Hackney

NHS
City and Hackney
Clinical Commissioning Group

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

Meeting on Thursday 9 July 2020 9.30 am

Until further notice, this meeting will be held remotely

1	**London Borough of Hackney Integrated Commissioning Board Agenda**	(Pages 1 - 128)

Contact Alex Harries, Integrated Commissioning Governance Manager – alex.harries2@nhs.net;

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

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

Joint Meeting in public of the two Integrated Commissioning Boards on Thursday 9 July 2020, 10.00 – 12.00
Microsoft Teams

Join Microsoft Teams Meeting

Item no.	Item	Lead and purpose	Documentation type	Page No.	Time
1.	**Welcome, introductions and apologies**	Chair	Verbal	-	10.00
2.	**Declarations of Interests**	Chair *For noting*	Paper	3-8	
3.	**Questions from the Public**	Chair	None	-	
4.	**Minutes of the Previous Meeting & Action Log**	Chair *For approval*	Paper	9-18	
Covid-19 response					
5.	**Update on the Prevention Workstream**	Sandra Husbands *For noting*	Verbal	-	10.05
6.	**CCG Contracting Position**	Sunil Thakker *For noting*	Verbal	-	10.10
7.	**Provider Alliance Update**	Jonathan McShane *For noting*	Verbal	-	10.15
8.	**Health Inequalities Framework**	David Maher / Anna Garner *For endorsement*	Paper (Appx C separate to agenda)	19-45	10.20

Hackney

CITY OF LONDON

NHS
City and Hackney Clinical Commissioning Group

9.	**Phase Two Update**	David Maher *For discussion*	Paper	46-72	11.00
10.	**CYPMF Neighbourhoods Approach**	Amy Wilkinson *For noting*	Paper	73-87	11.15
11.	**Voluntary Sector Operating Model**	Jake Ferguson *For noting*	Paper (to follow)	-	11.30
12.	**Homelessness Resourcing**	Siobhan Harper *Update*	Paper	88-92	11.45
For information items					
-	**ICB Terms of Reference (incorporating Local Outbreak Board)**	*For information*	Paper (to follow)		-
-	**Integrated Commissioning Glossary**	*For information*	IC Glossary	93-97	-

Date of next meeting:

13 August, Format TBC

Integrated Commissioning
2020 Register of Interests

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Simon	Cribbens	12/08/2019	City ICB advisor/ regular attendee Accountable Officers Group member	City of London Corporation	Assistant Director - Commissioning & Partnerships, Community & Children's Services	Pecuniary Interest
				City of London Corporation	Attendee at meetings	Pecuniary Interest
				Providence Row	Trustee	Non-Pecuniary Interest
Sunil	Thakker	11/12/2018	City and Hackney ICB advisor/ regular attendee	City & Hackney CCG	Chief Financial Officer	Non-Pecuniary Interest
Ian	Williams	20/03/2020	Hackney ICB advisor/ regular attendee	London Borough of Hackney	Group Director, Finance and Corporate Resources	Pecuniary Interest
				n/a	Homeowner in Hackney	Pecuniary Interest
				Hackney Schools for the Future Ltd	Director	Pecuniary Interest
				NWLA Partnership Board	Joint Chair	Pecuniary Interest
				London Treasury Ltd	SLT Rep	
				London CIV Board	Observer / SLT Rep	
				Chartered Institute of Public Finance and Accountancy	Member	Non-Pecuniary Interest
				Society of London Treasurers	Member	Non-Pecuniary Interest
				London Finance Advisory Committee	Member	Non-Pecuniary Interest
				Schools and Academy Funding Group	London Representative	Non-Pecuniary Interest
				Society of Municipal Treasurers	SMT Executive	
				London CIV Shareholders Committee	SLT Rep	
				London Pensions Investments Advisory Committee	Chair	Non-Pecuniary Interest
Ruby	Sayed	07/11/2019	City ICB member	City of London Corporate	Member	Pecuniary Interest
				Gaia Re Ltd	Member	Pecuniary Interest
				Thincats (Poland) Ltd	Director	Pecuniary Interest
				Bar of England and Wales	Member	Pecuniary Interest
				Transition Finance (Lavenham) Ltd	Member	Pecuniary Interest
				Nirvana Capital Ltd	Member	Pecuniary Interest
				Honourable Society of the Inner Temple	Member	Non-pecuniary interest
				Independent / Temple & Farringdon Together	Member	Non-pecuniary interest
				Guild of Entrepreneurs	Founder Member	Non-pecuniary interest
				Bury St. Edmund's Woman's Aid	Trustee	Non-pecuniary interest
				Housing the Homeless Central Fund	Trustee	Non-Pecuniary Interest
				Asian Women's Resource Centre	Trustee & Chairperson	Non-pecuniary interest
Mark	Jarvis	02/03/2020	City ICB advisor / regular attendee	City of London Corporation	Head of Finance	Pecuniary Interest
Anne	Canning	27/06/2019	Hackney ICB advisor / regular attendee Accountable Officers Group member	London Borough of Hackney	Group Director - Children, Adults & Community Health	Pecuniary Interest
					Partner works at Our Lady's Convent School, N16	Indirect interest
Honor	Rhodes	11/06/2020	Member - City / Hackney Integrated Commissioning Boards	City & Hackney Clinical Commissioning Group	Lay Member	Pecuniary Interest
				Tavistock Relationships	Director	Non-Pecuniary Interest
				HUHFT	Daughter is employed as Assistant Psychologist	Indirect interest
				n/a	Registered with Barton House NHS Practice, N16	Non-Pecuniary Interest
Gary	Marlowe	25/06/2019	GP Member of the City & Hackney CCG Governing Body ICB advisor / regular attendee	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				De Beauvoir Surgery	GP Partner	Pecuniary Interest
				City & Hackney CCG	Planned Care Lead	Pecuniary Interest
				Hackney GP Confederation	Member	Pecuniary Interest
				British Medical Association	London Regional Chair	Non-Pecuniary Interest
				n/a	Homeowner - Casimir Road, E5	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				City of London Health & Wellbeing Board	Member	Non-Pecuniary Interest
				Local Medical Committee	Member	Non-Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				CHUHSE	Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Anntoinette	Bramble	05/06/2019	Member - Hackney Integrated Commissioning Board	Hackney Council	Deputy Mayor	Pecuniary Interest
				Local Government Association	Member of the Children and Young Board	Pecuniary Interest
				Schools Forum	Member	Pecuniary Interest
				SACRE	Member	Pecuniary Interest
				Admission Forum	Member	Pecuniary Interest
				HSFL (Ltd)		Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Urstwick School	Governor	Non-Pecuniary Interest
				City Academy	Governor	Non-Pecuniary Interest
				Hackney Play Bus (Charity)	Board Member	Non-Pecuniary Interest
				Local Government Association	Member	Non-Pecuniary Interest
				Lower Clapton Group Practice	Registered Patient	Non-pecuniary interest
Marianne	Fredericks	26/02/2020	Member - City Integrated Commissioning Board	City of London	Member	Pecuniary Interest
				Farringdon Ward Club	Member	Non-Pecuniary Interest
				The Worshipful Company of Firefighters	Liveryman	Non-Pecuniary Interest
				Christ's Hospital School Council	Member	Non-Pecuniary Interest
				Aldgate and All Hallows Foundation Charity	Member	Non-Pecuniary Interest
				The Worshipful Company of Bakers	Liveryman	Non-Pecuniary Interest
				Tower Ward Club	Member	Non-Pecuniary Interest
Christopher	Kennedy	25/06/2019	Deputy Member - Hackney Integrated Commissioning Board	Hackney Council	Cabinet Member for Families, Early Years and Play	Pecuniary Interest
				Lee Valley Regional Park Authority	Member	Non-Pecuniary Interest
				Hackney Empire	Member	Non-Pecuniary Interest
				Hackney Parochial Charity	Member	Non-Pecuniary Interest
				Labour party	Member	Non-Pecuniary Interest
				Local GP practice	Registered patient	Non-Pecuniary Interest
Dhruv	Patel	12/08/2019	Member - City Integrated Commissioning Board	City of London Corporation	Deputy Chairman, City of London Corporation Integrated Commissioning Sub-Committee	Pecuniary Interest
				Clockwork Pharmacy Group SSAS, Amersham	Trustee; Member	Pecuniary Interest
				Clockwork Underwriting LLP, Lincolnshire	Partner	Pecuniary Interest
				Clockwork Retail Ltd, London	Company Secretary & Shareholder	Pecuniary Interest
				Clockwork Pharmacy Ltd	Company Secretary	Pecuniary Interest
				DP Facility Management Ltd	Director; Shareholder	Pecuniary Interest
				Clockwork Farms Ltd	Director; Shareholder	Pecuniary Interest
				P&A Developments	Company Secretary	Pecuniary Interest
				Clockwork Hotels LLP	Partner	Pecuniary Interest
				Capital International Ltd	Employee	Pecuniary Interest
					Land Interests - 8/9 Ludgate Square 215-217 Victoria Park Road 236-238 Well Street 394-400 Mare Street 1-11 Dispensary Lane	Pecuniary Interest
					Securities - Fundsmith LLP Equity Fund Class Accumulation GBP J P Morgan American Investment Trust PLC Ord	Pecuniary Interest
				City of London Academies Trust	Director	Non-Pecuniary Interest
				The Lord Mayor's 800th Anniversary Awards Trust	Trustee	Non-Pecuniary Interest
				City Hindus Network	Director; Member	Non-Pecuniary Interest
				Aldgate Ward Club	Member	Non-Pecuniary Interest
				City & Guilds College Association	Life-Member	Non-Pecuniary Interest
				The Society of Young Freemen	Member	Non-Pecuniary Interest
				City Livery Club	Member and Treasurer of u40s section	Non-Pecuniary Interest
				The Clothworkers' Company	Liveryman; Member of the Property Committee	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				Diversity (UK)	Member	Non-Pecuniary Interest
				Chartered Association of Buidling Engineers	Member	Non-Pecuniary Interest
				Institution of Engineering and Technology	Member	Non-Pecuniary Interest
				City & Guilds of London Institute	Associate	Non-Pecuniary Interest
				Association of Lloyd's members	Member	Non-Pecuniary Interest
				High Premium Group	Member	Non-Pecuniary Interest
				Avanti Court Primary School	Chairman of Governors	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Randall	Anderson	15/07/2019	Member - City Integrated Commissioning Board	City of London Corporation	Chair, Community and Children's Services Committee	Pecuniary Interest
				n/a	Self-employed Lawyer	Pecuniary Interest
				n/a	Renter of a flat from the City of London (Breton House, London)	Non-Pecuniary Interest
				Member	American Bar Association	Non-Pecuniary Interest
				Masonic Lodge 1745	Member	Non-Pecuniary Interest
				Worshipful Company of Information Technologists	Freeman	Non-Pecuniary Interest
				City of London School for Girls	Member - Board of Governors	Non-Pecuniary Interest
				Neaman Practice	Registered Patient	Non-Pecuniary Interest
Andrew	Carter	12/08/2019	City ICB advisor / regular attendee	City of London Corporation	Director of Community & Children's Services	Pecuniary Interest
				Petchey Academy & Hackney / Tower Hamlets College	Governing Body Member	Non-pecuniary interest
				n/a	Spouse works for FCA (fostering agency)	Indirect interest
David	Maher	19/06/2019	Accountable Officers Group Member ICB regular attendee/ AO deputy	City and Hackney Clinical Commissioning Group	Managing Director	Pecuniary Interest
				World Health Organisation	Member of Expert Group to the Health System Footprint on Sustainable Development	Non-Pecuniary Interest
				NHS England, Sustainable Development Unit	Social Value and Commissioning Ambassador	Non-Pecuniary Interest
Rebecca	Rennison	31/05/2019	Member - Hackney Integrated Commissioning Board	Target Ovarian Cancer	Director of Public Affairs and Services	Pecuniary Interest
				Hackney Council	Cabinet Member for Finance and Housing Needs	Pecuniary Interest
				Cancer52Board	Member	Non-Pecuniary Interest
				Clapton Park Tenant Management Organisation	Board Member	Non-Pecuniary Interest
				North London Waste Authority	Board Member	Non-Pecuniary Interest
					Land Interests - Residential property, Angel Wharf	Non-Pecuniary Interest
					Residential Property, Shepherdess Walk, N1	Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Fabian Society	Member	Non-Pecuniary Interest
				English Heritage	Member	Non-Pecuniary Interest
				Chats Palace	Board Member	Non-Pecuniary Interest
Carol	Beckford	09/07/2019	Transition Director	Hunter Health Group	Agency Worker	Non-Pecuniary Interest
Henry	Black	27/06/2019	NEL Commissioning Alliance - CFO	Barking, Havering & Redbridge University Hospitals NHS Trust	Wife is Assistant Director of Finance	Indirect interest
				East London Lift Accommodation Services Ltd	Director	Non-financial professional interest
				East London Lift Accommodation Services No2 Ltd	Director	Non-financial professional interest
				East London Lift Holdco No2 Ltd	Director	Non-financial professional interest
				East London Lift Holdco No3 Ltd	Director	Non-financial professional interest
				East London Lift Holdco No4 Ltd	Director	Non-financial professional interest
				ELLAS No3 Ltd	Director	Non-financial professional interest
				ELLAS No4 Ltd	Director	Non-financial professional interest
				Infracare East London Ltd	Director	Non-financial professional interest
Jane	Milligan	26/06/2019	Member - Integrated Commissioning Board	NHS North East London Commissioning Alliance (City & Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge CCGs)	Accountable Officer	Pecuniary Interest
				North East London Sustainability and Transformation Partnership	Senior Responsible Officer	Pecuniary Interest
				n/a	Partner is employed substantively by NELCSU as Director of Business Development from 2 January 2018 on secondment to Central London Community Services Trust.	Indirect Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				Stonewall	Ambassador	Non-Pecuniary Interest
				Peabody Housing Association Board	Non-Executive Director	Non-pecuniary interest
Mark	Rickets	24/10/2019	Member - City and Hackney Integrated Commissioning Boards	City and Hackney Clinical Commissioning Group	Chair	Pecuniary Interest
			Primary Care Quality Programme Board Chair (GP Lead)	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	Non-financial professional interest
			Primary Care Quality Programme Board Chair (GP Lead)	GP Confederation	Nightingale Practice is a Member	Professional financial interest
			CCG Chair Primary Care Quality Programme Board Chair (GP Lead)	HENCEL	I work as a GP appraiser in City and Hackney and Tower Hamlets for HENCEL	Professional financial interest
			CCG Chair Primary Care Quality Programme Board Chair (GP Lead)	Nightingale Practice (CCG Member Practice)	Salaried GP	Professional financial interest
Jake	Ferguson	30/09/2019	Chief Executive Officer Member	Hackney Council for Voluntary Service Voluntary Sector Transformation Leadership Group which represents the sector across the Transformation / ICS structures.	Organisation holds various grants from the CCG and Council. Full details available on request.	Professional financial interest Non-financial personal interest
Jon	Williams	02/03/2020	Attendee - Hackney Integrated Commisioning Board	Healthwatch Hackney	Director - CHCCG Neighbourhood Involvement Contract - CHCCG NHS Community Voice Contract - CHCCG Involvement Alliance Contract - CHCCG Coproduction and Engagement Grant - Hackney Council Core and Signposting Grant Based in St. Leonard's Hospital	Pecuniary Interest

Meeting-in-common of the Hackney Integrated Commissioning Board
(Comprising the City & Hackney CCG Integrated Commissioning Committee and the London Borough of Hackney Integrated Commissioning Committee)

and

Meeting-in-common of the City Integrated Commissioning Board
(Comprising the City & Hackney CCG Integrated Commissioning Committee and the City of London Corporation Integrated Commissioning Committee)

Minutes of meeting held in public on 11 June 2020
Microsoft Teams

Present:

Hackney Integrated Commissioning Board

Hackney Integrated Commissioning Committee

Cllr Christopher Kennedy	Cabinet Member for Health, Adult Social Care and Leisure	London Borough of Hackney
Cllr Antoinette Bramble	Cabinet Member for Community Safety, Policy and the Voluntary Sector	London Borough of Hackney
Cllr Rebecca Rennison	Cabinet Member for Finance, Housing Needs and Supply	London Borough of Hackney

City & Hackney CCG Integrated Commissioning Committee

Dr. Mark Rickets	CCG Chair	City & Hackney CCG
Jane Milligan	Accountable Officer	City & Hackney CCG
Honor Rhodes	Governing Body Lay member	City & Hackney CCG

City Integrated Commissioning Board

City Integrated Commissioning Committee

Randall Anderson QC	Chairman, Community and Children's Services Committee (ICB Chair)	City of London Corporation
Helen Fentimen	Member, Community & Children's Services Committee	City of London Corporation
Marianne Fredericks	Member, Community and Children's Services Committee	City of London Corporation

In attendance

Andrew Carter	Director, Community & Children's Services	City of London Corporation
Carolyn Kus	Director of Programme Delivery	London Borough of Hackney
Denise D'Souza	Interim Director of Adult Services	London Borough of Hackney

Gary Marlowe	Governing Body GP member	City & Hackney CCG
Jake Ferguson	Chief Executive Officer	Hackney Council for Voluntary Services
Jonathan McShane	Integrated Commissioning Programme Convenor	City & Hackney CCG
Ian Williams	Group Director, Finance and Corporate Services	London Borough of Hackney
Mark Golledge	Neighbourhoods Programme Lead	City & Hackney CCG
Nina Griffith	Unplanned Care Workstream Director	City & Hackney CCG
Paul Coles	General Manager	City of London Healthwatch
Philip Glanville	Mayor of Hackney	London Borough of Hackney
Siobhan Harper	Workstream Director: Planned Care	City & Hackney CCG
Dr. Sandra Husbands	Director of Public Health	London Borough of Hackney
Sunil Thakker	Director of Finance	City & Hackney CCG
Dr. Stephanie Coughlin	Clinical Lead	Homerton Hospital
Stella Okonkwo	Integrated Commissioning Programme Manager	City & Hackney CCG
Simon Cribbens	Assistant Director Commissioning & Partnerships, Community & Children's Services	City of London Corporation
Tim Shields	Chief Executive	London Borough of Hackney
Apologies – ICB members		
Cllr Anntoinette Bramble	Cabinet Member for Education, Young People and Children's Social Care	London Borough of Hackney
Other Apologies		
Mark Jarvis	CFO	City of London Corporation

1. WELCOME, INTRODUCTIONS AND APOLOGIES

1.1. The Chair, Randall Anderson, opened the meeting.

1.2. Apologies were noted as listed above.

2. DECLARATIONS OF INTERESTS

2.1. The **City Integrated Commissioning Board**

- **NOTED** the Register of Interests.

2.2. The **Hackney Integrated Commissioning Board**

- **NOTED** the Register of Interests.

3. QUESTIONS FROM THE PUBLIC

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

4. MINUTES OF PREVIOUS MEETING AND ACTION LOG

4.1. The **City Integrated Commissioning Board:**

- **APPROVED** the minutes of the Joint ICB meeting held in public on 13 March 2020.
- **NOTED** the updates on the action log.

4.2. The **Hackney Integrated Commissioning Board**:

- **APPROVED** the minutes of the Joint ICB meeting held in public on 13 March 2020.
- **NOTED** the updates on the action log.

5. ICB Development

5.1 Carolyn Kus introduced the item. She noted that the next ICB development session would be an opportunity to reflect on the last three months of working with Covid-19. Simon Standish would be conducting a series of interviews with integrated care colleagues.

5.2 The proposal to create a Local Outbreak Board was also discussed. Hackney was one of the local authorities which would be setting up the test, track and trace system. The first Local Outbreak Board would be scheduled for July – there were uncertainties around this but we also needed to move at pace.

5.3 **The City Integrated Commissioning Board**

- **DELEGATED AUTHORITY** to the Chair of the Community and Children's Services Sub-Committee to agree upon the changes to the ICB Terms of Reference to designate the ICB as the Local Outbreak Board.

5.4 **The Hackney Integrated Commissioning Board**

- **DELEGATED AUTHORITY** to the Chair of the Community and Children's Services Sub-Committee to agree upon the changes to the ICB Terms of Reference to designate the ICB as the Local Outbreak Board.

6. Homelessness Update

6.1 The item was introduced by Siobhan Harper. She noted that it had initially taken a while to get this co-ordinated, however progress had been very positive. The number of infections amongst homeless people were lower than one might expect.

6.2 Our next steps would be focused on sustainability. Accommodation set up by the GLA was likely to be stepped-down. There were ongoing negotiations with NEL that would also incorporate local government. Our objective was to eradicate rough sleeping.

6.3 Randall Anderson noted that the next phase was likely to be more challenging as there would be a variety of people in different settings. Gary Marlowe raised that there was an opportunity to do a more comprehensive assessment of this group.

6.4 Cllr Rennison also highlighted that we have issues with people with no recourse to public funds. The government had told us that it was up to local authorities to deal with this matter.

6.5 Marianne Fredericks said that she hoped that homeless people had benefited from these measures, but it would be much more challenging for them if they had to ultimately return to living on the streets. We needed more clarity from the government on this.

6.6 Jon Williams stated that Healthwatch needed to be involved in any co-production of future measures. Honor Rhodes added that the only way to move forward with such a marginalised group would be through co-production.

6.7 Siobhan Harper stated that the NE London stocktake would give us parameters around the health needs of homeless people going forward. There was a good opportunity, however, to understand this population well. We also have a further opportunity to put our beliefs into action around inequality and co-production.

6.8 Mayor Glanville stated that we need to understand the relationship between the ICB, NE London and the local leadership. It had been challenging to get things aligned at the borough level, let alone at the NE London level. Jane Milligan responded that there had been a London-wide approach to covid-19. The NEL response was about mobilising collective effort. There had also been an opportunity to make sure everyone has the opportunity for protection and housing.

- **A further paper on resourcing this program would be brought to the July ICB.**

6.9 **The City Integrated Commissioning Board**

- **NOTED** the report.

6.10 **The Hackney Integrated Commissioning Board**

- **NOTED** the report.

7. Phase Two Update

7.1 The item was introduced by David Maher. Points raised included the following:

- The paper represented the start of a piece of work that we would need to do with communities and providers.

- There was a need to ensure that patients have safe access to care, and we need to make sure our system is staffed in a way which prioritises safety.
- In terms of equalities, there is a significant debate we need to think about in terms of equity of access.
- Services would be separated between covid and non-covid. Similarly, we need to think about how staff organize themselves that that they are either working with covid or non-covid patients.
- We have engaged the Nightingale Hospital and expect we would commission around 400 beds to deal with a potential surge of covid-19 infections.
- We are also taking the opportunity to modernise mental health services.
- Also being worked on was the re-alignment of elective surgical capacity across NEL. Specialist services had also been consolidated.
- Multi-disciplinary teams were being embedded in local communities to ensure swift access to specialist support when needed. The work on this was hugely positive.
- Remote working was being deployed across primary care and was currently working well.
- We would also be using the “let’s talk” format to engage with residents about how to co-produce a set of plans which we would mobilise over the winter.

7.2 Randall Anderson asked if we understand the level of deferred procedures and treatments. David Maher responded that we did. We have a prioritisation framework in place to identify patients who need access to those procedures most urgently. We would have a clearer picture of this in July.

7.3 Cllr Kennedy stated that he was unsure about the mental health proposal for the Homerton and whether we were planning to keep inpatient beds there. We need to make sure these plans are in front of scrutiny committees as soon as possible.

7.4 Jake Ferguson welcomed the commitment of resources for those with the most unequal outcomes. The proposals for “virtual by default”, however, did not mention care workers. Voluntary sector partners were talking about radical changes being needed in how care was commissioned. There was also some disquiet about the inequitable treatment of staff. Nurses, for example, were being required to do face-to-face work whilst GPs and consultants were operating virtually to a substantial degree. We also need to understand the scope of virtual work, particularly in the context of discharge-to-assess.

7.5 David Maher added that we were putting up a mental health centre-of-excellence planning group. There would need to be some mental health facilities on the Homerton site for certain cases.

- **Workforce plans for Phase 2 to be brought back to a future ICB.**

- **David Maher to update ICB attendees outside the meeting on the discharge-to-assess model.**

7.6 Mark Rickets stated the need to respond to the impact of covid-19 and managing rehabilitation following infection whilst also attending to the things we did before. We would have a greater understanding of this disease in six months' time. We also need to be mindful that we are currently in a government stage of emergency planning, and we need to ensure that the responses we implement are proportionate. We also need to be mindful that we could create new inequalities if we do not get our response right.

