is relatively flat.

A property condition survey dated 2009, identified that the property was in need of repair and up- grading in terms of the central heating system in particular. It also identified blocked asbestos cement flues which were in urgent need of repair. We have also been provided with an M&E Register which attributes a cost in excess of £400,000 to maintain the M&E in the building.

The library is not surplus to requirements and would need to be reprovided as part of any redevelopment of the site. We also understand that the Council has been approached by two local GP practices in urgent need of new premises and that the library site would provide a suitable location for these practices, subject to timescales. We have high level requirements for both the library and GP surgeries should a redevelopment of the site occur and these have been taken into account as far as possible by the architects within their massing study alongside the provision of a number of on-site residential units of up to 20 units.

The ownership of the 2 GP Practices are as follows:

- Springfield Practice (this is owned by a retired GP who charges the practice market rent and it would be possible to terminate lease and transfer to new facility).
- Tollgate Lodge occupies from a Portakabin and pays market rent.

All of these plans demonstrate our commitment to jointly planning our estate with the Local Authority and working together to find solutions which will ensure our buildings are delivering real community benefit from a wide range of services