City & Hackney Integrated Care Partnership Board

This is also a meeting of the **Integrated Commissioning Board** which is a Committee in-Common meeting of the:

- The London Borough of Hackney Integrated Commissioning Sub-Committee ('The LBH Committee)
- The City of London Corporation Integrated Commissioning Sub-Committee ('The COLC Committee')
- North East London CCG Governing Body City and Hackney ICP Area Committee (The 'CCG Area Committee')

Joint Meeting in public on
Thursday 14 October 2021, 10.00 – 12.00
Microsoft Teams

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Item no.	Item	Lead and purpose	Documentation type	Time	Page No.
1.	**Welcome, introductions and apologies**	Chair	Verbal	10.00	-
2.	**Declarations of Interests**	Chair ***For noting***	Paper		3-11
3.	**Questions from the Public**	Chair	None		-
4.	**Minutes of the Previous Meeting & Action Log**	Chair ***For approval / ratification***	Paper		12-21
5.	**Report from the ICP Chief Officer**	Tracey Fletcher ***For noting***	Paper	10.05	22-25
6.	**NHSE Ageing Well Programme: 2021/22**	Nina Griffith ***For approval***	Paper	10.50	26-50
7.	**A proposal to permanently locate the inpatient dementia assessment services at East Ham Care Centre**	Eugene Jones ***For feedback***	Paper	10.20	51-102

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NHS North East London Clinical Commissioning Group

8.	**Neighbourhoods: Progress in 2021/22 and Future Plans**	Nina Griffith ***For feedback***	Paper	11.10	103-122
9.	**Monthly Financial Report**	Sunil Thakker ***For noting***	Paper	11.30	123-133
10.	**ICPB Register of Risks**	Matthew Knell ***For noting***	Paper	11.45	134-141
Items for Information					
-	**Integrated Commissioning Glossary**	***For information***	Paper	-	142-147

Date of next meeting:

11th November 2021 – Microsoft Teams

City and Hackney Integrated Care Partnership Board

Register of Interests

Name	Date of Declaration	Position / Role on ICPB	Nature of Business / Organisation	Nature of Interest	Type of Interest
Randall Anderson	15/07/2019	Member / ICB Co-Chair	City of London Corporation	Chair, Community and Children's Services Committee	Non-financial professional
			n/a	Self-employed Lawyer	Financial
			n/a	Renter of a flat from the City of London (Breton House, London)	Financial
			Member	American Bar Association	Non-financial professional
			Masonic Lodge 1745	Member	Non-financial personal
			Worshipful Company of Information Technologists	Freeman	Non-financial personal
			Neaman Practice	Registered Patient Renter of a flat from the City of London (Breton House, London)	Non-financial personal
Henry Black	30/07/2021	Member	NE London CCG	Chief Financial Officer / Acting Accountable Officer	Financial
			Barking, Havering & Redbridge University Hospitals NHS Trust	Wife is Assistant Director of Finance	Indirect
			Tower Hamlets GP Care	Daughter works as social prescriber	Indirect
			NHS Clinical Commissioners Board	Member	Non-financial professional
Anntoinette Bramble	12/08/2020	Member	Local Government Association	Board - Deputy Chair Company Director Labour Group - Deputy Chair	Non-financial professional
			JNC for Teachers in Residential Establishments	Member	Non-financial professional
			JNC for Youth & Community Workers	Member	Non-financial professional

			Schools Forum	Member	Non-financial professional
			SACRE	Member	Non-financial professional
			Admission Forum	Member	Non-financial professional
			Hackney Schools for the Future (Ltd)	Director	Non-financial professional
			St Johns at Hackney	PCC	Non-financial professional
			Unison	Member	Non-financial personal
			GMB Union	Member	Non-financial personal
			St Johns at Hackney	Church Warden & License Holder	Non-financial personal
			Co-Operative Party	Member	Non-financial personal
			Labour Party	Member	Non-financial personal
			Urstwick School	Governor	Non-financial personal
			City Academy	Governor	Non-financial personal
			National Contextual Safeguarding Panel	Member	Non-financial personal
			National Windrush Advisory Panel	Member	Non-financial personal
			Hackney Play Bus (Charity)	Board Member	Non-financial personal
			Christians on the Left	Member	Non-financial personal
			Lower Clapton Group Practice	Registered Patient	Non-financial personal
Paul Calaminus	30/04/2021	Member	East London NHS Foundation Trust	Chief Executive	Financial
			Partner is a Civil Servant	Department of Health	Indirect