7.7 Gary Marlowe stated that we should refer to "virtual where appropriate" as opposed to "virtual by default". Our plans would be to have low risk, high-volume areas and specialist services would be confined to specific circumstances. We have also not used the private sector as sufficiently as we would have liked – they were not being properly scrutinised.

7.8 David Maher highlighted the positivity of the community response to covid-19, and there was a lot of power in that social capital.

7.9 Helen Fentimen added that we need to examine what has changed through necessity with a view to examining where that change was a positive one.

- **A paper to come back to a future ICB on care homes.**
- **Jane Milligan would follow-up with Mayor Glanville on the NE London approach to workforce, specifically highlighting issues relating to zero-hours contracts.**

7.10 **The City Integrated Commissioning Board**

- **NOTED** the report.

7.11 **The Hackney Integrated Commissioning Board**

- **NOTED** the report.

8. Update on Prevention workstream transformation programmes to support the Covid-19 response - Make Every Contact Count, Community Navigation, Find Support Services

8.1 Kate Wignall introduced the item. She highlighted that the prevention programmes are supporting the humanitarian response. We also need to support peoples' wider health and wellbeing needs which was being done by providing training through public health contracts.

8.2 Tamsin Briggs also highlighted that in terms of Making Every Contact Count, we had been assisting staff to have the confidence and competence to talk about their wider health and wellbeing needs. We need to use momentum to broaden the reach.

The **City Integrated Commissioning Board**

- **NOTED** how Prevention transformation programmes have adapted to support the Covid-19 response and proposals on how to move forward during the next phase of the pandemic;

- **ENDORSED** Make Every Contact by acting as visible champions for embedding the principles of MECC across the local health and care system as a key component of next phase planning.

9.4 The **Hackney Integrated Commissioning Board**

- **NOTED** how Prevention transformation programmes have adapted to support the Covid-19 response and proposals on how to move forward during the next phase of the pandemic;

- **ENDORSED** Make Every Contact by acting as visible champions for embedding the principles of MECC across the local health and care system as a key component of next phase planning.

9. Reward & Recognition Policy

9.1 Jon Williams introduced the item. He noted that this policy would be kept under review and re-examined within one year.

9.2The **City Integrated Commissioning Board**

- **ENDORSED** the policy for implementation.

9.3 The **Hackney Integrated Commissioning Board**

- **ENDORSED** the policy for implementation.

10. Local Outbreak Control and Test, Trace and Isolate in City & Hackney

10.1 Sandra Husbands introduced the item. Points raised in introduction included the following:

- There would be a different approach now because high-risk people would be asked to isolate for a maximum for 14 days if contacted by a contact tracer.
- Lockdown measures would be eased. We are developing procedures in place for specific outbreaks in areas like care homes, schools, GP practises. These would be supported in collaboration with Public Health England.
- The ICB would also be designated as the Local Outbreak Board, with provider colleagues invited to the session to discuss the approach to covid-19 management in the City & Hackney area.

10.2 In terms of the data received on track and trace, the data which were received were not especially useful. It stated the number of tests that had been carried out, number of contacts. It did not indicate things such as how many contacts belonged to each case, how many people had been reached.

10.3 The other report received was an accedence report – this was a statistical report however Sandra Husbands stated that she was unsure that the data placed into this report was the correct data to identify the level of circulation and infection.

10.4 Regarding budget allocations, there was £300m allocated to local authorities. Budget for the City was just over £146,000 and just over £3m for the London Borough of Hackney. It was not currently clear how the money was able to be spent.

10.5 The data which were coming out were largely around performance. It didn't provide the necessary information to deal with a local outbreak.

10.6 Individuals displaying symptoms had responsibility to be tested, however those who had attended communal events would need to reach out to the people responsible for those events directly. Local authorities would therefore need to reach out to leaders of organisations, event organisers, etc. directly.

10.7 Helen Fentimen stated that we need to think about how, locally, we can enhance the test and tracing program. Local groups and community leaders need to be brought along on this.

10.8 Sandra Husbands added that testing and tracing would rely on frequent and timely information as to who was being tested. We need a clearer picture of the epidemiology of this and the local likelihood of infection, but these data were not being provided. As we do not have detailed local information we cannot calculate the likelihood of infection ourselves. We could aim to avoid a local lockdown by being rigorous with contact tracing.

10.9 Sandra Husbands also added that we need to consider a situation where we would force a building to close down, but this has not been fully thought-through yet.

10.10 Sandra Husbands also stated that we need to establish local testing. One challenge is that the case definition for covid-19 is very loose and therefore high numbers of people could end up being isolated on the basis of vague case definitions and potentially relating to people who have not had a covid-19 infection.

The **City Integrated Commissioning Board** is hereby asked:

- **ENDORSED** the draft outbreak control plan and the approach to developing a local contact tracing system and local outbreak management;
- **ENDORSED** the suggested approach to ensuring appropriate governance and accountability of the local outbreak management system and effective engagement with local communities.

The **Hackney Integrated Commissioning Board** is hereby asked:

- **ENDORSED** the draft outbreak control plan and the approach to developing a local contact tracing system and local outbreak management.

- **ENDORSED** the suggested approach to ensuring appropriate governance and accountability of the local outbreak management system and effective engagement with local communities.

11. Neighbourhood Health and Care Services – Update

11.1 The item was introduced from Jonathan McShane. David Maher, Nic Ib and Jonathan McShane were working on a program setting out the things which need to be agreed. A fuller update to the July meeting.

12. AOB & Reflections

12.1 Cllr Kennedy stated that we needed to give greater consideration to inequalities shown by covid-19 and how we respond as a system to that.

12.2 Honor Rhodes highlighted the need to hold onto what was positive about the past few months.

12.3 Jake Ferguson stated that the issue of inequalities would require a substantial change in the transference of power to people who had been most heavily impacted by covid-19. What in our ways of working was preventing us from having an acceptable outcome?

12.4 Marianne Fredericks stated that the past few months have shown what we can do when we are at our best. Helen Fentimen re-iterated this point and stated it shows what is possible when we are focused on necessity.

Date and time of next meeting

The next meeting will be held on 9 July – virtual.

City and Hackney Integrated Commissioning Programme Action Tracker

Ref No	Action	Assigned to	Assigned date	Due date	Status	Update
ICBMay-1	A dedicated **health inequalities paper** would be brought back to ICB in either June or July.	David Maher	14/05/2020	Jul-20	Closed.	On the agenda.
ICBMay-4	Sunil Thakker to bring back updated progress report on **CCG contracting position.**	Sunil Thakker	14/05/2020	Aug-20	Open	This will be brought to the August meeting following receipt of guidance from NHSE/I.
ICBMay-5	David Maher and Jonathan McShane to share a paper at a future ICB on the **provider alliance approach to service delivery, outcomes and patient experience.**	Jonathan McShane	14/05/2020	Jul-20	Open	
ICBMay-8	Anne Canning stated that she would bring back a paper to a future ICB on the interface between **Neighbourhoods and the CYPMF workstream.**	Anne Canning	14/05/2020	Jul-20	Closed	On the agenda for July.
ICBJun-1	A further paper on **Homelessness Resourcing** would be brought to the July ICB.	Siobhan Harper	11/06/2020	Jul-20	Closed	On the agenda for July.
ICBJun-2	**Workforce Plans** to be brought to a future ICB.	David Maher	11/06/2020	Aug-20	Open	On the forward planner for August.
ICBJun-3	**Discharge to assess** paper to be shared with ICB members.	David Maher	11/06/2020	Jul-20	Closed	Circulated with the papers for the July meeting.
ICBJun-4	A paper to be brought back to ICB on **care homes.**	Nina Griffith	11/06/2020	Aug-20	Open	On the forward planner for August.
ICBJun-5	Jane Milligan would follow-up with Mayor Glanville on the **NE London approach to workforce**, specifically highlighting issues relating to zero-hours contracts.	Jane Milligan	11/06/2020	Jul-20	Open	

Title of report:	A framework for tackling health inequalities in the City and Hackney and the role of ICB
Date of meeting:	09/07/2020
Lead Officer:	Jayne Taylor - Consultant in Public Health, ICP Prevention Lead
Author:	Jayne Taylor Anna Garner - Head of Performance and Integrated Commissioning Alignment
Committee(s):	Integrated Commissioning Board
Public / Non-public	Public

Executive Summary:

The impacts of COVID-19 on population health are clearly reinforcing long-standing inequalities in the City and Hackney, as elsewhere. The breadth and depth of these impacts requires collective and sustained partnership action.

The ICB has a clear role to play in setting a strategic framework for the design and delivery of an integrated health and care system that focuses explicitly on tackling health inequalities, as part of a broader population health strategy.

To this end, this paper proposes the adoption of a population health framework for the emerging City and Hackney operating model, and outlines a number of specific next step actions to take forward now to ensure that our recovery plans directly address the inequalities challenge that COVID-19 has clearly exposed.

Recommendations:

The **City Integrated Commissioning Board** is hereby asked:

- To **ENDORSE** the use of a population health framework for the City and Hackney operating model, as part of a broader health and wellbeing strategy, to ensure that the integrated health and care system supports the delivery of wider strategic aims to reduce health inequalities through concerted collective local action.
- To **COMMIT** to using all the levers at its discretion to call out, and take meaningful action to reduce, all forms of health inequality in the City of London.
- To **ENDORSE** the proposed next step actions as set out in this paper.
- To **ADVISE** on governance arrangements for agreeing short-term priorities and developing a longer-term City and Hackney population health delivery plan.

The **Hackney Integrated Commissioning Board** is hereby asked:

Hackney

CITY OF LONDON

NHS
City and Hackney Clinical Commissioning Group

- To **ENDORSE** the use of a population health framework for the City and Hackney operating model, as part of a broader health and wellbeing strategy, to ensure that the integrated health and care system supports the delivery of wider strategic aims to reduce health inequalities through concerted collective local action.
- To **COMMIT** to using all the levers at its discretion to call out, and take meaningful action to reduce, all forms of health inequality in Hackney.
- To **ENDORSE** the proposed next step actions as set out in this paper.
- To **ADVISE** on governance arrangements for agreeing short-term priorities and developing a longer-term City and Hackney population health delivery plan.

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	Y	The population health framework proposed in this paper has an explicit focus on taking preventative action and tackling health inequalities
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☐	
Empower patients and residents	Y	The proposed approach to co-creating a population health delivery plan is intended to empower patients and residents to shape our local approach to address long-standing inequalities.

Specific implications for City

None. Proposals apply equally to the City and Hackney.

Specific implications for Hackney

None. Proposals apply equally to the City and Hackney.

Patient and Public Involvement and Impact:

The proposals set out in this paper are based on a fully co-produced approach to developing a population health delivery plan for City and Hackney Integrated Care Partnership - utilising, and building on, existing community assets and resident engagement/involvement mechanisms (including Neighbourhoods). The COVID-19 inequalities matrix described (appendix 2) has been shaped by extensive community insight that has been gathered from various sources over the course of the pandemic.

Clinical/practitioner input and engagement:

Clinical/practitioner involvement will be key to co-creating a long-term population health delivery plan, and re-prioritising existing plans to focus explicitly on tackling health inequalities.

Communications and engagement:

A comprehensive comms and engagement plan will be developed to support the proposed approach set out in this paper, led by the IC Comms and Engagement Enabler Group.

Equalities implications and impact on priority groups:

This paper focuses specifically on a proposed framework for addressing health inequalities and ensuring local integrated care plans address the needs of priority groups.

Safeguarding implications:

None at this stage

Impact on / Overlap with Existing Services:

The proposals set out in this paper have implications for all health and care services in the City and Hackney.

Main Report

1. Introduction and context

The unprecedented impacts, direct and indirect, of COVID-19 on population health are clearly reinforcing and exacerbating long-standing health inequalities, both nationally and locally.

- The *direct* health impacts of COVID-19 disease are disproportionately affecting certain minority ethnic groups, older people, men,[1] people with underlying health conditions, care home residents and staff, those working in other public facing occupations, as well as individuals and families living in socially deprived circumstances. Untangling the contribution of these various overlapping risk factors is complex, but it is clear that underlying structural inequalities are playing a role.
- The *indirect* health impacts of lockdown and social distancing and the longer-term economic consequences of the pandemic will continue to affect some of our most vulnerable residents and communities for a long time to come - including many of those described above, as well as carers, certain faith communities, people with disabilities and those with no recourse to public funds.

A more detailed overview of the evidence and local intelligence is provided in appendix 1.[2]

The breadth and depth of these impacts emphasises the need for collective, system-wide action to address health inequalities that have been starkly exposed by the current pandemic. COVID-19 could be the catalyst for real change, and the development of the new City and Hackney operating model is a real opportunity to shape the future direction of integrated health and care services as part of this collective effort.

2. Responding to the challenge

The current pandemic has added an urgency to our local response to health inequalities. Because of the scale, breadth and uncertainty of the impact of COVID-19, we need to plan our response over three time horizons.

2.1 Immediate priorities

[1] While men are at greater risk of dying from COVID-19, there is some evidence to suggest that women are over-represented in some occupations considered most at risk of being infected with coronavirus; women are also more likely have been furloughed or made redundant during the lockdown, and to be suffering emotional impact from the pandemic.

[2] Currently, this analysis focuses on Hackney, due to data availability for the City

An absolute priority in our ongoing response to the pandemic and in getting services back up and running must be to ensure that:

a) we are not exacerbating existing inequalities
    - one example is the work being led by Hackney Council to address the digital divide, so that no residents are excluded from the digital Test & Trace system or disadvantaged by the 'virtual by default' approach to NHS service restoration
    - another is the equalities 'checklist' that has been developed to support the local NHS phase 2 assurance process
b) we are proactively targeting those who have been most disadvantaged by the pandemic and developing plans to reduce the unequal impact of any second peak, examples include
    - targeted work (with HCVS) to prevent the spread of infection in vulnerable communities as part of local outbreak control plans
    - action being taken to protect staff working in high risk roles.

2.2 Actions to implement over the short-medium term

Work is also needed to review, refresh and re-prioritise our pre-existing strategic plans through an explicit inequalities lens - both to ensure sufficient focus is placed on inequalities that have deepened as a result of COVID-19 (e.g. linked to ethnicity and deprivation) and that our plans are broadened to directly address the needs of vulnerable groups who have hitherto not been prioritised (e.g. people living in insecure, overcrowded accommodation who are at increased risk of infection and may have limited access to services).

Much of this work is already underway, including the creation of a set of tools to inform the ongoing development of City & Hackney's integrated care plans (see section 4 below), plus the extensive work being undertaken by the two local authorities to review existing priorities as part of their 'recovery' plans. Importantly, this work is being shaped not only by local and national data on COVID-19 inequalities, but by the rich community insight that has been (and continues to be) collected during the pandemic, which is providing powerful evidence on the local impacts on City and Hackney's diverse communities.

2.3 Longer-term strategic priorities

Ultimately, what is needed is a comprehensive strategy to meet the challenges posed by COVID-19. The wide-ranging impacts of the pandemic emphasise more than ever the need for sustained system-wide action to tackle the underlying causes of long-standing health inequalities.

There is a clear role for the Health and Wellbeing Boards to set the overarching strategic framework for tackling local health inequalities in the City and Hackney and for the ICB to lead the integrated health and care system contribution to this.

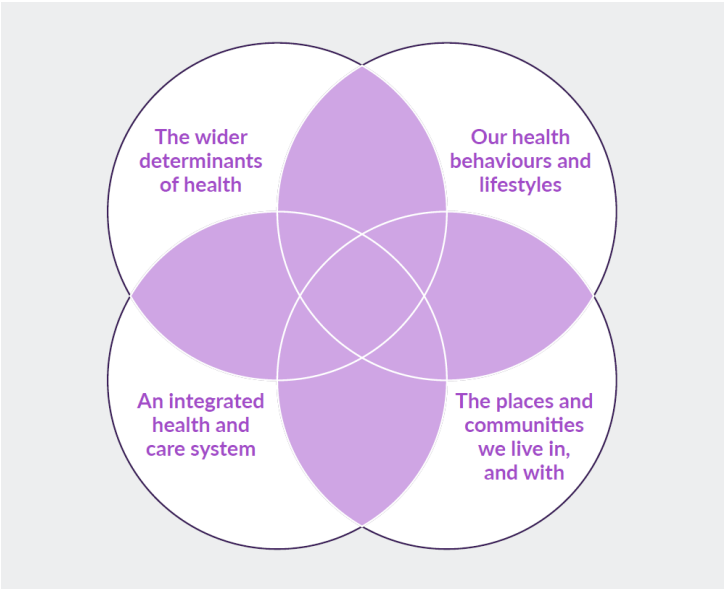
3. The role of the Integrated Commissioning Board

ICB has a key role in setting a framework for the design and delivery of an integrated health and care system that explicitly focuses on tackling health inequalities. Reducing inequalities, by embedding a 'population health approach', has been a long-standing local ambition of the City and Hackney integrated care system and a core feature of the Neighbourhoods model, but what does this mean in practice?

According to the King's Fund, a population health approach means *"improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies."*

The unequal distribution of population health outcomes is driven by a complex interaction of individual, community and structural factors. Tackling health inequalities, and improving population health, therefore requires action at multiple levels and across all sections of society. This means addressing all four 'pillars' of a population health system (Figure 1).

Figure 1: King's Fund Population Health Framework[3]



While an effective integrated health and care system is essential to meeting population health needs and reducing inequalities, it is insufficient on its own. The biggest drivers of population health outcomes are linked to social, economic and environmental conditions (income, employment, education, housing, transport, etc), and it is structural inequalities linked to these 'wider determinants' that make the most significant contribution to health inequalities - as has been laid bare by the current pandemic.

As well as health behaviours (including smoking, physical activity, diet and alcohol), which themselves are socially patterned, this framework also emphasises the importance of 'place' - the neighbourhoods and communities in which we live - as being key drivers of health and wellbeing at an individual and population level. Working with, and drawing on the assets within, our local communities must therefore be central to our response to tackling health inequalities.

The greatest opportunities to improve population health and reduce underlying inequalities lie in the areas of overlap and intersection of the four 'pillars'. Over and above ensuring that service plans directly consider and address inequity (of access, experience and outcomes), it is here that the integrated health and care system should focus its efforts. The Neighbourhood model is an excellent example of this, focused as it is on co-designing services and using community assets to meet hyper-local population needs within a defined 'place'. At a wider system level, the work being taken forward to develop a City and Hackney anchor network, with local authorities and NHS trusts working together to maximise their social value, has the potential to

[3] Buck et al (2018), *A vision for population health: towards a healthier future*, King's Fund

make a significant contribution to improvements in the economic and environmental determinants of health (e.g. through common employment and workforce policies and sustainable procurement strategies). And, by embedding 'make every contact count' as an approach across and beyond the health and care system, we can improve health literacy among some of our most disadvantaged communities - thus helping more people to better understand and take positive action to address the multiple factors that interconnect to influence their wellbeing.

The whole-system, asset-based approach suggested by this population health framework is consistent with plans being progressed at NEL level to tackle health inequalities as part of phase 2 planning (especially with respect to anchor institutions). It is also consistent with the principles underpinning the work to review Hackney's Community Strategy (i.e. 'building back better' through system-wide action and proactive community engagement, targeting support where it is needed the most), as well as the strong emphasis on inequalities within the City of London's recovery plans. Aligning the City and Hackney operating model with these wider programmes of work, as part of a comprehensive population health strategy, will maximise opportunities for tackling the underlying drivers of local health inequalities.

4. Proposed next steps

4.1 Identify short-term priorities to address health inequalities exposed by COVID-19

Work has begun, through the System Operational Command Group, to develop a set of tools to ensure that phase 2 plans retain an explicit focus on reducing (or at least not exacerbating) health inequalities. This includes:

- a COVID-19 inequalities matrix (appendix 2) - a visual tool to highlight priority areas for action and help identify gaps/where plans are not already in place
- a rapid equalities impact assessment tool (in development) - to guide decisions about phase 2 plans and make explicit our expectations about inequalities impacts
- an equalities dashboard (working group to be established) - to monitor progress and the impact of our actions.

The inequalities matrix has been informed by the COVID-19 engagement and insight log that has been created and managed by the Comms and Engagement Enabler Group, as well as other community insight gathered by HCVS and local authority partners. Continuing with this co-produced approach (using existing engagement and involvement networks and groups), the matrix will be used to prioritise some specific short-term actions to tackle inequalities that have been (further) exposed during the current pandemic and/or which could mitigate the inequalities impacts of a future/second 'peak'. Examples may include:[4]

[4] These examples above align with the recommendations of the recent Public Health England report, *Beyond the data: understanding the impact of COVID-19 on BME communities*. For example, use of

- tackling the ‘digital divide’ so that no residents are disadvantaged by new virtual models of care
- more tailored and nuanced communications (utilising behaviour change techniques) to counter anxieties within specific populations, and encourage vulnerable residents to access services and comply with test and trace protocols
- effective roll-out of meaningful workplace risk assessments, which recognise COVID-19 vulnerabilities, across all partner organisations, as well as other workforce initiatives (e.g. mentoring, BAME networks, apprenticeships)
- building on existing work on management of risk factors and long term conditions, to ensure that the most vulnerable groups are appropriately supported
- targeted work to address housing-related risks to poor health, including enhanced support to people living in insecure, overcrowded accommodation.

4.2 Develop a population health delivery plan for City and Hackney Integrated Care Partnership (ICP)

It is proposed that the tools described in 4.1 are used to review and re-prioritise our (pre-COVID) health and care transformation programmes and plans through an explicit inequalities lens. This can then support the co-creation of a long-term population health delivery plan for City and Hackney ICP, setting out specific actions that the health and care system will take to improve population health and reduce health inequalities (through collaborative action across the ‘four pillars’ described in section 3 of this paper).

Development of the population health delivery plan will need to align with the processes for refreshing both of the Hackney and City of London Joint Health and Wellbeing Strategies and be fully co-produced, utilising (and building on) existing community assets and resident engagement/involvement mechanisms - through Neighbourhoods, local authority and HCVS networks, IC Comms and Engagement Enabler Group, PPI committee, etc.

It is anticipated that some elements of the delivery plan will be implemented system-wide, while others will be more effectively delivered at Neighbourhood level, responding to specific localised population needs and utilising Neighbourhood assets.

We are, of course, not starting from scratch with this work. But we can make much more of existing transformation programmes that support a population health approach - for example, by embedding ‘make every contact count’ as a principle that drives everything we do. And we should build on the work already started to create a local anchor network, to harness the huge potential of our institutions to create wealth and improve opportunities for everyone living in the City and Hackney.

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culturally competent occupational risk assessment tools, and ensuring that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health.

Sign-off:

Workstream SRO: Sandra Husbands
London Borough of Hackney: Anne Canning
City of London Corporation: Andrew Carter
City & Hackney CCG: David Maher

Appendix 1: Summary of evidence and local intelligence on COVID-19 inequalities

Appendix 2: City and Hackney COVID-19 inequalities matrix (DRAFT in development)

COVID-19's Impact on Inequalities

Comparing national evidence to local data

Briefing Paper

Introduction

There is clear emerging evidence that the impact of COVID-19 and the resulting lockdown is having a disproportionate impact on some communities. The recent Public Health England review into ***Disparities in the risk and outcomes of COVID-19*** concluded that 'the impact of COVID-19 has replicated existing inequalities and, in some cases, has increased them.'

This briefing paper shows what the national evidence tells us about different risks by

- Age
- Deprivation
- Ethnicity
- Gender
- Occupation
- Care homes

The paper will then supplement the national evidence with local data and insight to provide a better picture of the different levels of risk for communities in Hackney.

1a. Older People: national evidence

Risk of mortality

- Older people are at a much higher risk of dying from COVID-19.
- Several papers (ONS, OpenSAFELY, PHE) have all shown that the risk of dying from COVID-19 dramatically increases for older people (with the number of deaths rising significantly after age 60)
- This may reflect that older people are more likely to have (multiple) comorbidities.

The impact of lockdown

- The ONS has published findings from a survey which finds that 50.1% of Adults over the age of 65 reported loneliness as a result of lockdown. This is significantly more than the average for the Great Britain population which is 30.9%.
- VCS groups have raised concerns that the effects of lockdown will be damaging for older people, particularly the restrictions on social interactions
- The Centre for Ageing Better has produced a briefing which discusses how lockdown might impact old people's' mental health, their ability to be active and their access to information as a result of a digital divide

1b. Older People: local data

Mortality and morbidity

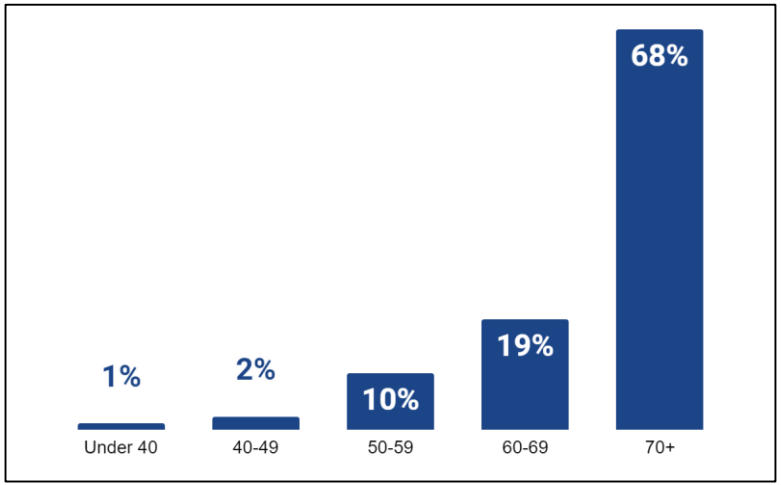
- Out of 175 deaths in City & Hackney involving COVID-19, 119 (68%) were among people aged 70+
- Only 3% of the deaths involved persons who were younger than 50.
- Local data suggests we are starting to see more people of younger ages be infected with Covid-19 but this is likely to reflect changes to testing eligibility.

The impact of lockdown

- HCVS has highlighted that the digital divide for older people continues to be an ongoing concern
- HCVS have also raised concerns of prolonged isolation and its effect on physical and mental health
- Evidence from the City & Hackney JSNA says that older residents are at much higher risk of social isolation

Deaths by age, sex, and place of death

Proportion of deaths in Hackney involving Covid-19 infection, 1 March to 27 May 2020, by age



1c. Care homes

The Kings Fund have reviewed location of death from Covid-19 in England and Wales.

- By week ending 1 May 2020, the number of deaths in care homes was almost three times higher than the average weekly number of deaths in care homes over the past five years.
- Deaths in care homes started to decline somewhat later than hospital deaths.

In Hackney:

- 135 (77%) deaths occured in hospital, 24 (14%) at home and 15 (9%) in a hospice, care or a nursing home. This reflects the relatively low proportion of Hackney's population in older people's care homes.
- All 4 of the older people's care homes in Hackney reported at least one outbreak of Covid-19 to PHE over March and April.

2a. Ethnicity: national evidence

Morbidity and mortality

- Several studies (IFS, ONS, Health Foundation, OpenSAFELY, PHE) show all non-white ethnic groups to be at greater risk of dying from Covid-19 even once some socio-demographic factors were taken into account.
- Public Health England have reported that people from Black ethnic groups were the most likely to be diagnosed with COVID-19. Additionally PHE has found that death rates from COVID-19 were highest among people of Black and Asian ethnic groups. This is the opposite of what is seen in previous years, when the mortality rates were lower in Asian and Black ethnic groups than White ethnic groups.
- An ONS evidence review suggests that, while only 2% of White British households experienced overcrowding, 30% of Bangladeshi households, 16% of Pakistani households and 12% of Black households experienced this which may impact upon transmission.

The impact of lockdown

- According to the IFS, the economic impact of lockdown may be more significant in some ethnic groups.
  - Bangladeshi, Pakistani, Black African and Black Caribbean men are more likely to work in lockdown sectors;
  - Bangladeshis, Black Caribbeans and Black Africans are more likely to have limited savings to fall back on.
- The Fawcett Society has published survey findings which suggest additional pressures on Black and minority ethnic groups as a result of lockdown.
  - 42.9% Black and minority ethnic women said they believed they would be in more debt than before the pandemic compared to 37.1% of white women and 34.2% of white men.
  - 23.7% of Black and minority ethnic mothers reported that they were struggling to feed their children compared to 19% of white mothers.

2b. Ethnicity: local data

Morbidity and mortality

- A paper by researchers at Queen Mary University of London and King's College London studied COVID-19 presentations to GP practices in City & Hackney, Newham, Tower Hamlets and Waltham Forest. The paper concluded that there is a two-fold increase in odds of infection for South Asian and Black adults compared to White adults.
- Black and minority ethnic communities have higher rates of underlying health conditions like Diabetes and CVD which put them at greater risk of dying from COVID-19, although white groups have higher reported rates of COPD and asthma.

Under-reporting within certain groups may also affect our local understanding of underlying conditions.

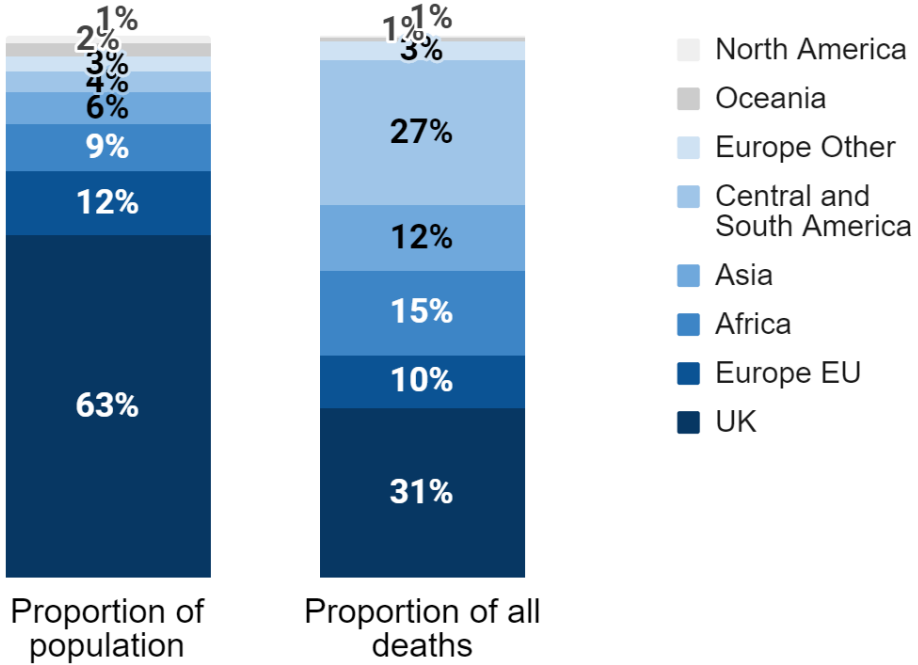
We have information locally on positive cases and country of birth which we know is a poor proxy for ethnicity.

The impact of Lockdown

- There are some local concerns about lockdown being enforced unfairly, linked to the historic impact of Stop and Search on Black and minority ethnic communities, and how this could be exacerbated;
- We are yet to understand the impact of lockdown on mental health outcomes within the community but given the disproportionate impact of mortality in certain groups, we may also expect to see differences in long-term outcomes.
- Some groups may also struggle to access digital services more than others. We need to consider this as we move to the next phase on disease management via the track and trace approach.

2c. Ethnicity: local data

Covid-19 deaths by place of birth (12th March - 27th May 2020)



- Country of birth is not a great predictor of ethnicity.
- Out of 175 deaths, 120 (69%) were among residents born outside the UK.
- In comparison, only around 37% of Hackney residents were born outside the UK.

3a. Deprivation: national data

Impact upon mortality

- Both the ONS and PHE conclude that mortality rates from COVID-19 in the most deprived areas are more than twice that of the least deprived areas.

Impact of lockdown

- People in lower SES jobs may have reduced opportunities to work from home, which may make them more exposed to the virus or unable to work and therefore experience financial losses.
  The poorest groups in society are more likely to have underlying chronic conditions, which may increase their risk of dying from COVID-19.
  A number of papers show that poorer students are negatively impacted by lockdown. Teachers reported that students from poorer backgrounds have less resources to complete school work and the quality of their work is also lower than usual.
- The Children's Commissioner has also written about the greater risk that 2 million children at as a result of lockdown. This is due to them experiencing from food poverty or from living in households with higher needs - parental mental ill-health, substance misuse, domestic abuse.
- According to the Food Foundation, the COVID-19 pandemic has quadrupled the number of adults who experience food poverty.

3b. Deprivation: local data

Occupation/ SES and Covid-19

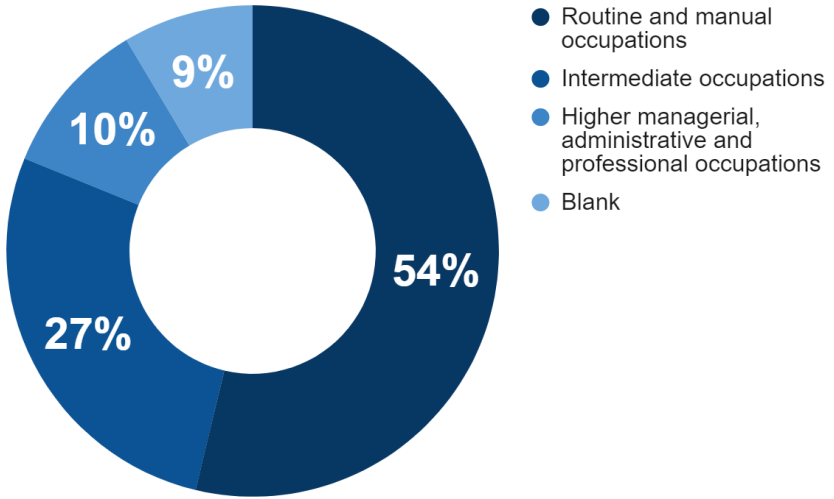
- Most COVID-19 deaths were registered among people from a lower socio-economic background
- Of all deceased for whom the occupation was known, 94 (54%) of deaths were among people employed in routine and manual occupations.
  This is in contrast to around 32% of Hackney's population being in routine and manual occupations
- [Note - it is likely that most people were retired*]

Reviewing Hackney's data by postcode

- There are many challenges faced by reviewing Hackney's data by postcode. This doesn't always give a clear understanding of the impact of deprivation, particularly when numbers are small.

Deaths by social class

Proportion of deaths involving Covid-19 infection, 1 March to 27 May 2020, by socio-economic status



3c. Deprivation: local response

Food poverty

- Currently in Hackney around 1,800 households are receiving food parcels; however the local service is gradually being phased out. Of these recipients, 70% said they are struggling to pay for food.
- Recently Hackney's 'I Need Help' service made 85 referrals to the Food Bank; referrals are estimated to increase to around 500 people over the coming weeks.

Financial issues

- **Hackney JCP**: Between 13 March and 12 April 2020 Hackney Jobcentre Plus had 4442 new UC claims. By 12 April 2020 it had 13356 UC claims. Previously it had around 200 new claims a week and this is now 1000 claims a week.
  Hoxton JCP: Between 13 March and 12 April 2020, Hoxton JCP 3613 new UC claims. By 12 April 2020, Hoxton JCP had 10290 UC claims.
  Not specifically related to deprivation but the Council's Covid-19 Community Survey highlighted that around a ⅓ of respondents would face 'significant financial difficulties' for mortgage/rent payments; food shopping; and household bills, as a result of the pandemic and lockdown.

Digital divide

- This issue has come out repeatedly in Neighbourhood Conversations with the community.
- Groups are concerned about for children and young people who need to digital equipment and access to complete school work and access support services
- There are also concerns that the digital divide will mean that there will be issues for people in accessing the latest public health messaging

4a. Occupation: national evidence

National evidence

- In the male population, 5 out of 9 occupation groups had a higher risk of dying from COVID-19 than the overall male working age population. Workers in 'low-skilled' categories were at the greatest risk of dying from COVID-19.

- Male workers with increased risk include workers in construction, security, taxi services, bus and coach drivers.

Among women, only 1 of the 9 occupation groups had a statistically significant higher mortality rate than the average for the female working population. This occupation group was 'Caring, leisure, and other service occupations.'

- **Both men and women care workers are at greater risk of dying of COVID-19** than the whole working population. However, male social workers had a significantly elevated risk of dying from COVID-19. Male care workers had a mortality rate of 23.4 per 100,000 (compared to 9.9 for whole male working population). Female care workers had a mortality rate of 9.6 per 100,000 (compared to 5.2 for whole female working population).

- The Kings' Fund report that higher mortality is reported also for NHS and social care staff from Black, Asian and minority groups. This excess Covid-19 mortality in these groups is only partially attributable to clinical factors and deprivation.

5a. Gender: Morbidity and Mortality

a. National Evidence

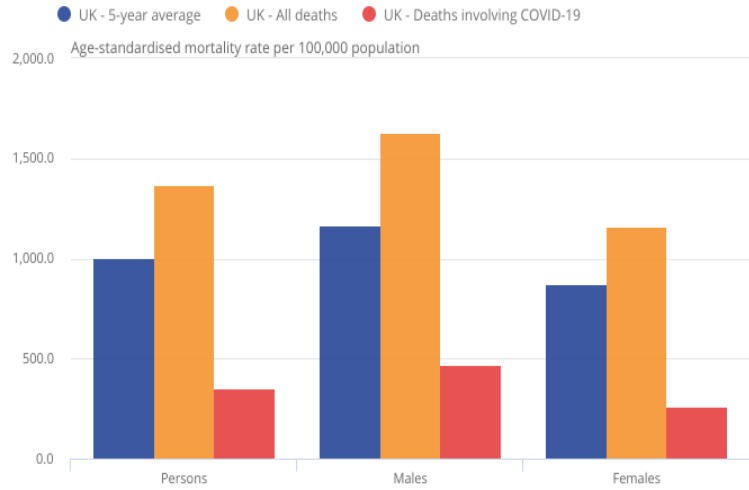
- There is clear evidence (Health Foundation; ONS; OpenSAFELY; PHE) that men are at greater risk of dying from COVID-19 than women.
- Research by the Health Foundation suggests that the socioeconomic gradient in mortality from COVID-19 could be steeper for women.
- The IFS warns that women may be vulnerable to long-term labour market disadvantages in the coming economic downturn.

a. Local evidence

- Using Hackney data (up to 3rd June), out of 175 deaths involving Covid-19 infection:
    - 100 (57%) of these were male and 75 (43%) were female deaths.
    - The age-standardised mortality among males is significantly higher compared to females.

Figure 2: Males had a higher age-standardised mortality rate compared with females for both all causes and deaths involving COVID-19

Age-standardised mortality rate per 100,000 population, deaths occurring in March and April 2020, registered by 15 May 2020, by sex, UK



Source: Office for National Statistics, National Records of Scotland, and Northern Ireland Statistics and Research Agency

7. Air Quality: National and international evidence

- A paper published by researchers at Harvard found that a small increase in long-term exposure to fine particulate matter (PM2.5) leads to a large increase in the COVID-19 death rate.

- A paper published by researchers at the University of Cambridge found that the levels of multiple markers of poor air quality, including nitrogen oxides and sulphur dioxide are associated increased numbers of COVID-19-related deaths across England, after adjusting for population density.

- A paper published in April 2020 found a strong correlation between increment in air pollution and an increase in the risk of COVID-19 transmission within London boroughs.

Conclusion

- It is evident that the situation in the City and Hackney mirrors what we are seeing nationally and in other countries, with disproportionately high cases of infection and deaths amongst older people, people from Black and Asian Communities, people from lower SES backgrounds, and men.
- The social and economic consequences of Covid-19 will extend beyond the period of the outbreak and also need consideration.

- What do we need to do next?
    - Continue to review the literature as it emerges and assess the local data on cases, deaths and the impact of lockdown;
    - Co-ordinate our efforts with others locally to develop a comprehensive local understanding and response; and
    - Consider how the work of the ICB can support efforts to tackle health inequalities that are being exacerbated by Covid-19.

City and Hackney System Operational Command:

Phase Two Restoration and Recovery Plan

Draft submitted to NEL ICS, 5th June 2020

Homerton University Hospital NHS Foundation Trust

City & Hackney GP Confederation
A community interest company

#FairerHackney hackney cvs

NHS East London NHS Foundation Trust

City of London

Hackney

NHS City and Hackney Clinical Commissioning Group

Background and context

- At the end of March 2020, System Operational Command arrangements were established in City and Hackney to provide a coordinated emergency planning and resilience response across the local health and care system during the pandemic
- During Phase One of the pandemic response, SOC co-ordinated operational leadership of the local system, ensuring successful joint working between GP practices, community health services, social care, mental health services, the voluntary sector, the local acute hospital, and links to wider public services. SOC was able to build on strong relationships and leadership structures which existed already through City and Hackney's integrated commissioning programme
- All transformation programmes and Workstream Programme Boards under City and Hackney's Integrated Commissioning Programme architecture were suspended, and the Integrated Commissioning Board moved to a short monthly update call
- During Phase One System Operational Command was able to respond swiftly and effectively to the pandemic. Assurance and approval processes were streamlined and safely minimised. National changes, including the direction to suspend activity-based contract payments and implement block contracts supported this streamlined response
- As we move from the crisis footing of Phase One into a second 'restoration and recovery' phase, SOC's priorities will be to ensure that service delivery is fully restored in the context of the ongoing pandemic (addressing the 12 Expectations) but also to restart our existing programmes of transformation work and reshape our long term plan ambitions in a new context. In Phase Two SOC will move from managing delivery of a short-term Action Plan to a longer-term Integrated Delivery Plan
- SOC will need to continue to provide the swift and effective operational leadership of our pandemic response that it achieved during Phase One. It will also need to co-ordinate the delivery of our programmes of transformation work during a period of transition, as we implement the necessary changes to establish an Integrated Care Partnership within NEL ICS
- It will be for the statutorily accountable parts of our local system to decide upon the specific organisational, contractual and governance structures which will underpin the Integrated Care Partnership, drawing on wider changes at CCG and ICS level. SOC will be responsible for operationally delivering these changes as part of the Integrated Delivery Plan

An ongoing system commitment to reducing health inequalities

- The terrible toll exerted by the COVID-19 pandemic serves as another reminder of the deep social and economic inequalities which affect the health and wellbeing of our local populations
- The organisations that make up City and Hackney's local health and care system remain committed to a long term change programme which will move our focus from health and care service provision towards a better understanding of and response to the wider determinants of health; achieving more effective outcomes for local people and responding more holistically to the complexity of their needs, and to the specific needs of different local populations. Our vision of integrated care supports frontline staff to work with local people, harnessing their strengths and connecting them with resources to support their wellbeing; and advocating on behalf of our most complex and vulnerable service users
- This vision has run through our commitment to integrated commissioning, our Neighbourhoods programme, our local Long Term Plan response and through close partnership working between provider organisations. It will be at the heart of our Integrated Delivery Plan and will inform the restoration and recovery work of the SOC in Phase Two.

Our vision

Working together across City and Hackney to support people and their families to live the healthiest lives possible and receive the right care when they need it.

- **More support** for patients and their families to get healthy, stay well and be as independent as possible
- **Neighbourhoods** where people and communities are actively supported to help themselves and each other
- **Joined up support** that meets the physical, mental and other needs of patients and their families
- **High quality** GP practices, pharmacies and community services that offer patients more support closer to home
- **Thriving local hospitals** for patients when they need them

Our strategic objectives

We have developed five strategic objectives for the programme:

- **Deliver a shift in resource and focus on prevention** to improve the long term health and wellbeing of local people and address health inequalities
- De**liver proactive community based care** closer to home and outside of institutional settings where appropriate
- **Ensure we maintain financial balance as a system** and achieve our financial plans
- De**liver integrated care** which meets the physical, mental health and social needs of our diverse communities
- **Empower patients and residents**

The following partner organisations have been involved for some time in City and Hackney's existing integrated commissioning work:

- The London Borough of Hackney
- Corporation of the City of London
- City and Hackney NHS Clinical Commissioning Group
- East London NHS Foundation Trust
- City and Hackney GP Confederation
- Homerton University Hospital NHS Foundation Trust
- City and Hackney Local Pharmaceutical Committee
- Schools and Children's Centres
- Hackney Centre for the Voluntary Sector
- A range of local voluntary and community organisations
- Healthwatch City of London
- Healthwatch Hackney

SOC Phase Two Plan sections

City and Hackney SOC Phase 2 Plan sections	
OOH service recovery: Restoration, access & safety	This section of our plan sets out how we will ensure as a system that all Out of Hospital services: • Are fully restarted (where services have been reduced or paused as a result of the initial pandemic response) • Are compliant with Infection Prevention and Control guidance, inc. appropriate segregation and remote access • Have resilience plans in place to respond to surges in demand associated with a second peak • Have considered the equalities impact of service changes and taken steps to address these or escalate to SOC • Specific support to Shielded Patients, Care Homes, and packages of care for vulnerable people with LTCs
Restoration of elective work: Maintaining tight integration with the local system	• Linking our local support packages for long term conditions with changes in planned care • Ensuring that primary care and Neighbourhoods links and pathways with secondary care are maintained (ie. Advice and guidance, diagnostics, MDT involvement) • Ensuring effective local patient engagement, communications and co-design in relation to planned care restoration • Maintaining effective discharge pathways with changes to planned care
Updated transformation plans: Delivering our Long Term Plan and integrated care ambitions	• Integrated Delivery Plan for Phase 2 • Urgent care and rapid response – before hospital • Population Health Management and Intelligence • Clinical leadership – expanded role of Clinical Practitioner Forum • Inequalities Framework
Phase Two governance and support arrangements	• Revised SOC Term of Reference • Roadmap for creation of a local Integrated Care Partnership including SOC links to wider local system changes (establishment of a Neighbourhood Health and Care Partnership, establishment of single CCG) • Changes to our Strategic Enabler functions (Workforce, Digital and IT, Estates, Comms and Engagement, Community connection and VCS, Primary Care, and Population Health Intelligence • Revised system PMO arrangements

Out of hospital local service recovery:

Restoration, access and safety

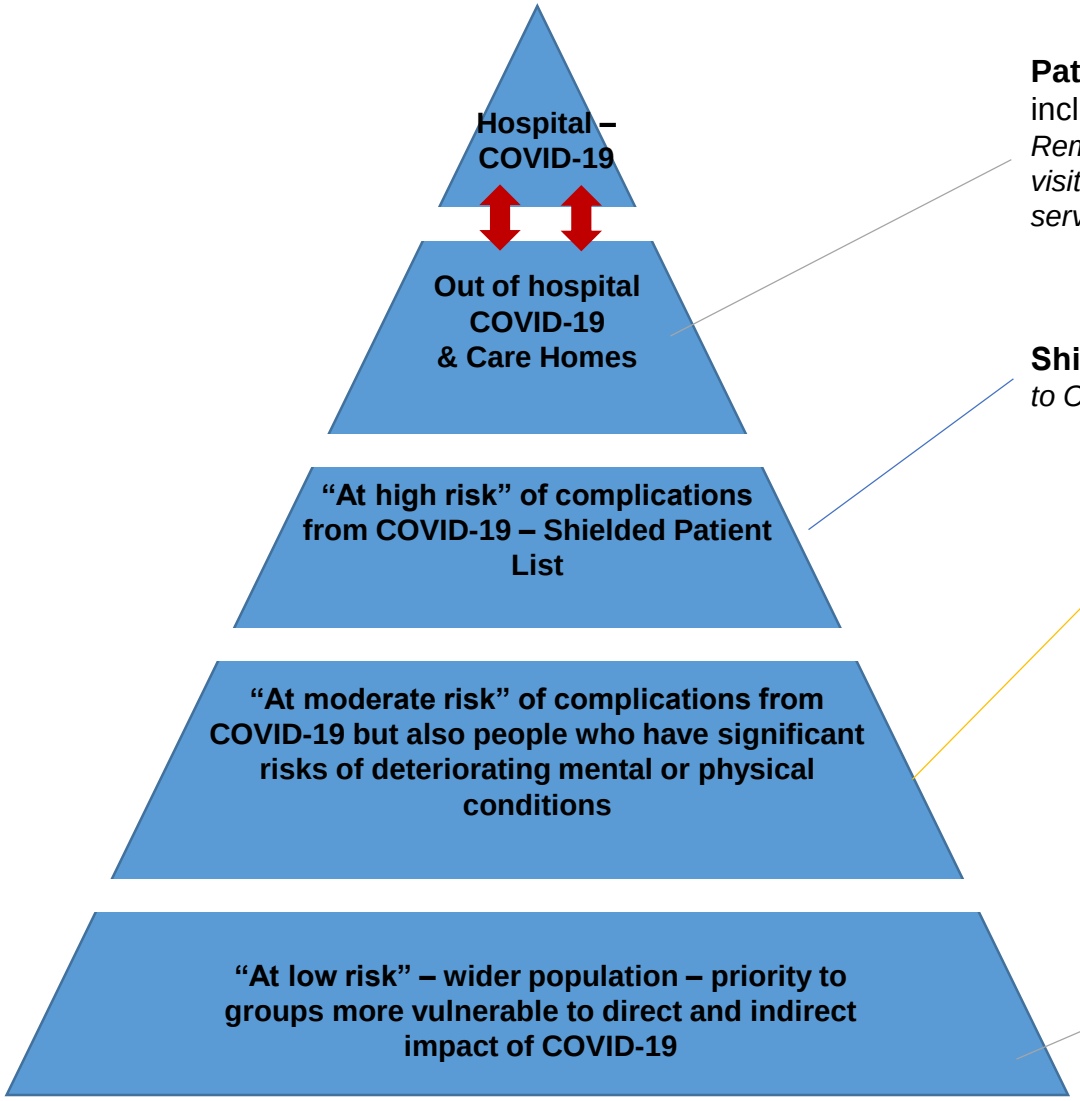
SOC assurance on service safety, resilience and restoration

- During Phase Two SOC has a responsibility to ensure that local health and care services have resumed and are accessible and safe in the context of the pandemic response, and that service users are aware of changes to services, and that the equalities impact of changes have been considered and addressed
- Individual organisations remain statutorily and legally responsible for health and care services they provide, including CQC responsibilities. SOC does not intend to duplicate Board Assurance Frameworks and other accountability frameworks, but to co-ordinate a local system response
- During June 2020 SOC is requiring each organisation providing out of hospital health and care services to provide it with an assurance that all of their services:
    - Have plans in place during Phase Two to resume a **full service (**where services were reduced in scope or paused during the phase one crisis response)
    - Are **complying with infection prevention and control guidance in relation to service access and service segregation, as well as safeguarding guidance**, and have plans in place for delivering any remedial actions and deadlines for resolution
    - Have prepared **emergency resilience and surge plans in preparation for a second peak** of COVID-19 infections
    - Have effectively communicated service changes and engaged with **service users and communities** over service restoration work
- SOC acknowledges that the size of organisations and levels of risk involved in services will have an impact on their ability to respond. SOC will identify common themes where support and guidance may be needed, particularly for smaller grant-funded organisations
- In particular SOC will ask organisations to provide specific details about any problematic areas or risks in relation to these service restoration plans, and by mid-July SOC will develop a **Service Restoration Exception Plan**
- From mid-July a sub-group of SOC will ensure that all outstanding issues relating to IPC compliance, service access and restoration, the equalities impact of changes, and surge and resilience planning are escalated and resolved, and that all exceptions have been addressed

Service assurance questions for accountable local organisations

Service restoration plans	Infection Prevention and Control and remote access	Safeguarding arrangements	Surge Plans	Equalities Impact assessment	Service user engagement
If services have been paused or reduced in scope, are you assured about the plans in place for full service restoration? By when have you assured yourself that all services will be fully restored?	Are you assured that your services have implemented the appropriate IPC guidance and that services are safe on an ongoing basis?	Are you assured that appropriate arrangements are in place for safeguarding children and young people – particularly in the context of changes to service access?	Are you assured that EPRR plans have been updated to prepare an effective response in the event of a second peak of COVID-19 infections?	Are you assured that you have considered the equalities impact of changes to services on service users, particularly economically and socially disadvantaged or vulnerable groups?	Are you assured that changes to the access or availability of services has been effectively communicated with both existing service users and potential service users?
Are you assured that all of your services (where appropriate) are accessible to patients on the Shielded List?	Are you assured that measures are in place for all services to provide remote or virtual access? Are you assured that full use is being made of digital telemedicine and remote testing opportunities?	Are you assured that appropriate arrangements are in place for safeguarding vulnerable adults – particularly in the context of changes to service access?	Are you assured that your service(s) would proactively escalate early warnings of potential rises in infections or risky behaviours that may require a system response?	Are you assured that access is still protected for those without digital access or who with specific access or language requirements?	Are you assured that service users and communities have been engaged in co-design of service changes?
Are you assured that COVID-19 services changes will not diminish co-ordinated and integrated work with other local services to ensure patient-centred care?	Have you assured yourself of the safety of your staff based on a combination of risk factors including health status, race and ethnicity?	Are there any specific risks or service challenges arising from the above that should be escalated to SOC?	Are there any specific risks or service challenges arising from the above that should be escalated to SOC?	Are there any specific risks or service challenges arising from the above that should be escalated to SOC?	Are there any specific risks or service challenges arising from the above that should be escalated to SOC?
Are you assured that any learning from the Phase One response has been captured and shared where relevant?	Are you assured that your service is integrated appropriately with testing and contact tracing resources?				
Are there any specific risks or service challenges arising from the above that should be escalated to SOC?	Are there any specific risks or service challenges arising from the above that should be escalated to SOC?				

Our risk stratified response to COVID-19 in City and Hackney



Patients with COVID symptoms supported out of hospital including care homes –
Remote consultations, COVID treatment centre in primary care, visiting arrangements for a patient in their home, community services

Shielding Patient List ("At high risk") *–Defined according to Chief Medical Officer definitions (circa 1.28m nationally).*

Vulnerable cohort ("At moderate risk") - *Medically vulnerable based on eligibility for flu jab – (circa 19m nationally).*

There is a national definition for those at moderate risk (eligibility for flu jab). Locally we would also add those who are vulnerable for social reasons (e.g. homeless) or because of mental health (e.g. SMI)

3. Wider population ("At low risk") – Wider population impacted by the changes associated with COVID-19 e.g. economic impact

Restoration of elective work:

Maintaining tight integration with the local system

A NEL-wide approach to the restoration of acute elective work

Complex elective procedures

Complex elective procedures typically have more co-dependencies and require a more specialist workforce. Complex cases are higher risk and therefore require the strictest protocols for screening, testing and segregation. Therefore the first component of our model is the consolidation of complex elective care across a smaller number of sites. This will increase the resilience of the workforce for these services, and enable us to deliver these services in a COVID-protected space.

Complexity in elective care may refer to the nature of the surgery, the needs of the patient or both. There are patients who are complex and require additional support during their hospital stay.

Simple elective surgical procedures

'Simple' elective services are higher in volume and have greater throughput. In NEL there is a backlog of activity which needs to be worked through, due to the suppression of activity over the first COVID peak, against a backdrop of long waits in some services that must also be addressed.

The second component of the NEL-wide elective care model is the creation of high volume centres for the management of simple elective surgical procedures. This will enable us to make the most efficient use of our theatre space and workforce, as well as maintaining COVID protected space for elective care. To support the delivery of this, we are developing lead providers for our high volume specialties across NEL. Initial proposals for these lead providers have been developed, though they need further work before they can be formally agreed.

Outpatient services

The next component of the NEL model is the safe delivery of **outpatient services**. The COVID pandemic has expedited much transformation of outpatient services, including the expansion of virtual consultations, advice and guidance and community services. Retaining the progress made will be critical to our elective model going forward and we plan to move to virtual by default. Further work is required to assess how we should configure outpatient services across the sector while retaining equitable access.

Diagnostics

Finally, the delivery of diagnostics is a critical enabler for the model as outlined above and across NEL we have established a diagnostics and imaging hub with Barts Health as the lead provider to progress this work.

Local considerations in relation to the restoration of elective work

As part of the work under our Integrated Delivery Plan, in Phase Two we will work to ensure that:

- Our local proactive support packages to primary care for specific cohorts of patients with long term conditions (who are at greatest risk of exacerbation or deterioration) continue to link in with proposed changes in elective care delivery, including diagnostics, monitoring, outpatient activity and advice and guidance links to secondary care clinicians
- Effective MDT links with secondary care which have been established through the Neighbourhoods programme and PCN development are maintained during changes in elective pathways
- Our plans for communications and engagement will ensure that:
    - The successful Clinical Practitioner Forum which we established during Phase One is fully informed and engaged in changes to elective care
    - We effectively explain these changes to local people and service users and involve them in co-design and co-production of changes where possible
- The rapid discharge pathways we have developed in partnership with social care partners remain effective in the context of any changes to elective care pathways
- Our local system approaches to cancer screening, diagnosis and referrals are still effective
- We work as a local system to recast our operating plan in the light of changes in activity in the past few months to ensure that resources continue to be allocated most effectively

Based on analysis of local non-elective emergency admissions for high risk conditions in March and April compared to a baseline of previous years, data shows a concerning drop in activity which potentially suggests a ‘storing up’ of presentations of acute illness, which could lead to a peak of non-COVID-related emergency admissions in the coming months. Our plans to address this risk include:

- Working with partners to further analyse data to understand whether a reduction in emergency activity could be the result of more effective out-of-hospital interventions - and if so, building our learning from this
- Ensuring that further activity and capacity planning and analysis is done in the high-risk areas which gave greatest cause for concern: MI, ischaemic heart disease, cellulitis, sepsis, heart failure, COPD, asthma, diabetes and paediatric injuries

Updated transformation plans:

Delivering our Long Term Plan and integrated care ambitions through Neighbourhoods

Our Integrated Delivery Plan

Building on the success of our co-ordinated system leadership in phase one, we believe that a future system delivery plan is best organised around a single **thematic view** of groupings of **population health outcomes and improvement areas** rather than four or five plans reflecting the way that services are structurally organised

Our Integrated Delivery Plan is featured as a 'plan on a page' on the next slide, and SOC is currently going through a process to develop a full and detailed plan to use in co-ordinating our work during Phase Two.

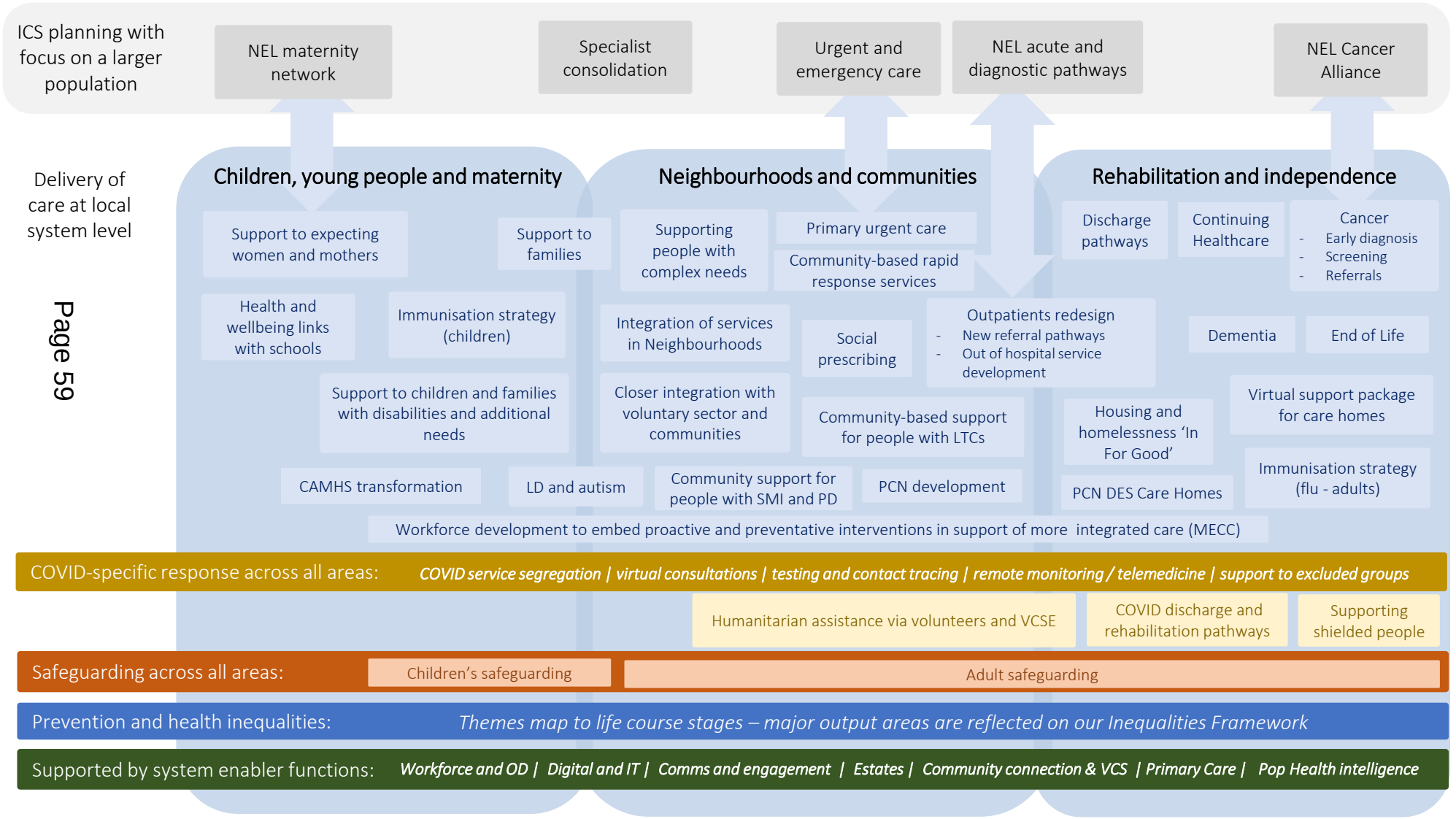
The functional areas we have grouped our planning actions around:

- Follow the aims of the Long Term Plan in wishing to avoid the influence of historic organisational and contractual structures, with greater priority placed on keeping people healthy and independent in **out of hospital** settings (at home or in the community)
- Loosely map to **life course stages**, in order to link with wider partnership work on reducing health inequalities
- Maintain our focus on **Neighbourhoods** as the building blocks of integrated community support
- Encourage a focus on **population health outcomes, prevention** and **wellness (**as opposed to illness) as supported by local residents through our Outcomes Framework

It is our aim during Phase Two to build a single delivery-focused view of our various transformation plans as a local system which encourages cross-cutting approaches and the greater collaboration necessary to deliver integrated care. This will include consideration of how best to utilise and develop existing integrated programme approaches.

Integrated delivery plan on a page – functional areas

This high-level plan details the major programmatic areas of integrated health and care provision which will be delivered by local mental health, primary care, social care, community health and voluntary sector organisations working in partnership in City and Hackney



A focus on neighbourhoods and communities

Our Neighbourhoods Programme continues to be at the heart of the way we are organising out-of-hospital services, managing our population health response and collaborating with Primary Care Networks and local public services. In Phase Two key actions and milestones are:

High-level actions in Phase Two	Milestones	Functions on the Integrated Delivery Plan this meets
Phase one: Establish adults MDTs across all Neighbourhoods to support people with complex needs and begin to capture learning	Now to end of July 2020 (this is to cover the period we've asked PCNs to chair / lead initially although the will have all launched by mid-end of June)	Supporting people with complex needs Integration of services in Neighbourhoods
Phase one: Establish children and families MDTs across all Neighbourhoods to support people with complex needs and begin to capture learning	Now to end of July 2020 (to be checked with Amy Wilkinson)	Support to families Supporting people with complex needs Integration of services in Neighbourhoods
Phase two: Embed adults and children and families MDTs in all including the provision of OD support for leadership and wider neighbourhood team.	July 2020 to end of March 2021	Integration of services in Neighbourhoods
Develop and agree a sustainable model for all Neighbourhood MDTs. This includes MDT chairing, administration and a sustainable model for care coordination / navigation.	End of September 2020 (sustainable model commencing from 2021/22)	Support to families Supporting people with complex needs Integration of services in Neighbourhoods
Initial development of population health needs and inequalities (in light of COVID-19) and identification of priorities within Neighbourhoods	End of September 2020	Prevention and health inequalities (cross-cutting)

In Phase Three the following high-level actions will take place by March 2021:

- Evaluation approach established to capture the learning / impact of Neighbourhood Teams and MDTs
- Deliver service transformation to fully align services with Neighbourhoods in the following areas (for the adults MDT): Adult Community Nursing, Adult Community Therapies, Adult Social Care, Mental Health, Care coordination / Community Navigation and Voluntary Sector
- Develop and test models for Neighbourhood Partnerships including learning from other areas
- Further development and engagement of population health priorities within Neighbourhoods

What the Neighbourhood MDT looks like

What we are now working towards:

- Regular review of patients who are most vulnerable within a virtual Neighbourhood MDT
- A focus on supporting people with complex and acute needs and vulnerabilities
- A core group of professionals who are actively involved
- Resourced administration for Neighbourhood MDTs
- Effective routes of referral into virtual Neighbourhood MDTs initially from GP Practices but then from individual organisations
- Remote monitoring support to enable remote consultation wherever possible

Other supporting work in neighbourhoods and communities

Urgent care and rapid response before hospital

In Phase Two we will work with NEL partners to develop improved pathways from 111 to support reduction in ED attendances and agree specific pathways from 111 into primary care and into SDEC or hot clinics at the Homerton hospital site

Primary Care Networks development

PCNs are central to the clinical leadership and delivery of our vision for Neighbourhoods. In Phase Two we will:

- Work with PCNs to establish their role within the local system as providers and as system leaders
- Work with the GP Confederation to continue to support PCNs to develop their management infrastructure
- Continue to build capacity in Neighbourhoods teams so they can support PCNs to work with partners in taking a population health approach and provide multi-agency care

Community-based support for people with LTCs

In Phase One we developed local proactive support packages to primary care targeted to specific identified cohorts of patients with long term conditions (who have been identified as being at greatest risk of exacerbation or deterioration). In Phase Two this work will continue with further support for remote monitoring and telemedicine as well as self-care support and resources

Taking a population health approach

In Phase Two we plan to build on tools already provided by CEG and partners and request further support from NEL ICS colleagues with provision of more effective and proactive population health data tools to support targeted work at Neighbourhood and practice level

Supporting clinical leadership

In Phase Two we will expand upon and build the role of the Practitioner Forum which has been an effective virtual forum for clinical and practitioner leadership and engagement. We will adapt plans for embedding and supporting collaborative quality improvement projects led by clinical staff as part of our Neighbourhoods OD and PCN development work.

Closer integration with the voluntary sector and communities

In Phase Two we will confirm a local VCS Target Operating Model and establish the VCN strategic enabler by July 2020

Responding to mental health challenges in Phase Two

Mental health responses are embedded in our approaches across our Integrated Delivery Plan, reflecting our commitment to integrated care including consideration for wellbeing and recognising the impact of mental health on physical health. However, in Phases Two and Three we face a number of significant challenges, and our plan response is as follows:

High-level challenge	Plan response in next two weeks:	Plan response in next month:	Plan response by end of Phase Two:	Plan response in next six months:
Capacity to meet mental health demand HLP predict a 30% increase in mental health demand across London as a result of the pandemic. Services have reduced capacity due to high staff sickness and absence. LTP Mental Health investment is also largely on holding pending clarifications re. contracts and financial flows.	Mental health capacity and demand modelling completed highlighting key gaps	Develop costed plans to address gaps	Implement plans	Monitor implementation
Mental health inequalities Health inequalities for mental health service users have in many instances been exacerbated by the pandemic because of the effect of deprivation on the digital divide and access to the resources that maintain wellbeing, as well as the impact on cultural practices and communities.	Complete offer of SMART phones through personal health budgets	Agreed plans with providers for: i) Socially distanced IT hubs for patients who are not able to access digital services ii) plans for face to face contract prioritising patients who are either can not use or are not best served by digital services iii) clarifying BAME community group plans to support mental health within specific communities	Implement plans	Monitor implementation
Shielded and vulnerable patient psychological wellbeing Those on the shielded list and those part of vulnerable groups e.g. those with an LTC are likely to experience a higher level of mental health problems due to the the stress of an ongoing restricted lifestyle. People recovering from Covid may also be experiencing the effects of trauma.	Develop and send out psychological wellbeing pack for those on the shielded list with links to IAPT. Adapt the IAPT website to more clearly address Covid related needs.	Develop a stronger pathway between LTC patients and IAPT services	Monitor IAPT access and LTC access rate	Monitor IAPT access and LTC access rate
CAMHS return to schools The return to school presents an opportunity to resume the schools CAMHS Transformation Plans. This could however create a surge in demand. There are also risks attached to children who do not return.	Agree plans including how to reach children not returning	Implement plans including restoration of CAMHS transformation plans	Monitor implementation	
Return to BAU for suspended MH services *This will be covered under the first part of this plan, Out of Hospital Service Recovery, alongside all other health and care services*				

Addressing health inequalities in Phase Two

- The direct impacts of COVID-19 disease are disproportionately experienced by people from certain minority ethnic groups, older people, men, people with underlying health conditions, working in particular occupations and those living in socially deprived circumstances (untangling the contribution of these various overlapping risk factors is complex).
- The indirect impacts of lockdown and social distancing are also affecting some of the most vulnerable people and communities, including many of those described above as well as carers, certain faith communities, people with disabilities and those with no recourse to public funds.
- In Phase One SOC co-ordinated work to provide additional targeted support to vulnerable communities and groups such as the Charedi community and people in the community living with serious mental illness and personality disorder, working with community partner organisations. Our plans in Phase Two will build upon these targeted interventions and go further in tackling long-standing inequalities.

City and Hackney SOC Inequalities Framework	
Purpose:	• To ensure phase 2 planning retains an explicit focus on reducing health inequalities • To form the basis of a population health framework for City & Hackney
Principles:	• We will prioritise actions which target those who have been most detrimentally affected by COVID-19, and where we can make most impact as a partnership (taking a stratified approach) • No action will be taken as part of our phase 2 plans that further exacerbates pre-existing inequalities • Longer-term, we will continue to prioritise actions to reduce long-standing inequalities
Tools:	• Prioritisation matrix: a visual tool to highlight priority areas for action and help identify gaps/where plans not already in place • Decision-making tool - rapid EIA to guide decisions about phase 2 plans and make explicit our expectations about inequalities impacts • Equalities ‘dashboard’ - to monitor progress/impact of our actions

Phase Two governance:

Towards a local Integrated Care Partnership

Changes in governance during Phase Two

- We are moving from the reactive crisis footing of Phase One into the second phase of our response to COVID-19, and SOC is required to co-ordinate a ‘new normal’; addressing both the new realities of service delivery under the pandemic (addressing the 12 Expectations) but also continuing to make the necessary changes to deliver our local long term plan response as an Integrated Care Partnership within NEL
- NEL ICS is maintaining level 4 incident command and control for phases one and two of the recovery plan, and during phase two other SOC groups within NEL are renaming themselves as Integrated Care Partnership Delivery Groups, in acknowledgement of this transitional phase for local systems. In Phase Three NEL will implement the ICS structures it will agree over the next 5-6 months.
- It will be for the statutorily accountable parts of our local system to decide upon the specific organisational, contractual and governance structures which will underpin the Integrated Care Partnership, and this will draw on wider changes at CCG and ICS level. SOC will be responsible for operationally delivering these changes as they are agreed, and they will form part of the Integrated Delivery Plan

This section of our plan sets out:

- Revised Terms of Reference for the SOC in Phase Two of recovery and restoration
- Changes to our Strategic Enabler functions (Workforce, Digital and IT, Estates, Comms and Engagement, Community connection and VCS, Primary Care, and Population Health Intelligence)
- Revised system PMO arrangements

Terms of Reference

Membership

Tracey Fletcher – Chair
Stephanie Coughlin (GP Clinical Lead)
Catherine Pelley (Nursing Lead)
Nina Griffith (Workstream Director)
Siobhan Harper (Workstream Director)
Amy Wilkinson (Workstream Director)
Jayne Taylor (Workstream Director)
Dan Burningham (Workstream Director)
Richard Bull (CCG Primary Care Director)
Simon Galczynski (Adult Social Care LB Hackney)
Chris Pelham (City of London)
Laura Sharpe (C&H GP Confederation)
Dean Henderson (C&H Borough Director, ELFT)
Sallie Rumbold (Community Health Services)
Mark Golledge (Neighbourhoods Lead)
Vanessa Morris (Voluntary & Community Sector)
Nic Ib (PMO)

Minimum meetings frequency

- Weekly on a Thursday
- Papers circulated afternoon before meeting

Meetings and administration

- Nominated admin support –*PMO team*
- Actions formally logged
- Decisions taken
- Notes, actions, decisions out to all members within one day

Purpose & Remit

In Phase Two of the COVID-19 response, the C&H SOC group will perform three main functions:

- Finalising and implementing the recovery plan for the City and Hackney local system, including recasting local transformation plans in the context of the 'new normal'
- Tracking activity and capacity locally to respond quickly to early signs of a second peak in COVID-19 infections and to initiate necessary resilience plans
- Co-ordinating our strategic programmes of delivery at system level during a transition period when governance and structures will adapt in preparation for establishing an Integrated Care Partnership in City and Hackney during Phase Three

At weekly meetings the group will review delivery progress against the SOC Integrated Delivery Plan and regular population health modelling reports.

The group will establish more effective and direct relationships with the local system strategic enabler functions so that their work more effectively supports delivery of the SOC Integrated Delivery Plan

The group will engage with NEL ICS workstreams as necessary and will escalate 'asks' to these in relation to local delivery work. The group will report in to the NEL ICS Recovery and Restoration Group as required, who will provide overall oversight for the ICS Recovery programme

In Phase Two the SOC will continue to provide a forum for leads to discuss challenges in development and/or implementation of plans and to seek support in resolving issues.

Activities OUT of scope

Non-Covid-19 related activities other than consideration of plans for phase three of the recovery and restoration plan.

Accountability and Authority

Accountable to NEL ICS Recovery and Restoration Group

Close liaison with Accountable Officers Group to ensure appropriate governance for significant decisions which impact on system partner organisations

Key interdependencies with other working groups and ICC activities

- City and Hackney C-19 Health Protection Board (formerly Pandemic Leadership Group)
- Local authority local resilience forums
- NEL ICS workstreams

Accountability and authority

City and Hackney Integrated Care Board

Acting as Local Outbreak Control Board providing public-facing oversight of local public health response

City and Hackney Accountable Officers Group

Providing a periodic opportunity to step back from the immediate focus of System Operational Command / ICS DG and reflecting strategically on the wider links to the local authorities and local partners

LB Hackney

Local Resilience Forum strategic co-ordination group

Gold: Tim Shields

City of London

Local Resilience Forum strategic co-ordination group

Gold: Peter Lisley

Escalation

City & Hackney System Operational Command (Integrated Care Partnership Delivery Group)

Chair: Tracey Fletcher (Homerton CEO)

Operational system management of the major re-organisation of provision within the local health and care system, in response to COVID-19

Escalation

Escalation

NEL ICS Recovery and Restoration Group
(formerly Strategic Operational Command)

Chair: Jane Milligan (AO)

NEL workstream groups:

- Acute care
- UEC
- Cancer
- Out of Hospital Care
- Public health
- Primary care
- Mental health
- Maternity

Enablers (Finance, Digital, Corporate Governance, Comms, Workforce, Estates)

C-19 Health Protection Board (formerly Pandemic Leadership Group)

Chair: Sandra Husbands (Dir Pub Health)

- Provide infection control expertise
- Lead development and delivery of Local Outbreak Plan (DPH)
- Link directly to regional PHE team and London Coronavirus Response Cell (LCRC)

SOC/ICP DG Leads

System Operational Command / ICP DG Leads are accountable for delivery of the Integrated Delivery Plan:

Stephanie Coughlin (GP Clinical Lead)
Catherine Pelley (Nursing Clinical Lead)
Nina Griffith (Workstream Director)
Siobhan Harper (Workstream Director)
Amy Wilkinson (Workstream Director)
Jayne Taylor (Workstream Director)
Dan Burningham (Workstream Director)
Richard Bull (CCG Primary Care Director)
Laura Sharpe (GP Confederation)
Simon Galczynski (Adult Social Care LBH)
Chris Pelham (City of London)
Dean Henderson (Borough Director, ELFT)
Sallie Rumbold (Community Health Services)
Mark Golledge (Neighbourhoods Programme Lead)
Vanessa Morris (Community and Voluntary Sector)

Support required from system enabler functions during Phase Two

- During Phase One of the COVID-19 response, we did not formalise links between existing system enabler functions and SOC, although several SROs of enablers are members of SOC
- These functions are essential to delivery of Phase Two recovery plans and it will now be appropriate to agree clearer lines of responsibility in relation to SOC in order to align the work of enablers more effectively with phase two operational delivery
- In June and July, SOC will work to more directly align the work of the enabler groups with integrated delivery plans and programmes of work, including establishing a population health intelligence enabler group.
- This work will go hand in hand with the development of the Integrated Delivery Plan

Workforce

- System workforce strategy & vision to support integrated care in Neighbourhoods
- Workforce planning
- Education & Training
- System Organisation Development support & cultural change
- Nursing/midwifery/AHP leadership and engagement
- Psychological impact of the pandemic on staff

EXISTING

Digital and IT

- Single view of a person's health and care record
- Coordinated care and care planning
- Information and control for patient/empowerment
- Supporting a co-ordinated local approach to virtual consultations and telemedicine

EXISTING

Estates

- Local system estates strategy & planning
- Capital & investment strategy
- Estates delivery
- Primary care provision
- Commercial developments
- Corporate governance: estates and facilities

EXISTING

Comms and engagement

- Overarching system-wide communications & engagement
- Intelligence on community and service user responses to pandemic
- System support for co-design and co-production
- Support for legal consultation duties in response to service changes

EXISTING

Community connection and VCS

- Local system co-ordination of work involving links with community organisations and the voluntary sector
- System co-ordination of community navigation and connection roles and functions

EXISTING

Primary care

- Responsible for ensuring that population-level enhanced services contracts support admissions avoidance, LTP ambitions and integrated of services through PCNs in Neighbourhoods
- Required as part of delegated primary care commissioning governance

EXISTING

Population health intelligence

- Responsible for modelling local COVID-19 response and co-ordinating local early warning triggers for second peak response
- Population health – data sets and support for anticipatory care and other data-informed new service models

NEW

Revised PMO arrangements during Phase Two

- In support of establishing our Integrated Delivery Plan, during June and July, SOC Leads will arrange for PMO and programme leads from major transformation programmes to co-ordinate with each other and review opportunities to streamline and simplify programme support and reporting arrangements. This will also be informed by plans for development of a local Integrated Partnership Board.

Appendix

Reminder of the 8 tests and 12 expectations

SOC Phase Two: Reminder of 8 tests

Meet patient needs			Address new priorities		Reset to a better health & care system		
1. Covid Treatment Infrastructure	2. Non-Covid Urgent Care	3. Elective Care	4. Public Health Burden of Pandemic Response	5. Staff and Carer Wellbeing	6. Innovation	7. Equality	8. The New Health & Care Landscape
Maintain the total system infrastructure needed to sustain readiness for future Covid demand and future pandemics	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Quantify the backlog; act now to slow growth in backlog as much as possible; develop the plan for clearing over time	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Catalogue the interventions now in place; identify additional actions now to support staff; develop the plan for recovery	Catalogue the innovations made; determine those to be retained; evaluate; plan for widespread adoption	Understand the needs of people and places who are the most impacted by inequalities and co-create models based on what matters to them	Catalogue the service and governance changes made and made more possible; deliver the new system
(e.g., capacity and surge capability in primary care, critical care, equipment, workforce, transportation, supply chain; strict segregation of health and care infrastructure; treatment innovation; role of the Nightingale)	(e.g., reductions in presentations; reduced access for cancer diagnostics and treatment; implications of screening programme hiatus; care for those with long-term conditions)	(e.g., prevention and community-based treatment, the rapid increase in 52 week waiters and the overall RTT backlog; major increase in capacity to diagnose and treat; use of independent sector for waiting list clearance)	(e.g., mental illness, domestic violence, child abuse, other safeguarding issues, lack of exercise, economic hardship; retaining the positives such as handwashing/ acceptance of vaccination, air quality, greater self care for minor conditions)	(e.g., meeting physical and psychological burden; developing a "new compact and a new normal" for support to staff in social care, primary care, community care, mental health, critical care, acute care settings; BAME staff and carers a particular priority)	(e.g., virtual primary care. outpatients, remote diagnostics, new approaches to triage, workforce models, use of volunteers, remote working, pace and urgency to decision making, financial models)	(e.g., capturing the right data to inform service design, need models of identifying and reaching out proactively to meet need; integrated health and care approaches to addressing inequalities)	(e.g., stepping up the new borough-based ICPs; domiciliary and residential care infrastructure; configuration of specialist services; governance and regulatory landscape implications; streamlined decision-making)
#1 We retained resilience to deal with on-going Covid 19 and pandemic needs	**#2 We did everything we could to minimise excess mortality and morbidity from non Covid causes**	**#3 We returned to the right level of access performance for elective cases prioritised by clinical need**	**#4 We put in place an effective response to the other effects on public health of the pandemic**	**#5 We helped our people to recover from dealing with the pandemic and established a new compact with them**	**#6 The positive innovations we made during the pandemic were retained, improved and generalised**	**#7 The new health and social care system that emerged was fundamentally better at addressing inequalities**	**#8 The new health and social care system that emerged was materially higher quality, more productive and better governed**

SOC Phase Two: Reminder of 12 expectations

1. A way of operationalising strict segregation of the health & care system between covid and non covid and a much stricter separation between urgent and elective work especially by site, with international best-in-class infection prevention and control practices
2. A permanent increase in critical care capacity and surge capability, centred on tertiary sites
3. Virtual by default unless good reasons not to be: primary care, outpatients, diagnostics, self care, support services
4. Triage/single points of access/resources and control at the front end of pathways e.g., through sector-level PTLs for all pathways prioritised by need and “talk before you walk” access to keep people safe and best cared for
5. New community-based approaches to managing long term conditions/shielded patients
6. New approaches to minimise hospital stay to that which is required to meet needs e.g. discharge models which maintain reductions in DTOCs/Long Length of Stay, same day emergency care, community-based rapid response
7. Disproportionate focus and resources for those with most unequal access and outcomes
8. Further consolidation and strengthening of specialist services
9. A single, more resilient ICS-level platform for corporate support services and further consolidation and sharing of clinical support services
10. New integrated workforce and volunteer models and new incentives to drive the behaviours needed to deliver these new models of care
11. Further alignment and joining together of institutions within the ICS
12. A new approach to consent through systematic deliberative public engagement e.g. citizens juries

Title of report:	The CYPMF Neighbourhoods Approach
Date of meeting:	9th July 2020
Lead Officer:	Amy Wilkinson (WSD CYPMF)
Author:	Amy Wilkinson Jenny Zeinau (CYPMF Transformation Programme Manager) Ellie Duncan (CYPMF Children's Programme Manager CCG)
Committee(s):	Integrated Commissioning Board 9th July 2020 Children, Young People, Maternity and Families Strategic Oversight Group, for ongoing discussion Jan 2020, May 2020, June 2020. City of London Integration Programme Board June 2020 CYPMF Neighbourhoods Working Group July 2020 Strategic Operational Command July 2020
Public / Non-public	Public

Executive Summary:

The main report details work done to date on developing an integrated approach to delivery for children, young people, maternity and families at a neighbourhood level. A partnership working group has been developing this since April 2019, and done a range of consultation 'hearts and minds' sessions to inform an approach. The working group has input strategically to the wider programme work (vision, data profiles, mapping), and secured funding for a CYMPF neighbourhoods project manager to drive this forward. Workshops and consultation have highlighted 3 key areas to address:

- **0-5's:** Re-working current midwifery / health visiting / primary care joint working arrangements, pathways for vulnerable families and closer working with early year's settings early help structures
- **5-19s:** Establishing more effective ways of working with schools and focussing on early help for adolescents (those 'under the threshold' for social care)
- **Families:** Putting structures in place to support adult multi-disciplinary work where there are children in the family, and putting joint plans in place with children's practitioners

Some early neighbourhood level pilots are currently delivering, testing approaches to improving immunisations in the North East of Hackney and a CYP Psychiatric Liaison post in Woodberry Wetlands.

The report outlines proposals for future development, now the project manager is in place. Building on recent COVID work around vulnerable groups we are also looking at how we can continue to share data better across partners to support complex families.

Recommendations:

The **City Integrated Commissioning Board** is asked:

- To **NOTE** and discuss the report

The **Hackney Integrated Commissioning Board** is asked:

- To **NOTE** and discuss the report

Strategic Objectives this paper supports:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☐	
Empower patients and residents	☒	

Specific implications for City

The CoL is actively part of the development conversations around CYPMF Neighbourhoods (Chris Pelham and Rachel Green), and we will need to work up an approach that will work for one neighbourhood specifically, with slightly different needs.

Specific implications for Hackney

The CYPMF approach will be rolled out across all 8 PCN / Neighbourhood areas in partnership with all key agencies across the system.

Patient and Public Involvement and Impact:

The new CYPMF Neighbourhoods project manager is currently working up the engagement and communications strands of the overall project. There have been some early discussions as part of 'Young Futures' (LBH Young Hackney) conversations with children and young people in terms of what they would like to prioritise at neighbourhood level, and very early design conversations with our Young Peoples' advisory group in 2019. This work will be moved on as a fundamental part of the project shortly, in line with our workstream engagement strategy. We will now prioritise input from families, schools and early years.

Clinical/practitioner input and engagement:

There has been clinical and practitioner input into the development of the approach in terms of:

- Dr Rhiannon England, Dr Steph Coughlin and Dr Suki Francis have been part of the monthly CYPMF Neighbourhoods working group. The rest of the working group are professionals from HUFT (Health visiting and Speech Language therapy services), Hackney Learning Trust (Head of early years) and LBH Children and Families Services (Director of CFS and Head of Young Hackney), and linking with the CoL as appropriate, supported by the CYPMF and Unplanned Care WS teams.
- Dr Ben Saw and Dr Tesheen Kahn have led pilot work and thinking on immunisations and psychiatric liaison work

- Wider consultation into the design of the approach has involved system partners from those above, along with public and patient representatives, wider primary care colleagues, midwifery, and Voluntary Sector representatives
- This work is also reporting to our workstream Strategic Oversight Group, make up of heads of partner services across City and Hackney, with Public and patient representation, and chaired by our SRO (Anne Canning).

Equalities implications and impact on priority groups:

While this work proposes a City and Hackney wide approach, it provides the opportunity to tailor specific pieces of work to very direct local need at neighbourhood level. Inclusion of robust children and families' data within the the neighbourhood data profiles enables us to build on inequalities work and to target interventions to specific need - An example of this is the immunisations pilot work in the North East of Hackney. We will also consider key groups affected by disparities through COVID-19, link to our Young Black Men's work on mental health and incorporate what our children and families articulate as areas of need. It is likely that we will focus specific interventions on Adverse Childhood Experiences (training, parenting support) at neighbourhood level. This work will be further mapped out by the project manager shortly.

Safeguarding implications:

A key opportunity exists to support Primary care and other partners around children and families that do not meet thresholds for children's social care, but may benefit from some Early Help work. This would support current safeguarding work and strengthen local partners working with vulnerable families.

Impact on / Overlap with Existing Services:

Working to a 'Neighbourhoods' footprint will have an impact on most of our wider health, education and social care services for children and families. As a project group and workstream we have worked through some key issues around the interface between the 6 cluster areas (eg. HUFT community health services and midwifery are organised in teams in the 6 cluster model, as are schools and early years settings) and the 8 neighbourhoods. In general children's services across the board are well engaged in the planning work, consultation and the approach, and are excited by the opportunities neighbourhood working presents. While a lot of Multi-disciplinary work already exists across Children's services there are agreed gaps and we will focus on these, and on strengthening relationships across Primary care and services to improve outcomes.

Supporting Papers and Evidence:

Main report

Sign-off:

Workstream SRO: Anne Canning, Director of Children's, Adults and Community Health

London Borough of Hackney: Anne Canning, Director of Children's, Adults and Community Health

City of London Corporation: Andrew Carter, Director of Communities and Children's Service

City & Hackney CCG: David Maher, Managing Director

The Children, Young People, Maternity and Families Neighbourhoods Approach: Progress and Way forward
June 2020

1.0 Context

As part of the development of the City and Hackney wider **'Neighbourhoods' Programme,** the CYPMF workstream and key partners have been working to scope a 'children, young people, maternity and families' approach that could be delivered at neighbourhood or Primary Care Network level. The pace of this work has recently been expedited to support recovery and subsequent phases as we move through the COVID-19 pandemic, in line with adult neighbourhood work. Going into 20/21, 'developing new approaches that further strengthen multi-agency working for children, young people and families' is a key priority for the wider Neighbourhood work.

2.0 Progress to date

The development of the CYPMF Neighbourhoods Approach has been led by our CYPMF Neighbourhoods working group since April 2019. The group (made up of key CYP partner agencies and the wider Neighbourhoods team) has:

- Worked with Public Health intelligence team and Neigbourhoods team to ensure that the neighbourhood **data profiles** include relevant data on maternity, children and young people
- Mapped, and teased out, the **interface** between the 8 neighbourhoods and 6 strategic children's centres, other children's centres, 4 youth hubs, primary and secondary schools and GP surgeries
- Fed into the wider Neighbourhood's operating model and **vision** to reflect CYPMF representation and scoping work
- Scoped the wide range of **multi-disciplinary working arrangements that exist** already across City and Hackney's children and families landscape, and researched models of place based integrated delivery for children and families already in place across the UK
- Secured funding (through CPEN) for a **CYPMF Neighbourhoods Project manager** (1 year fixed term), to take forward the development of the approach. She started in post June 22nd 2020.
- Delivered a wider programme of **early consultation**, including 3 separate workshops with key stakeholders across the system, to identify and work through some key challenges and agree opportunities for moving the work forward.
- Secured funding and commenced some **initial pilot** pieces of work at neighbourhood level, based on need identified through Primary Care to test out approaches that may be scaled up in the longer term:

    - **Immunisations:** A PCN / neighbourhood level approach to increasing immunization uptake in the North East of Hackney has been in place since the measles outbreak (late 2019). This has included:
        - A series of 'Special event' clinics delivered within the Orthodox Jewish community
        - Fortnightly clinics at Lubavitch children's centre

- Consideration of immunisations during community paediatrics baby clinics (Stamford Hill and Cranwich Road)
- An immunisations nurse working across the PCN/locality

This work is managed at the PCN level, through the confederation, funded by the CCG (non-recurrently) and feeds into to CYPMF Neighbourhood working group, and our wider City and Hackney immunisation work This targeted approach has been funded again for 20/21 but needs to be further expanded in the light of the COVID-19 pandemic and significant drop in immunisations (this is being explored).

- **Primary Care Psychiatric Liaison Pilot:** A child therapist is now in place (as of June 2020 - fixed term for 1 year, non-recurrently funded by the CCG) for Woodberry Wetlands to work with young people that have either medically unexplained symptoms or a long-term condition (sickle cell, epilepsy, diabetes) and who do not meet threshold for CAMHS. The therapist will accept referrals from neighbourhood / PCN GPs.
    - Based in Cedar Practice, she will join the CAMHS Primary Care Liaison Team multi-disciplinary team to input on cases and support across the neighbourhood with CAMHs input as required.
    - The role will also drive forward thinking about service development at the neighbourhood level, and ensure evaluation with a view to establishing a model of service delivery to extend to other GP surgeries.

This role will work closely with the new CYPMF neighborhoods project manager to shape the work and ensure learning and transferability, as we think about sustainability.

3.0 Current Position

- Through the Pandemic, we have continued to consult on the overall neighbourhoods approach for children and families, and expedited some of the multi disciplinary meeting work, alongside the adult work
- Through consultation on the broader approach, there is broad consensus on key gaps and opportunities across all system partners
- There is strong multi-disciplinary working across the children's landscape already and we are seeking to build on, not to duplicate or confuse, and there is broad consensus on the need to interface between the children centre / education based cluster model and the PCN / neighbourhood geographies, but not change cluster arrangements at this stage. Most community health service delivery is based on the 6 cluster model (Health visiting, midwifery and community therapy teams)
- Partners can see value in the approach generally, although ways of engaging are likely to be different ie. For children's social care, primary care, secondary care services and education. Some of these partners are further ahead in their thinking than others, and some will require a level of resource to move this forward.
- The project manager, supported by the wider team and system partners will start to consolidate the approach with a project plan.

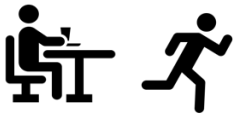
4.0 Consultation and Developing the approach

- The next step is to take forward an overall approach, made up of 3 elements, based on the need identified through consultation. Key themes emerging include:

0-5's and their families

- Link meetings between GPs and health visitors (which midwifery also attends) could be broadened out to pilot/ test a wider MDT approach for triage to other support.
- Health visiting have been reviewing pathways for their most vulnerable parents as part of their Covid response.
- There is a gap in linking to adult services who may be supporting/ able to support vulnerable pregnant women and families with children under 5, including substance misuse and adult mental health services etc. via neighbourhoods.
- There is MDM working across maternity and children's centres that could be expanded, particularly for pregnant women
- There is opportunity to work more closely with children's centre MAT's (Multi-agency teams) around early help for under 5's and their families

5-19s and their families



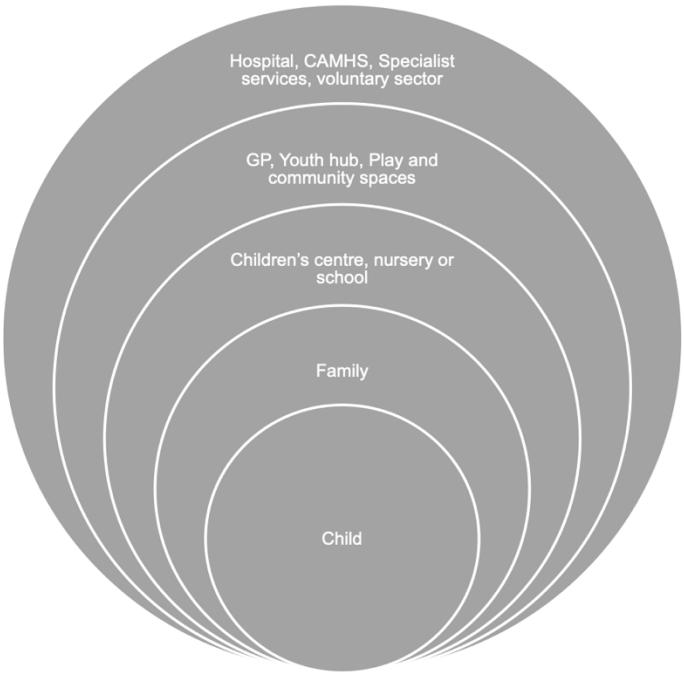
- The relationship between primary care and schools is a key gap identified in all consultation meetings.
- Strengthening school nursing's role as health partner with schools is important, as is strengthening the links with Young Hackney, and CoL Youth Services
- Early Help and CYP partnership panel links could be explored further to think MDT responses at Neighbourhood level for those who do not meet threshold for CSC services.
- A neighbourhood MDT could be approached as a step up from schools or primary care to prevent the need for statutory intervention, or as a step down from CSC, and could be a meeting that is convened on an as-needed basis.
- CYP with SEND, parents with wider needs or those that do not meet threshold for CFS input may benefit most from an MDT neighbourhoods approach.
- Families where threshold is not met for statutory support and engagement is an issue may benefit from localised 'Early Help' approaches where local protective factors could be identified which may include voluntary sector support

Vulnerable Families

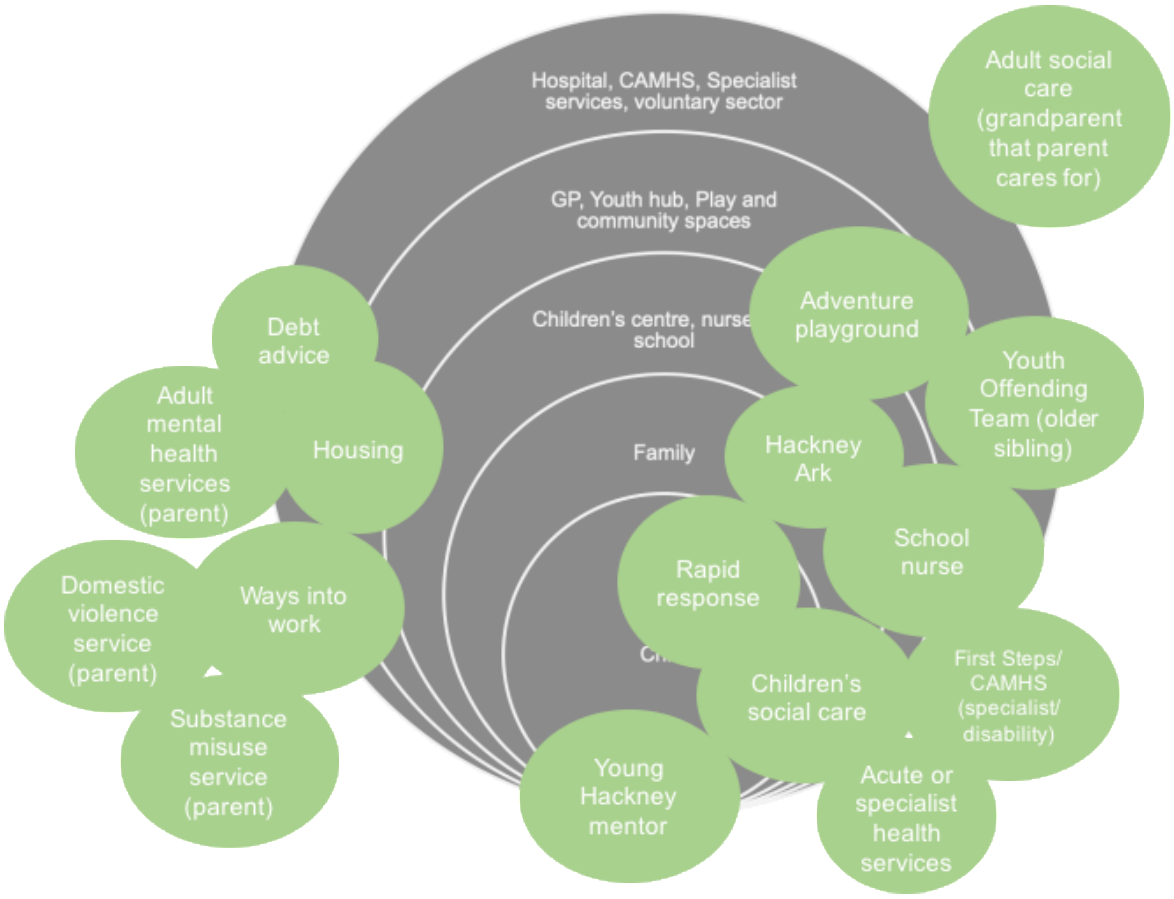
- There is a gap in linking children's and adult's services, where the adults may be vulnerable or part of an MDT discussion, particularly for very complex families and those with differing levels of engagement.
- The opportunity to ask about, and discuss children in adults MDTS – essentially developing 'Families' MDTs was seen as valuable.
- This would be key where there is work around the adult with substance misuse and adult mental health services, among others
- There are a huge range of services working with complex families, which may require some co-ordination, as set out below:

5.0 Key Partners: Who is involved in multi-disciplinary CYP and Families work?

Key partners and services that may be working with Children and Families with relatively low level need:



Key partners and services that may be working with Children and Families with higher level need:



6.0 The Approach and Next Steps

Bringing this together, we are proposing to work on 3 areas as below:

Early Years (-0 to 5)

- Maternity MDMs, links to children's centre MATs and early help support, re-working of current health visitor / primary care link meeings

5-19 year olds

- Strenghten the relationships between primary care and local schools including SENCOs, work with those who do not meet a threshold for CSC (ie the Early help cohort), and those with SEND

Families

- Work with adult MDMs to develop links that support the children in families where there are broader issues, incldluing estabishing where children might be affected and estabishing protocols for better join up

While we will incorporate some MDT's, the approach will be wider than that and incorporate a range of ways of strengthening working relationships and building knowledge across organisations.

Immediate steps forward include:

O-5's and Families work:

A developmental approach to a 'Families' MDT is moving forward in the Woodberry Wetlands PCN / Neighbourhood:

- The Cluster A & B (relevant geographical area) MAT (Children's Centre) Chair will attend the adults MDT shortly, to begin to scope the interface, with a view to proposing 'stuck' cases for discussion in the Neighbourhood MAT
- The Primary Care Liaison nurse will be developing an approach which can be tested around children's mental heath, and linking more widely to the adult mental health community work
- A link person is being identified in FAST to screen for whether families are known
- There is scope to incorporate early help pilots currently being developed across the system and move forward immunisation pilot work
- Agreeing plans for increasing immunisation uptake at PCN / neighbourhood level
- Work to build on the 'MECC' approach, that is being trailed in midwifery currently and health visiting shortly, with a view to wider early years roll out

5-19's:

The link to schools, SENCO's and to Young Hackney is crucial for this age group, and key next steps are:

- Strengthening links with SENCO's and schools on a geographical basis –ie. Meeting local teachers / GPs, knowing which schools families are linked to and developing lines of communication
- Re-working health input to Children and Families Service CYP Panels. This model needs refreshing and there is opportunity to make this work better across the system for families
- Some basic protocols and communication, in terms of the range of support that is available to adolescents both in school and out of school, particularly for those that don't meet statutory children's social care thresholds.
- Agreeing the most helpful and appropriate ways of working with schools post COVID
- Scope what a 'MECC' approach for those that work with adolescents might look like

The project manager will be driving this forward and looking at roll out, and sustainability more widely.

7.0 Considerations yet to be worked through:

Through consultation and working groups, while we have worked through a number of key challenges:

- the geographical alignment to cluster model

- the difference between the function of children's social care and adult social care and the implications of this, ie. That if a child is known to children's social care, they are likely to be at risk of harm, as opposed to needing low level health care (as may be the case if they are known to adult's social care)
- the high level of multi-disciplinary working across children and families' organisations already, which means that additional 'structures' need to add value and be bought into, not imposed or duplicate

We are also conscious that we have yet to work through:

- how we ensure the voice and lived experience of children and families remains central to our planning and delivery model
- How community resilience work including MDTs/ strategic development of work to support vulnerable residents and VCS engagement (Community Navigation/ Social Prescribing) is worked into our approach.
- How we build on key developments in ways of working during COVID-19, including taking into account disparities and inequalities exacerbated and develop models that deliberately seek to mitigate these.
- Working with issues of consent, for discussions on families

And more specifically:

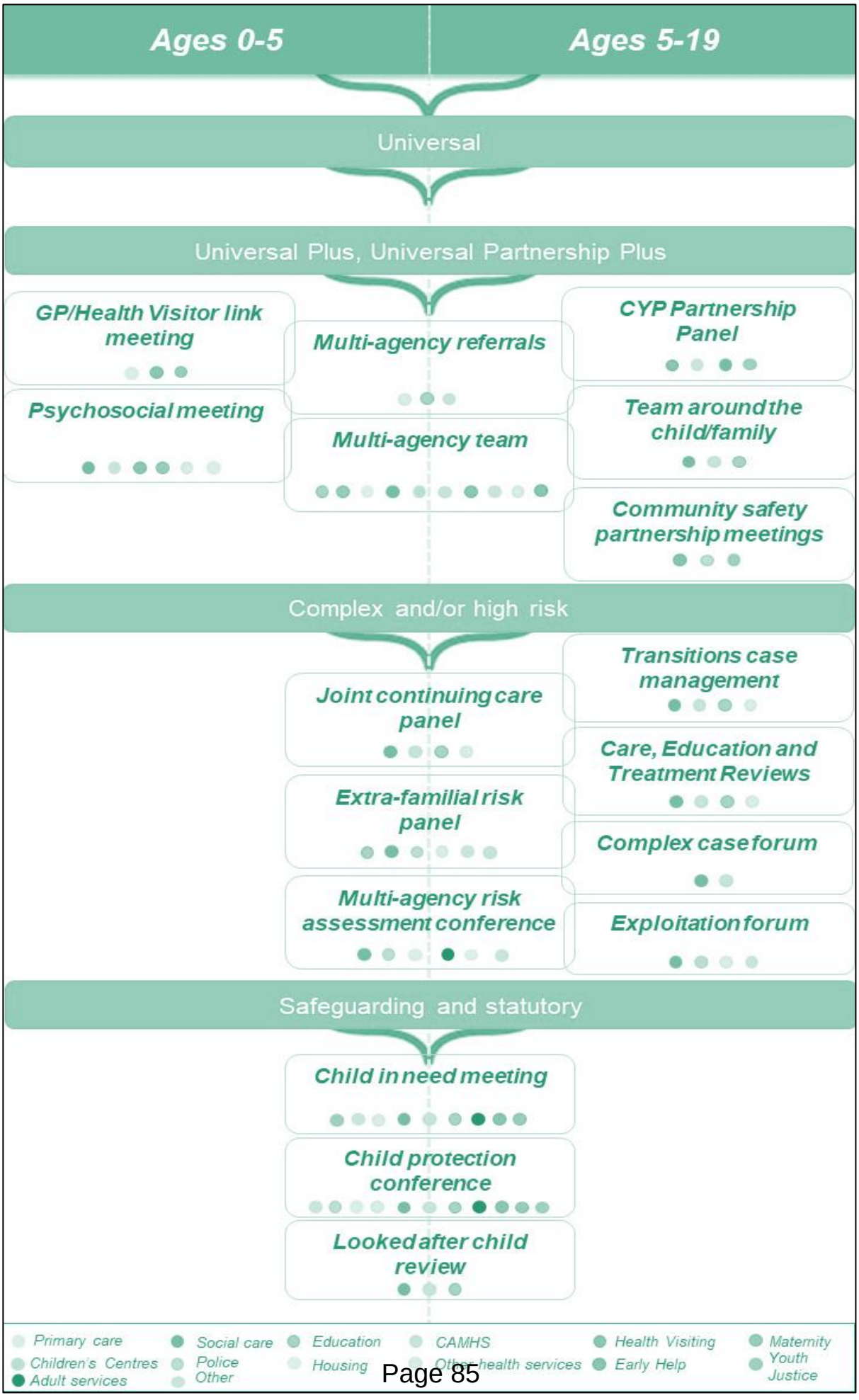
- What the appropriate level of practitioner input from children and families' services would be. It may be that, like the adult MDT, there is a key contact for the MDT generally with access to Mosaic but that if a case worker is allocated, they would join virtually to discuss the case
- How far can we progress a standardised referral form?
- Housing is a key partner given the number of vulnerable families who are likely to be referred where housing is a factor. What is the best way to build the working relationship?
- Information sharing and recording issues: we will need to be clear on what should be recorded where
- Registered vs. resident population issues, particularly with secondary aged young people who are more likely to access schools and services outside City and Hackney, or come to school from outside City or Hackney

8.0 Governance

This work is being taken forward by the workstream, overseen by the CYPMF Neighbourhoods working group, and reporting to the workstream Strategic Oversight Group and onto the System Operational Command. It is a key delivery vehicle for the early life course theme, set out in the System Operational Command Phase 2 Restoration and Recovery Planning, as below:

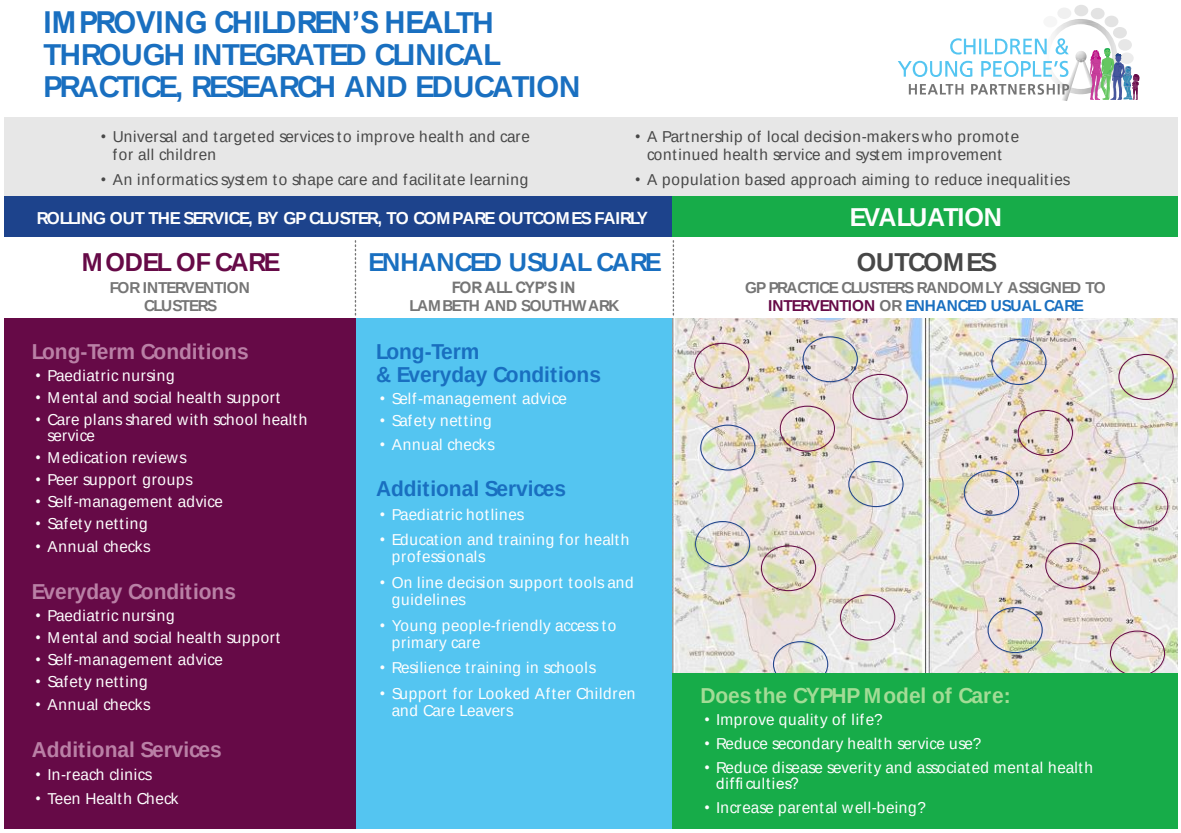
System Operational Command Integrated Health and Care provision High Level Plan ('Restoration and Recovery'):

Appendix 1: Mapping of Current Multi-Disciplinary work: City and Hackney 2020



Appendix 2: Children and Young People's 'Neighbourhoods' work in other areas

1. **Southwark and Lambeth:** Children and Young People's Health Partnership



https://www.cyphp.org/. 2 year evaluation plan outlined: https://bmjopen.bmj.com/content/9/8/e027301

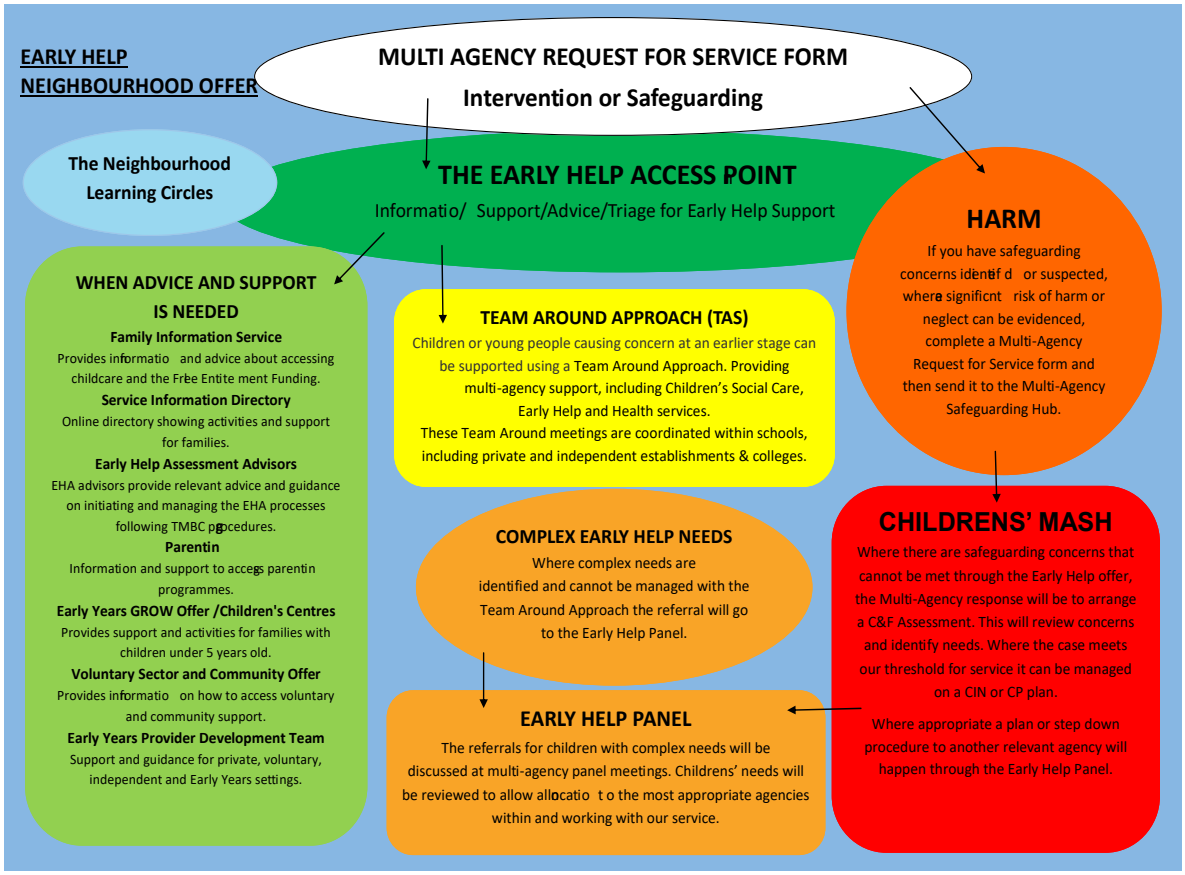
2. **Essex County:** Child and Family Wellbeing Service and Family Hubs

Essex County Council, Virgin care and Barnardos integrated approach where services are delivered by neighbourhood 'family hubs' (formerly children's centres). The integrated service restructure and workforce redesign:

- Incorporates the merging of staff groups and teams from ten previous provider organisations and the integration of management functions and service delivery teams from Virgin Care and Barnardo's.
- Consolidated local delivery sites building partnership with communities to build resilience, and sessional events for hard to reach groups
- Merging and updating electronic records to improve safety and remove repetition for services users.
- Community Development Plans and community engagement strategy looking at the needs of each district and how the service can build local community involvement to provide the resilience for local people.

https://essexfamilywellbeing.co.uk/ and https://essexfamilywellbeing.co.uk/service/healthy-family-service/family-hubs/

3. **Tameside:** Early Help Neighbourhood Offer



Leaflet about the service: https://www.tameside.gov.uk/TamesideMBC/media/earlyyears/Early-Help-Access-Point-Trifold-Pamphlet-November-2019.pdf and Tameside Early Help Strategy: https://www.tameside.gov.uk/TamesideMBC/media/Children/EarlyHelpStrategyGuide.pdf

4. **Greenwich** 'Start Well' and 'Live Well' Early Help restructure, Children and Young People's Health and Wellbeing Services 2020:

Large scale whole system prevention focussed approach organised geographically using an integrated system delivery model. Prioritising 1001 days, expansion across all ranges from childhood to employment and strengthening adolescent support and incorporating digital technology and communication across all services.

Proposals for the new service include:
The integration of HV and children's centre, school nursing and universal youth, development of social prescribing for children and young people and interactive borough-wide digital offer including digital passport at start of secondary school. Establishment of integrated multi-disciplinary teams in children's centres to include practitioners/ services for parents and children including health advocates (breastfeeding/ weight/ healthy food/ MH), specialist workers for teenage and young mothers, wellbeing coaches, nursery nurses, family support workers, child and family practitioners, digital communication officers.

Title of report:	Update on Care and Support for Rough Sleepers- July 2020
Date of meeting:	Thursday 9th July 2020
Lead Officer:	Siobhan Harper
Author:	James Courtney
Committee(s):	Integrated Commissioning Board
Public / Non-public	Public

Executive Summary:

The update summarises developments with housing, health and social care services for rough sleepers in the City of London and Hackney.

Recommendations:

For information.

Strategic Objectives this paper supports:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☐	The paper is an update and does not propose a change to services.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☐	
Empower patients and residents	☐	

Specific implications for City

The paper provides an update on care/support for rough sleepers in the City.

Specific implications for Hackney

The paper provides an update on care/support for rough sleepers in Hackney.

Patient and Public Involvement and Impact:

The paper is an update and so patients/members of the public have not been engaged on any proposal.

Clinical/practitioner input and engagement:

Dr Rhiannon England, GP Clinical Lead for Homeless Services, and housing operational staff attended the initial partnership group meeting

Communications and engagement:

No- it is an update on service provision. No service change proposed. We will engage communications if there is any recommendation to update the public. **Comms Sign-off** n/a

Equalities implications and impact on priority groups:

No service change proposed. Provision of services for rough sleepers and wider priority issues related to this are discussed in the paper.

Safeguarding implications:

This paper does not specifically raise any safeguarding concerns.

Impact on / Overlap with Existing Services:

There are no proposals in the report

Supporting Papers and Evidence:

None

Sign-off:

London Borough of Hackney/ City of London Corporation/City & Hackney CCG: Siobhan Harper, Planned Care Workstream Director, City and Hackney CCG Formal sign off for all stakeholders not undertaken as this is an update. All stakeholders engaged in the development of the paper and signed off content.

Update on Care and Support for Rough Sleepers- July 2020

Headlines

- City of London and London Borough of Hackney continue to support more rough sleepers with accommodation as part of the COVID-19 pandemic response
- GLA is looking to close its accommodation and is working with Local Authorities to manage the transfer/support of rough sleepers
- Both City of London and London Borough of Hackney are working to ensure they maintain increased bed capacity to support rough sleepers through 2020-21
- City of London is negotiating the provision of more hostel beds within the City
- London Borough of Hackney has leased two hotels in Finsbury Park and are transferring rough sleepers from other accommodation to these two sites- this process is scheduled to be complete by mid-July
- Public Health are undertaking a Needs Analysis Survey led by clinicians- results will be available by August.
- There is concern about the lack of national policy on testing for rough sleepers and clinical/operational staff with no COVID symptoms. There is a risk this may lead to future outbreaks.
- Rough Sleeping and Mental Health Programme (RAMHP) are a new GLA commissioned ELFT Mental Health Service for rough sleepers operating in City of London, Hackney, Tower Hamlets and Newham. Partners are working to liaise with the new service to ensure support for rough sleepers is coordinated.
- A City and Hackney Health and Rough Sleepers Partnership Group aims to meet regularly to help coordinate the planning of future services.

Accommodation Provision

The City of London and London Borough of Hackney worked to ensure all rough sleepers were housed locally in the response to COVID-19. This meant housing more people and commissioning more accommodation to meet the local need.

The table below summarises the number of rough sleepers accessing the different types of support.

	Number of Rough Sleepers supported with accommodation	Number of Rough Sleepers supported by GLA accommodation	Number of Rough Sleepers in directly procured accommodation	Number of street homeless
City of London	117	86	31	14
London Borough of Hackney	192	22	170	9

The GLA commissioned accommodation in the immediate response that local authorities could access for rough sleepers with a lower level of need. Both the City and LBH also directly procured accommodation. The City procured beds in a Travel Lodge Hotel, outside of the City, and re-purposed the use of an YHA hostel in the City. LBH procured two hotels and a range of other accommodation units. The City have housed rough sleepers in accommodation that was part of their pre-COVID offer. London Borough of Hackney is using it pre-COVID temporary accommodation to house families- approximately 3,400 households. The newly procured accommodation provides an enhanced offer and so is more effective at meeting the complex needs of rough sleepers.

Both the City and LBH continue to house rough sleepers with No Recourse to Public Funds. City of London estimates that 30-40% of their housed rough sleepers have NRPF. London Borough of Hackney are housing 44 rough sleepers with NRPF- the majority of these residents are from outside of the EU. LBH have made a public commitment to support these rough sleepers once lockdown ends.

Some rough sleepers have chosen not to access accommodation. Both the City and LBH provide regular outreach to these residents and host multi-agency meetings to ensure care/support is coordinated.

Future Accommodation Planning

The GLA are reducing their accommodation offer and working with local authorities to ensure residents are transferred safely. The City estimates they will need to support up to 50 residents through this transition; LBH will need to support up to 22 rough sleepers. Both the City of London and London Borough of Hackney are committed to ensuring that residents can access accommodation so they are 'in for good'.

The City is negotiating with the Youth Hostel Association to provide more beds for the rest of 2020-21.

LBH have leased two hotels near Finsbury Park for the next 12 months and is looking to transfer all rough sleepers into this accommodation- if they need this support. This is scheduled to be completed by mid-July. LBH are looking to provide wrap around care for rough sleepers housed in the accommodation. They are liaising with housing support care providers to deliver this. These accommodation options will provide more stability to the current accommodation offer.

London Borough of Hackney Rough Sleeper Move on Group

LBH have developed a Rough Sleeper Move On Group with representation from cabinet members and key stakeholders. It will focus on accommodation, support, health and NRPF. The group meets weekly and are preparing a bid to central government for long term funding for the rough sleeper pathway and associated services.

London Borough of Hackney Cost Modelling

The Society of London Treasurers and London Councils have completed a costing exercise for submission to Central Government.

The costing has been split into 3 distinct phases:

- Emergency- March to June 2020
- Transition- July 20 - March 21
- Settled Accommodation- April 21- March 22

The cost to LBH is in the millions. Exact figures will be shared when available.

Health Provision

ELFT continues to provide its homeless outreach service. The service provides all aspects of primary care in hotel/accommodation settings and aims to support rough sleepers without GPs to register. It's staffed by 2 GPs- providing 12 clinical sessions- and 3 nurses. The service currently covers Newham, Tower Hamlets, Hackney and the City. It covers all hotel residents placed in these boroughs. There have been initial discussions about moving to a borough based model, but these are at an early stage.

The UCLH Find and Treat Service continue to provide COVID-19 testing and some testing for TB, HIV, Hep B and C and overall health screening work. Dental care has been highlighted as a specific concern.

A development group is in place to establish a response for rough sleepers including step-up/step-down care at the Homerton Hospital.

Needs Analysis
Full results of the UCL Find and Treat interventions will be available in August and Public Health are planning an event to discuss the findings. The survey uses clinical tools and the screening is done by clinicians. It will give much more granular detail of the health needs of local rough sleepers and inform the development of services.

Testing for Rough sleepers without Symptoms
Stakeholders have expressed concerns about the lack of testing offer for rough sleepers and operational/clinical staff with no COVID-19 symptoms. Currently, there is no national policy and there is significant movement of residents between accommodations. There is a risk that this leads to further outbreaks. There is a clinical view that we urgently need a local policy of frequency of asymptomatic testing for staff and clients in all multiple occupancy settings

Rough Sleeping and Mental Health Programme (RAMHP)
GLA have commissioned a new mental health service for rough sleepers across Central, North-East, West and East London. The service is provided by ELFT in East London and will cover Tower Hamlets, Newham, Hackney and the City. It will be staffed by 4 mental health practitioners and will have input from a consultant psychiatrist. The service is a two year pilot with the aim of delivering better quality of life outcomes for rough sleepers.

The service is not yet fully operational, but it has seen 34 clients to date and has conducted outreach to local hotels/accommodation. It is also receiving referrals from health and social care. Local partners are engaging with the service to understand how best to work with them. Initial introductions were disrupted due to the COVID-19 response. Both the City of London and Hackney have existing outreach mental health workers and so the new staff will add into a comprehensive outreach mental health provision.

City and Hackney Health and Rough Sleepers Partnership Group
Key stakeholders from partner organisations met on 30th June 2020 to discuss current provision and future planning. The group are looking to meet regularly to plan a collaborative approach to future changes in services for rough sleepers.

Integrated Commissioning Glossary

ACERS	Adult Cardiorespiratory Enhanced and Responsive Service	
AOG	Accountable Officers Group	A meeting of system leaders from City & Hackney CCG, London Borough of Hackney, City of London Corporation and provider colleagues.
CPA	Care Programme Approach	A package of care for people with mental health problems.
CYP	Children and Young People's Service	
	City, The	City of London geographical area.
CoLC	City of London Corporation	City of London municipal governing body (formerly Corporation of London).
	City and Hackney System	City and Hackney Clinical Commissioning Group, London Borough of Hackney, City of London Corporation, Homerton University Hospital NHS FT, East London NHS FT, City & Hackney GP Confederation.
CCG	Clinical Commissioning Group	Clinical Commissioning Groups are groups of GPs that are responsible for buying health and care services. All GP practices are part of a CCG.
	Commissioners	City and Hackney Clinical Commissioning Group, London Borough of Hackney, City of London Corporation
CHS	Community Health Services	Community health services provide care for people with a wide range of conditions, often delivering health care in people's homes. This care can be multidisciplinary, involving teams of nurses and therapists working together with GPs and social care. Community health services also focus on prevention and health improvement, working in partnership with local government and voluntary and community sector enterprises.
CS2020	Community Services 2020	The programme of work to deliver a new community services contract from 2020.
DToC	Delayed Transfer of Care	A delayed transfer of care is when a person is ready to be discharged from hospital to a home or care setting, but this must be delayed. This can be for a number of reasons, for example, because there is not a bed available in an intermediate care home.
ELHCP	East London Health and Care Partnership	The East London Health & care Partnership brings together the area's eight Councils (Barking,

		Havering & Redbridge, City of London, Hackney, Newham, Tower Hamlets and Waltham Forest), 7 Clinical Commissioning Groups and 12 NHS organisations. While East London as a whole faces some common problems, the local make up of and characteristics of the area vary considerably. Work is therefore shaped around three localized areas, bringing the Councils and NHS organisations within them together as local care partnerships to ensure the people living there get the right services for their specific needs.
FYFV	NHS Five Year Forward View	The NHS Five Year Forward View strategy was published in October 2014 in response to financial challenges, health inequalities and poor quality of care. It sets out a shared vision for the future of the NHS based around more integrated, person centred care.
IAPT	Improving Access to Psychological Therapy	Programme to improve access to mental health, particularly around the treatment of adult anxiety disorders and depression.
IC	Integrated Commissioning	Integrated contracting and commissioning takes place across a system (for example, City & Hackney) and is population based. A population based approach refers to the high, macro, level programmes and interventions across a range of different services and sectors. Key features include: population-level data (to understand need across populations and track health outcomes) and population-based budgets (either real or virtual) to align financial incentives with improving population health.
ICB	Integrated Commissioning Board	The Integrated Care Board has delegated decision making for the pooled budget. Each local authority agrees an annual budget and delegation scheme for its respective ICB (Hackney ICB and City ICB). Each ICB makes recommendations to its respective local authority on aligned fund services. Each ICB will receive financial reports from its local authority. The ICB's meet in common to ensure alignment.
ICS	Integrated Care System	An Integrated Care System is the name now given to Accountable Care Systems (ACSs). It is an 'evolved' version of a Sustainability and Transformation Partnership that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local

		authorities, choose to take on clear collective responsibility for resources and population health. They provide joined up, better coordinated care. In return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners.
ISAP	Integrated Support and Assurance Process	The ISAP refers to a set of activities that begin when a CCG or a commissioning function of NHS England (collectively referred to as commissioners) starts to develop a strategy involving the procurement of a complex contract. It also covers the subsequent contract award and mobilisation of services under the contract. The intention is that NHS England and NHS Improvement provide a 'system view' of the proposals, focusing on what is required to support the successful delivery of complex contracts. Applying the ISAP will help mitigate but not eliminate the risk that is inevitable if a complex contract is to be utilised. It is not about creating barriers to implementation.
LBH	London Borough of Hackney	Local authority for the Hackney region
LAC	Looked After Children	Term used to refer to a child that has been in the care of a local authority for more than 24 hours.
LARC	Long Acting Reversible Contraception	
MDT	Multidisciplinary team	Multidisciplinary teams bring together staff from different professional backgrounds (e.g. social worker, community nurse, occupational therapist, GP and any specialist staff) to support the needs of a person who requires more than one type of support or service. Multidisciplinary teams are often discussed in the same context as joint working, interagency work and partnership working.
MECC	Making Every Contact Count	A programme across City & Hackney to improve peoples' experience of the service by ensuring all contacts with staff are geared towards their needs.
	Neighbourhood Programme (across City and Hackney)	The neighbourhood model will build localised integrated care services across a population of 30,000-50,000 residents. This will include focusing on prevention, as well as the wider social and economic determinants of health. The neighbourhood model will organise City and Hackney health and care services around the patient.

NEL	North East London (NEL) Commissioning Alliance	This is the commissioning arm of the East London Health and Care Partnership comprising 7 clinical commissioning groups in North East London. The 7 CCGs are City and Hackney, Havering, Redbridge, Waltham Forest, Barking and Dagenham, Newham and Tower Hamlets.
NHSE	NHS England	Executive body of the Department of Health and Social Care. Responsible for the budget, planning, delivery and operational sides of NHS Commissioning.
NHSI	NHS Improvement	Oversight body responsible for quality and safety standards.
	Primary Care	Primary care services are the first step to ensure that people are seen by the professional best suited to deliver the right care and in the most appropriate setting. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
PIN	Prior Information Notice	A method for providing the market place with early notification of intent to award a contract/framework and can lead to early supplier discussions which may help inform the development of the specification.
QIPP	Quality, Innovation, Productivity and Prevention	QIPP is a programme designed to deliver savings within the NHS, predominately through driving up efficiency while also improving the quality of care.
QOF	Quality Outcomes Framework	
	Risk Sharing	Risk sharing is a management method of sharing risks and rewards between health and social care organisations by distributing gains and losses on an agreed basis. Financial gains are calculated as the difference between the expected cost of delivering care to a defined population and the actual cost.
	Secondary care	Secondary care services are usually based in a hospital or clinic and are a referral from primary care. rather than the community. Sometimes ‘secondary care’ is used to mean ‘hospital care’.
	Step Down	Step down services are the provision of health and social care outside the acute (hospital) care setting for people who need an intensive period of care or further support to make them well enough to return home.

STP	Sustainability and Transformation Partnership	Sustainability and transformation plans were announced in NHS planning guidance published in December 2015. Forty-four areas have been identified as the geographical 'footprints' on which the plans are based, with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). A named individual has led the development of each Sustainability and Transformation Partnership. Most Sustainability and Transformation Partnership leaders come from clinical commissioning groups and NHS trusts or foundation trusts, but a small number come from local government. Each partnership developed a 'place-based plans' for the future of health and care services in their area. Draft plans were produced by June 2016 and 'final' plans were submitted in October 2016.
	Tertiary care	Care for people needing specialist treatments. People may be referred for tertiary care (for example, a specialist stroke unit) from either primary care or secondary care.
	Vanguard	A vanguard is the term for an innovative programme of care based on one of the new care models described in the NHS Five Year Forward View. There are five types of vanguard, and each address a different way of joining up or providing more coordinated services for people. Fifty vanguard sites were established and allocated funding to improve care for people in their areas.

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Analysis of impact of COVID-19 on health inequalities in Ci

Objectives

Guide local decision making and service planning: for organisations across City and Hackney
Monitor inequalities impacts of pandemic, response and recovery
Collate data sources (national and local, quantitative and qualititative) in once place
Identify gaps in local knowledge and priorities for engagement and further insight activity
Identify priority groups/areas for action - short, medium and longer-term

Framework: mapping impacts of the pandemic against vulnerable/a

Data sources and evidence listed below used to identify which population groups (columns) at gr show specific at risk groups, and which evidence source shows this (numbers). Shaded boxes with time.

			Vulner Children
Direct impacts of SARS-Cov2 virus pandemic		Increased likelihood of exposure to virus, via e.g.	
		Vulnerability to complications/death	
Impacts due to the pandemic response (not Covid19 related)	Changes in service delivery	Changes in health service delivery (including	people
		Changes in service use by populations, fear of	accessibility of
		Changes in wider service delivery: prevention/public health services, libraries, other LA services	
		Change in wider service delivery: VCSE organisations have been impacted by response and the resulting change in how they support people	
		Financial sustainability of care homes	
	Health related impact of 'lockdown'	Under/untreated health conditions	
		Health-related behaviour changes (e.g.	physical activity
		Social isolation	
		Mental health: impact of shielding, self-neglect,	
	Safety related impacts of 'lockdown'	Child safeguarding	7
		Domestic abuse	7
		Community safety e.g. racially motivated incidents	
		Vulnerable housing/homelessness	7
		Employment status/loss of earnings	7: Young adults (16-24) most impacted
		Increase in debt/poverty	
		Food poverty or insecurity/hunger: including access to and appropriateness of emergency food parcels	11: Impact of school closure: no free school meals

	Economic impacts of 'lockdown'	Education outcomes including impact of digitial divide	11: Differences in home schooling. Differences in ability to access online resources
	businesses and employees	Impact on shut down businesses and their Impact of easing lockdown: maintaining social	

Evidence used to populate matrix: data sources **(shown as numbers in matrix)**

Data	1: Public Health Covid19 data and reports 2: ONS analyses of deaths by deprivation 3: City and Hackney JSNA 4: ONS analysis of deaths by occupation 5: Intensive Care National Audit and Research Centre (ICNARC) 10: National PHE disparities report 11: C&H Public Health evidence summary 12: QMUL study on suspected Covid19 cases 13: BAME women and Covid19 - research evidence (Fawcett Society) 14: Institute of Fiscal Studies: Deaton review
Community insight	6: Community insight - City and Hackney 7: LBH Policy and Strategy Team Cumulative Impact Assessment Insight collected from Primary Care, including PCN social Insight collected from Neighbourhoods City TBC
References	9: New Policy Institute study on multigenerational housing

ty and Hackney (DRAFT in development)

at risk groups

eater risk of different impacts of the pandemic (in what ways - rows). Matrix cells
ı no evidence number means potential impact but no evidence known at this

able groups due to: age		Vulnerable groups due to: condition/disability or caring			
Children with additional needs	Older people	LD/ Dementia	Multimorbidity	Disability including sensory impairment	Shielded patients
	households				
	Underlying LTCs;	prevalance of LTCs;	12, 10, 11		shielded pts
	likely to have digital			impairment on access	
	complications				access to standard
	6: people rely on libraries for digital access				
	future demand				
	increased need for				
	6: Older people; 11			7	
	6: Older people			7	
7					
	Shielding population and older people			11: adults with dasability at greater risk of food poverty	

Vulnerable groups due to: link with risks in care homes					
Care homes residents	Care workers	Carers	Ethnicity	Religion	Migration status
	4: Care workers		households	higher occupancy	households
10.Over 1/3 of all Covid deaths in care			BAME		
				Lack of internet access in some	finding it more
		opportunity to access	more broadly)		services
Current residents					
		7	13		
		7			
			South East Asian community		
					6
			7: BAME; 13 BAME women		
			Cultural appropriateness of food parcels	Cultural appropriateness of food parcels	

		7: Impact of predicted grades 7: Impact of digital divide

		Vulnerable groups due to: gender or sexuality		Vulnerable groups due to: housing situation	
People with no recourse to public funds	Deprivation	Gender	Sexuality	Rough sleepers	Those in temporary or vulnerable accommodation
	workers			incidence in rough	accommodation/f
	3: Obesity and LTCs	deprivation gradient			
healthcare	benefits: less likely to				
	6: people rely on libraries for digital access				
	11: lower SES groups more likely use A&E				
7 7			7 7		
7					
7	Those in temporary accommodation			Sustainability of temporary pandemic	
	14, 11	11 Women's employment status more likely to be affected			
7	14, 11				
	11				

7: Impact of predicted grades 7: Impact of digital divide. 14; 11.		

City and Hackney: Discharge Single Point of Access Service (DSPA)

April 2020

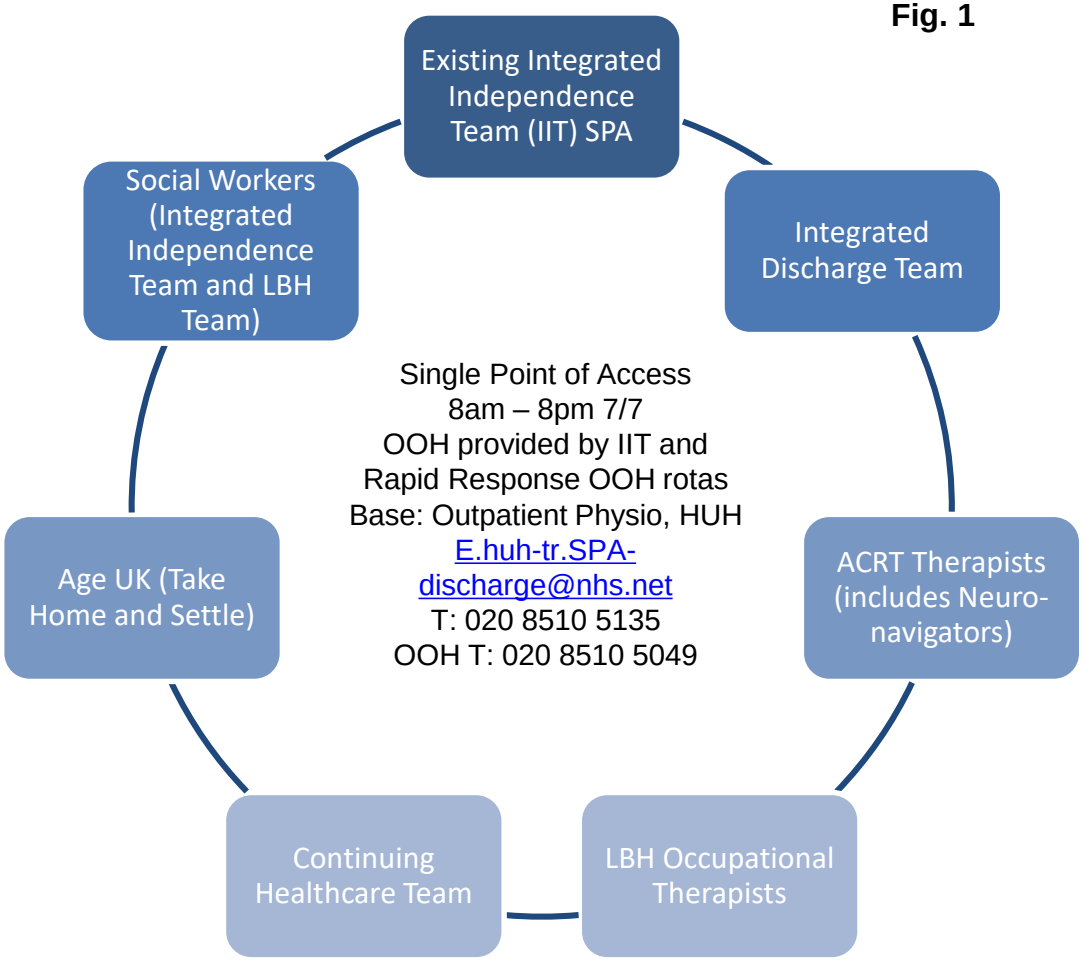
1. Discharge Single Point of Access (DSPA)

The existing Single Point of Access within the Integrated Independence Team (IIT) will be expanded as per fig 1 to enable a dedicated SPA and case coordination function to support same day discharge. The team will benefit from the support from the IIT Rapid Response Team with therapy resource from LBH and the Adult Community Rehabilitation Team (ACRT) reassigned to bolster the Rapid Response Team.

The SPA team will work seamlessly with

- LBH Brokerage Service
- Community therapy provision (LBH Occupational Therapy and HUH ACRT)
- Primary Care
- Wider Voluntary Sector
- Established Neighbourhood Staff, for example Well Being Practitioners
- Hospital porters, hospital transport (including LAS and St Johns Ambulance Service)
- Adult Safeguarding
- Adult Community Nursing

Fig. 1



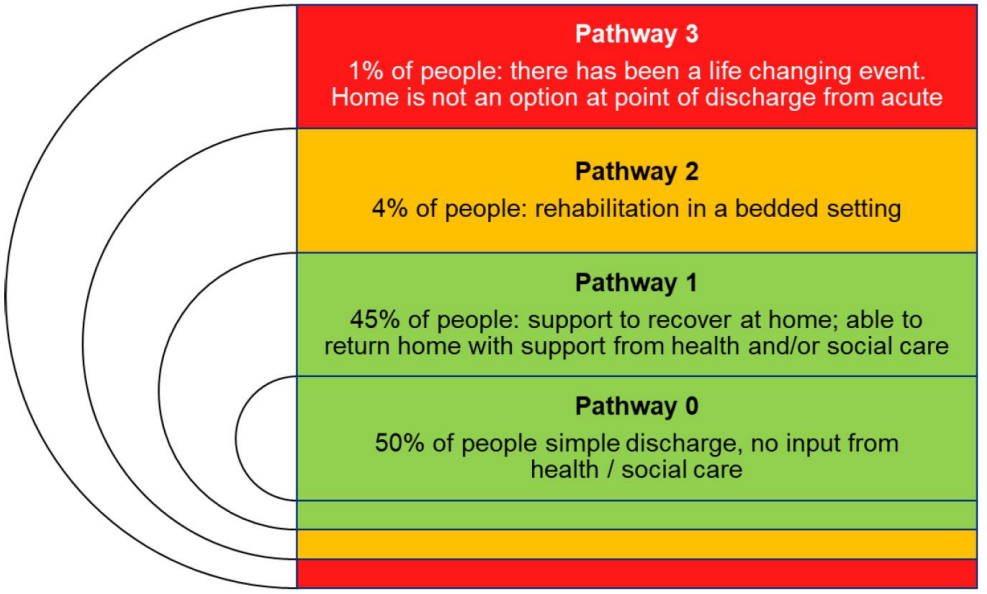
2. Patient criteria and discharge

There are four clearly defined pathways set out for discharge under this model, the overriding principal is for a Home First approach wherever possible however there will be instances where patients will need to be discharged into interim arrangements so as to meet the agenda of maximising bed and acute hospital staff capacity.

The ward criteria for identifying patients suitable for discharge is simplified to all patients that are medical optimised (clinically safe) for discharge. This applies to all patients regardless of COVID status although the Infection Control Precautions will be adhered to in planning for discharge.*

It is expected that 50% of the patients will not be discharged via the SPA in-reach process and consequently the ward will manage the discharge (Pathway 0) as usual with support from a discharge coordinator.

Fig. 2



* https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients

3. Pathways and Referral Process

- The SPA team will in-reach to all acute wards twice daily (Mon-Fri) at 9am (whiteboard) and 2pm. A list of medically optimised patients which are ready for same day discharge will be collated via this process. Weekends will initially be a once per day attendance to each ward via the existing weekend discharge team process with the added availability of the brokerage service. Out of area hospitals will refer direct to the Discharge SPA instead of IIT and ACRT.

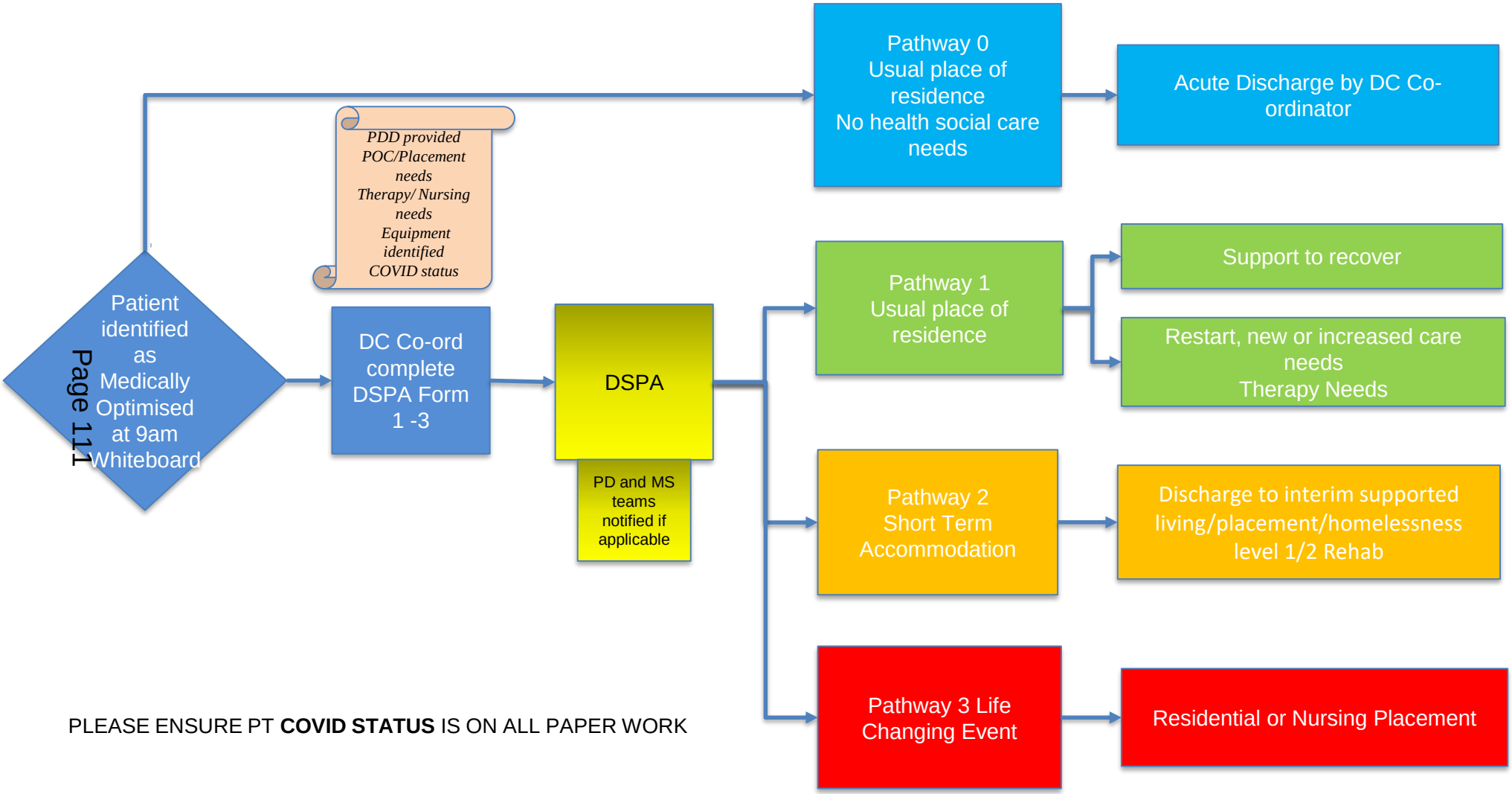
- Usual referrals to other routine services such as Adult Community Nursing will continue by the wards.

- Emergency Department/OMU and ACU continue to refer to IIT Rapid Response as usual.

- Patients in the last days or weeks of life are to be referred directly to the Continuing Health Care Team using the existing Fast Track paperwork who will arrange for rapid discharge to home, care home or hospice. The Hospital Palliative Care Team, where the patient is already known to them can refer directly to hospice.

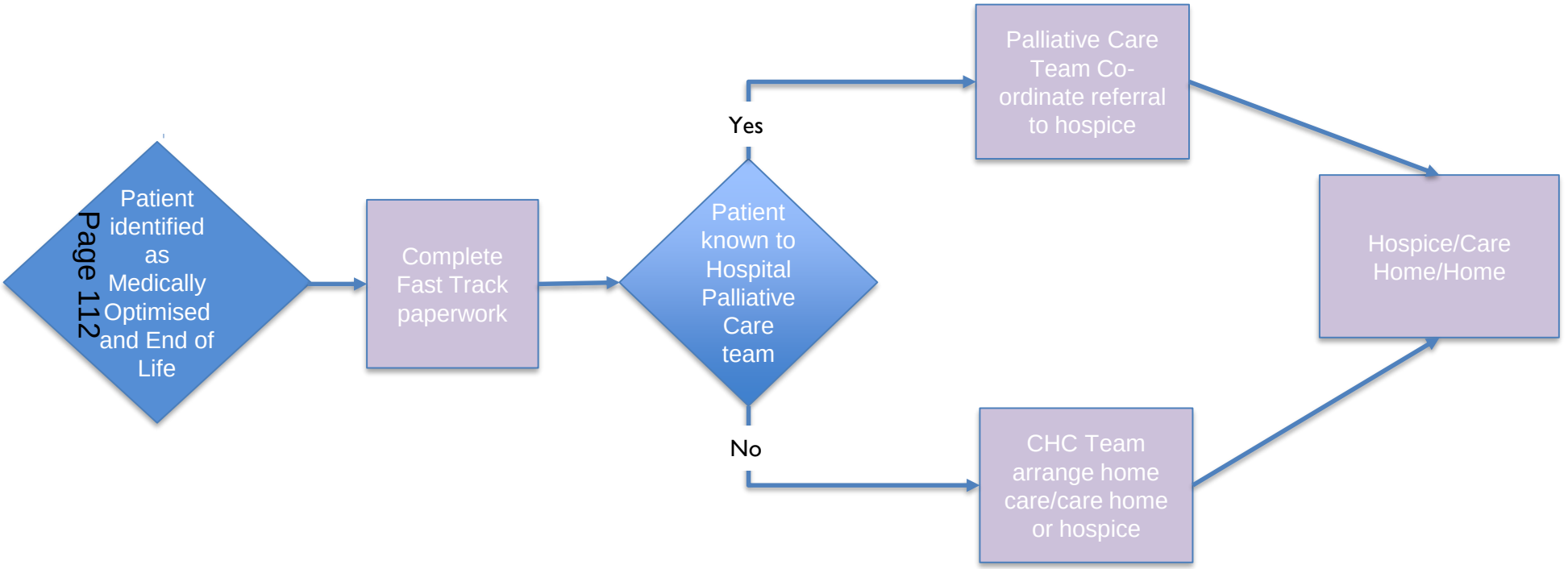
- Duties under the Mental Capacity Act 2005, DOLS and Safeguarding apply during this period and need to be considered/assessed prior to making a decision about discharge

3. Pathways 0-3 Process



PLEASE ENSURE PT **COVID STATUS** IS ON ALL PAPER WORK

3. End of Life Pathway



PLEASE ENSURE PT **COVID STATUS** IS ON ALL PAPER WORK

4. Summary of Roles and Responsibilities

	Pathway 0	Pathway 1	Pathway 2	Pathway 3	End of Life
Responsible for confirming Medically Optimised and safe for discharge	Acute Ward	Acute Ward	Acute Ward	Acute Ward	Acute Ward
Responsible for Discharge Coordination (apart from Discharge Summary and TTA's which is always the ward role)	Acute Ward + Discharge Coordinator	DSPA	DSPA	DSPA	DSPA
Criteria for Pathway	No input required from Health or Social Care May require input from voluntary provision Provide with ward number	Safe to be left between care calls Requires short or longer term support care package	Requires rehabilitation in a bedded setting (in excess of community provision)	Requires nursing home (care needs in excess of community provision)	In last days or weeks of their life

4. Roles and Responsibilities – Acute Ward

Acute Wards
Have a senior clinical decision maker available to support staff with positive risk taking.
Review patients daily and identity patients for discharge that day at 9am morning whiteboard meetings.
Undertake a second 2pm review of all patients in acute beds to agree who is suitable for discharge that day.
All suitable patients to be added to the discharge list by the SPA team member attending the 9am and 2pm reviews.
Where possible include the COVID-19 test results in documentation.
Duties under the Mental Capacity Act 2005, DOLS and Safeguarding apply during this period and need to be considered/assessed prior to making a decision about discharge.
Discuss decision to discharge with the patient and family and provide the patient with the Discharge Leaflet applicable to the discharge destination.
Refer patients in the last days or weeks of life directly to the Continuing Health Care Team using the existing Fast Track paperwork who will arrange for rapid discharge to home, care home or hospice. The Hospital Palliative Care Team, where the patient is already known to them can refer directly to hospice.
Discharge summaries and TTAs to be completed as usual.
The guidance stipulates that Maintaining good decision making is critical when planning for discharges.

Every patient on every general ward should be reviewed on a twice daily board round to determine the following. If the answer to each question is 'no', actively consider discharge to a less acute setting.

- Requiring ITU or HDU care
- Requiring oxygen therapy/ NIV
- Requiring intravenous fluids
- NEWS2 > 3
  (clinical judgement required in patients with AF &/or chronic respiratory disease)
- Diminished level of consciousness where recovery realistic
- Acute functional impairment
  in excess of home/community care provision
- Last hours of life
- Requiring intravenous medication > b.d. (including analgesia)
- Undergone lower limb surgery within 48hrs
- Undergone thorax-abdominal/pelvic surgery with 72 hrs
- Within 24hrs of an invasive procedure
  (with attendant risk of acute life threatening deterioration)

4. Roles and Responsibilities – Discharge Single Point of Access (DSPA)

Single Point of Access Team
Facilitate the rapid discharge of patients from hospital within 3 hours of notification of being medically optimised.
Attend the 9am and 2pm ward reviews and ensure all suitable patients are added to the discharge list.
Work jointly with the acute wards in rapidly assessing the needs of the patient to determine what is required to support the discharge, for example equipment, care support or placement (interim, housing with care, nursing home, inpatient rehabilitation) and to refer/liaise with the relevant teams/agencies as required. The care coordinator role will be pivotal in this.
The DSPA Social Worker to complete the immediate service request on MOSAIC so that brokerage can initiate the care agency process.
Identify who is best placed (single professional or MDT) to follow the patient at home either on the day of discharge or the following day to undertake a community based assessment of need and to rapidly arrange for any additional requirements to be put in place. All patients will be provided with a ward contact number on discharge as a safety net and the DPSA will risk assess all patients for urgency of community follow up.
Ensure community based continuation of therapy input and nursing care as identified at assessment. This will be achieved via referral to existing teams and/or redeployment of staff to provide the relevant treatment at home or placement.
Maintain a robust database for all referred patients, and as part of this track patients on pathways 1-3 for follow up and ongoing assessment of long term need once post discharge recovery is complete.

5. Urgent Housing Options Pathway

The guidance covers moving homeless adults, including those discharged from hospital and prison, into emergency temporary accommodation; the categories are:

- People who are symptomatic and need to self-isolate
- People who are asymptomatic with underlying health needs
- People who are asymptomatic with no underlying health needs who are street homeless
- People who are street homeless with complex needs

Routes into the accommodation will be via:

1. **Hospital Discharge Team**

   People being discharged from hospital will be referred into Brokerage who will arrange a bed in the Travel Lodge for an initial assessment of need with a view to identify their ongoing housing options and develop a personalised package of care/support: brokerage.email@hackney.gov.uk 8 a.m. until 8 p.m. 7 days per week.

2. **Hackney Street Outreach Team via Streetlink (rough sleepers only) /Greenhouse**

   The second cohort will be those who are actively homeless: CHAIN verified, non-CHAIN verified and those with No Recourse to Public Funds. Many with low/ medium support needs will be accommodated through the GLA's pan-London homelessness provision, but every effort must be made to accommodate those who are street homeless in Hackney and picked by Hackney Street Outreach Team/Streetlink, especially those with high support needs.

3. **Probation/CRC/Immigration Centre (Home Office)**

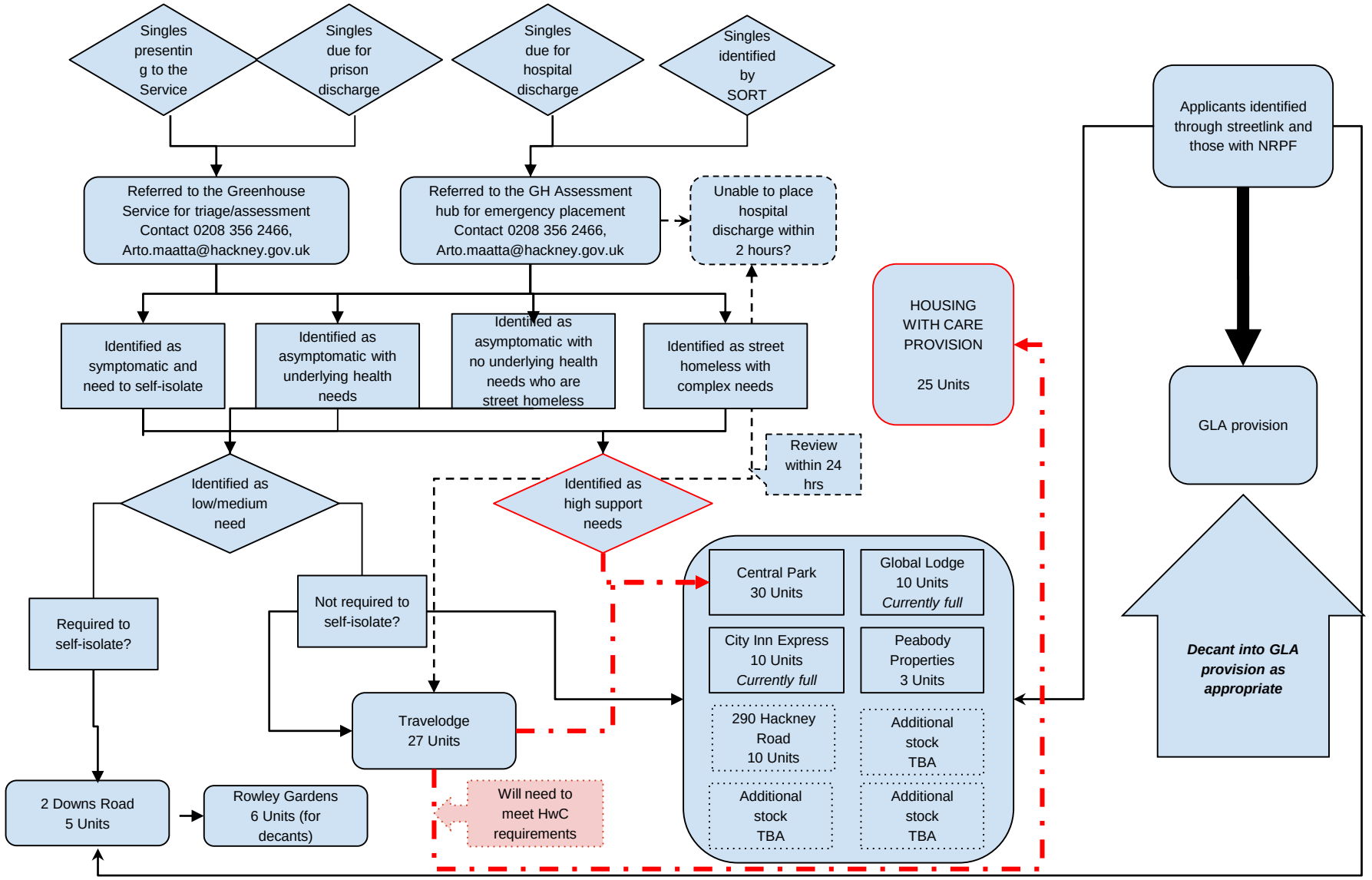
   The third cohort may have been released from prison or an immigration centre.

For cohort 2 and 3, homeless referrals must contact Arto Maatta, Benefits and Housing Needs Team Manager - Singles, 0208 356 2466, Arto.maatta@hackney.gov.uk in the first instance to arrange booking into the Pathway.

All new referrals will access the Pathway via the Assessment Hub at the Travel Lodge; exceptions will be:

- Symptomatic rough sleepers who need to isolate immediately
- Asymptomatic rough sleepers picked up by Hackney SORT or the Streetlink Rapid Response Team who will verify the rough sleeping status of the individual and place them based on the immediate need for vulnerable, street-homeless individuals to self-isolate, and to mitigate the additional workload involved in moving people between setting

5. Urgent Housing Options pathway



5. Contact Details

Osian Powell (HUH Divisional Operations Director) Osian.powell1@nhs.net
SRO

Mervyn Freeze
Head of IIT and Adult Community Nursing
m.freeze@nhs.net

Simon Galczynski (Adult Social Care LBH)
Simon.galczynski@hackney.gov.uk

Nina Griffith (Unplanned Care Workstream Director) nina.griffith@nhs.net

Simon Cole
Head of Integrated Discharge Service
Simon.cole5@nhs.net

Chris Pelham (City of London)
Chris.Pelham@cityoflondon.gov.uk

Arto Maatta, Benefits and Housing Needs Team Manager
0208 356 2466
Arto.maatta@hackney.gov.uk

6. NEL Discharge Hubs

	Tower Hamlets	City & Hackney	Newham	Waltham Forest	Redbridge	Barking & Dagenham	Havering
Catchment area	London Borough of Tower Hamlets resident	London Borough of Hackney resident or Corporation of London resident	London Borough of Newham resident	London Borough of Waltham Forest resident	London Borough of Redbridge resident	London Borough of Barking and Dagenham resident	London Borough of Havering resident
Hospital Supported	Royal London Hospital and St Barts	Homerton University Hospital	Newham University Hospital	Whipps Cross University Hospital	Whipps Cross University Hospital and BHRUT	Barking, Havering and Redbridge University Trust	
Central Telephone Number	07741703940 or 07388998676	020 8510 5135 (Mon to Fri 8am-8pm) 020 8510 7750 (Mon to Fri 8pm-8pm, Weekends & bank holidays 10am – 6pm)	0207 363 8147	07590 806158	0300 300 1743		
Email Contact	elft.thintegrateddischargehub@nhs.net	**huh-tr.SPA-Discharge@nhs.net**	elft.newhamidh@nhs.net	nem-tr.shdt@nhs.net	Hospitaldischargeservice@nelft.nhs.uk		
Hours of operation	8am to 8pm, 7 Days a week						

Homerton Discharge SPA contact details and referral form have been shared with other Hubs to enable discharge back to City and Hackney.
Discharge Hubs have been notified to contact adultsduty@cityoflondon.gov.uk for City of London residents.

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

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

City & Hackney Local Outbreak Board

Joint Meeting in public of the two Integrated Commissioning Boards and the Community Services Development Board on
Thursday 9 July 2020, 09:30-10:00
Microsoft Teams

Join Microsoft Teams Meeting

Chair – Cllr Christopher Kennedy

Item no.	Item	Lead and purpose	Documentation type	Page No.	Time
1.	**Welcome, introductions and apologies**	Chair	Verbal	-	09:30
2.	**Declarations of Interests**	Chair *For noting*	Paper		
3.	**Questions from the Public**	Chair	None	-	
4.	**Papers for discussion** • Data Integration	Chair *For noting*	Papers (others to follow)		

Date of next meeting:

13 August, Format TBC

Title of report:	*Update on the COVID-19 data integration work*
Date of meeting:	8 July 2020
Lead Officer:	**Diana Divajeva (Principal Public Health Analyst)**
Authors:	**Diana Divajeva, Remi Omotoye**
Committee(s):	Local Outbreak Control Board
Public / Non-public	Public

Executive Summary:

Data integration is an essential part of the City and Hackney Outbreak Control Plan and one of the workstreams of the Good Practice Network programme. It underpins local action and enables more effective decision making.

Currently, COVID-19 data are available from a number of sources, in a number of formats, and at a different level of detail. The data flow mainly through email updates and some of the indicators are available from national dashboards. The process of compiling, processing the data, and presenting them in local reports is currently very labour intensive and can result in information not being updated in a timely manner. This prompts the need for streamlining the process of data sharing and combining all data sources into one database.

This paper outlines the rationale and approach to the production of a local COVID-19 dashboard, and highlights how it can aid the local response to COVID-19 prevention and outbreak management.

Recommendations:

The **City Integrated Commissioning Board** is asked:

- To **NOTE** the report

The **Hackney Integrated Commissioning Board** is asked:

- To **NOTE** the report

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	The dashboard will combine information from across the system and where possible will include analyses by socio-demographic characteristics as well as geospatial analyses. This can help in focusing the resources on the

		areas with most need as well as in prioritising actions.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	Emerging trends from the analyses can be used to provide proactive support to the residents in the community.
Ensure we maintain financial balance as a system and achieve our financial plans	☒	Predictive indicators could be used to plan services and allocate resources; this when done in a timely manner can remove the need for outsourcing and can potentially provide savings to the authorities.
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	The dashboard will combine information from across the system, aiding the delivery of integrated services.
Empower patients and residents	☒	Public facing dashboard is aimed at behaviour change through presenting residents with the summary epidemiological profile of City and Hackney. Residents will be able to see the key current COVID-19 statistics and how that changed over time. Interpretation of the information in the dashboard will be provided in jargon-free and easy to understand language.

Specific implications for City

Internal-facing dashboard will provide immediate access to information for City & Hackney Public Health, City practitioners and policy makers, to help prevent outbreaks and identify clusters. Socio-demographic and geospatial analyses can aid with prioritising actions and inform local plans. Public-facing dashboard will inform residents about the current infection levels, providing reassurance and potentially aiding in compliance with epidemic containment measures.

Specific implications for Hackney

Internal-facing dashboard will provide immediate access to information for City & Hackney Public Health, Hackney practitioners and policy makers, to help prevent outbreaks and identify clusters. Socio-demographic and geospatial analyses can aid with prioritising actions and inform local plans. Public-facing dashboard will inform residents about the current infection levels, providing reassurance and potentially aiding in compliance with epidemic containment measures.

Patient and Public Involvement and Impact:

Patients and the public have not been involved in designing and procuring the dashboard. Public-facing dashboard will inform residents about the current infection levels, providing reassurance and potentially aiding in compliance with epidemic containment measures. Dashboard can also be used to signpost to City and Hackney COVID-19 services.

Clinical/practitioner input and engagement:

Practitioners from across the system, as well as colleagues from other Local Authorities, have been involved in actively shaping the national and the regional databases as well as in advising on efficient data flows. City and Hackney Public Health Intelligence Team (PHIT) participate in several working groups including City and Hackney System Intelligence Group (SIG) and the North East London (NEL) Analytics Forum. This engagement informs the information that will be presented in the proposed dashboard.

Communications and engagement:

For practitioners and local decision makers, the work will be disseminated through the existing communication channels such as the local Health Protection Board, SIG and NEL Forum. For the public, the communication channels are to be determined.

Comms Sign-off

We have not yet engaged with the Communication Officers regarding this work - this will be done in due course.

Equalities implications and impact on priority groups:

Local death records show that COVID-19 pandemic has disportionately affected migrant communities and people from a lower socio-economic background. When the socio-demographic data for such indicators like testing, cases, and contacts become available, we will use this information to target any groups that stand out as not accessing the testing services or are over-represented among the positive cases. We will also target geographic areas with high infection rates, if applicable. The aim of these actions is to further reduce the mortality rates from COVID-19.

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

We will aim to reduce the duplication of effort by using the existing data sources where applicable. To achieve this we will work with the Joint Biosecurity Centre, the PHE and the NEL Analytics Forum. We will engage with colleagues from across the system to ensure effective dissemination of information and exchange of knowledge.

Main Report

Background and Current Position

Context

City and Hackney are part of the London Good Practice Network, one of the eleven groups of local authorities selected across the country to share good practices, flag any issues boroughs face in the development of their Local Outbreak Control Plans and collect matters which need escalation to a national level. City and Hackney was assigned to participate in the national data integration workstream, which has been combined with plans for delivery of a required local dashboard to support the local system. The importance of the dashboard has been acknowledged and supported at meetings of the Contact Tracing Working Group, the Testing Working Group, and the COVID-19 Health Protection Board.

Currently, COVID-19 data are available from a number of sources, in a number of formats, and at a different level of detail. The data flow mainly through email updates and some of the indicators are available from national dashboards. The process of compiling, processing the data, and presenting them in local reports is currently very labour intensive and can result in information not being updated in a timely manner. This prompts the need for streamlining the process of data sharing and combining all data sources into one database.

This report is to provide the board with reasons on why a dashboard is required, and the processes that are being undertaken to deliver it, including the benefits and opportunity costs.

Course of action

- Putting together the list of indicators to be included in the dashboard.
- Mapping data flows for relevant indicators, including any associated data storage processes and GDPR requirements.
- Putting together Data Sharing Agreements, where appropriate.
- Procuring the data.
- Integrating data into a single platform.
- Sharing live updates with stakeholders and the public.

Financial Implications

- Purchase of a visualisation tool - Tableau - to visually present patterns and informations for action, in an accessible way to audiences
- Package is expected to cost around £17,000.

B**enefits**

A Public Health owned and operated dashboard is:

- Fully customisable
- Full ownership and editorial rights
- Can be used for other projects, including the JSNA
- Can be used to clean and analyse large datasets
- Can be used to automate time consuming data processing tasks
- The latter three factors leading to significant efficiency gains, making the tool a good investment

Assessment of Risks

- Might require some time to train, but a basic dashboard can be created within hours, days
- Will require ongoing licence payments, to maintain the dashboard beyond the pandemic period

Proposals

Timely, comprehensive, and reliable information on the spread and the impact of COVID-19 on our communities can help to support effective local action. City and Hackney PHIT aim to build on the existing work in tracking the outcomes of the pandemic by creating a comprehensive database and visualisations, using indicators which reflect both direct and indirect impacts of the pandemic. The Principal Public Health Analyst will be responsible for strategic oversight and operational delivery of the data integration work and the Senior Public Health Analyst will be responsible for timely data collection and reporting.

Aim of the dashboard

The PHIT data integration work is aimed at:

- Preventing outbreaks and clusters
- Minimising risk of second wave of infections
- Informing local plans and decisions
- Coordinating system response to COVID-19
- Providing support for vulnerable population groups

The Board is asked to consider and note the proposal and agree to it as a basis for developing a local dashboard for City and Hackney.

Conclusion

Creating the integrated data repository and practitioner as well as public-facing dashboard will achieve several goals including but not limited to timely dissemination of information to

aid decision making; ability to foresee the rise in COVID-19 cases; comprehensive overview of direct and indirect outcomes of the pandemic; health promotion.

Supporting Papers and Evidence:

City and Hackney data integration work forms a part of the Local Outbreak Control Plan. Data integration is one of the workstreams of the NHS Test and Trace Good Practice Network programme.

Sign-off:

[Papers for approval by the ICBs must be signed off by the appropriate senior officers. Any paper with financial implications must be signed by the members of the Finance Economy Group.
If there are any legal implications which require consultation with legal counsel, please make reference to that below.
Please ensure you have appropriate sign off for your report, along with the papers.
Papers which have not been signed-off by the appropriate officers will not be considered]

Workstream SRO: Dr Sandra Husbands, Director of Public Health

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

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

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

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