Andrew Carter	13/05/2021	Member	City of London Corporation	Director – Community & Childrens' Services	Financial
			ADASS	Member	Non-financial professional
			ADCS	Member	Non-financial professional
Robert Chapman	15/04/2021	Member	London Borough of Hackney	Cabinet Member for Finance	Financial
			Sun Babies	Trustee	Financial
			Shareholders Representative & Member	Shareholders Committee	Financial
			North London Waste Authority Unit	Member	Financial
			Local Authority Pension Fund Forum	Vice Chair	Financial
			Investment Governance & Engagement Committee, Local Government Pensions Scheme Advisory Board	Member	Financial
			Labour Party	Member	Financial
			The Co-operative Society	Member	Financial
			Hackney Co-operative Party	Member	Financial
			SERA c/o the Co-operative Party	Member	Financial
			Socialist Health Association	Member	Financial
			The Labour Housing Group	Member	Financial
			Friends of Hackney Tower & Churchyard	Member	Financial
			GMB	Member	Financial
			UNITE	Member	Financial
			TSSA	Retired Member	Financial

			Triangle Care Services	Trustee & Director	Non-financial professional
			Friends of the Elderly	Trustee & Director	Non-financial professional
			Hackney Endowed Trust Ltd.	Director	Non-financial professional
			National Trust	Member	Non-financial professional
			Friends of the Royal Academy	Member	Non-financial professional
			Friends of the Tate	Member	Non-financial professional
			Friends of the British Museum	Member	Non-financial professional
			National Gallery	Member	Non-financial professional
			Thamesreach	Trustee	Indirect interest
Paul Coles	05/10/2021	Member	Healthwatch City of London	General Manager	Financial
				Contract with City of London Corporation for a local Healthwatch service in the City of London	Financial
			International Brigades Memorial Trust	Treasurer	Non-financial professional
			Chartham Parish Council, Kent	Parish Councillor	Non-financial professional
Dr Stephanie Coughlin	09/10/2020	Attendee	Lower Clapton Group Practice	GP Principal	Financial

			BMA & RCGP	Member	Non-financial professional
Sue Evans	12/08/2021	Member	NE London CCG / City & Hackney ICP Area Committee	Lay Member	Financial
Helen Fentimen	14/02/2020	Substitute Member	City of London Corporation Labour Party Unite Trade Union Governors Prior Weston Primary School and Children's Centre	Member Member Member Chair	Non-financial professional Non-financial professional Non-financial professional Non-financial professional
Tracey Fletcher	26/08/2020	Member	Homerton University Hospital NHS FT Inspire	Chief Executive Trustee	Financial Non-financial professional
Marianne Fredericks	26/02/2020	Member	City of London Farringdon Ward Club The Worshipful Company of Firefighters Christ's Hospital School Council Aldgate and All Hallows Foundation Charity The Worshipful Company of Bakers Tower Ward Club	Member Member Liveryman Member Member Liveryman Member	Non-financial professional Non-financial professional Non-financial professional Non-financial professional Non-financial professional Non-financial professional Non-financial personal

Sir John Gieve	29/07/2021	Member	Homerton University Hospital NHS FT	Chair	Financial
			Vocalink Ltd. 1 Angel Lane, London EC4R 3AB	Non-executive Director	Financial
			MNI Connect	Member	Non-financial professional
			Pause (Charity), 209-211 City Road London	Partner is Trustee & Strategic Board Member	Indirect interest
Siobhan Harper	26/10/2020	Member	NE London CCG / City & Hackney ICP	Transition Director	Financial
			Sister is lead commissioner for London on criminal justice and mental health at NHSE		Indirect
Dr Sandra Husbands	26/08/2020	Member	Director of Public Health	London Borough of Hackney	Financial
			Association of Directors of Public Health	Member	Non-financial professional
			Faculty of Public Health	Fellow	Non-financial professional
			Faculty of Medical Leadership and Management	Member	Non-financial professional
Christopher Kennedy	09/07/2020	Member / ICB Co-Chair	London Borough of Hackney	Cabinet Member for Health, Adult Social Care and Leisure	Financial
			Lee Valley Regional Park Authority	Member	Non-financial personal
			Hackney Empire	Member	Non-financial personal
			Hackney Parochial Charity	Member	Non-financial personal
			Labour party	Member	Non-financial personal
			Local GP practice	Registered patient	Non-financial personal
Dr Haren Patel	10/10/2020	Member	Latimer Health Centre	Senior Partner	Non-financial professional
			Acorn Lodge Care Home	Service Provision	Financial interest
			Pharmacy in Brent CCG	Joint Director	Indirect interest

			Hackney Marsh	Joint Clinical Director	Non-financial professional
			RMOC – NHS England	GP Member	Non-financial professional
Honor Rhodes	11/06/2020	Member	North East London CCG	Associate Lay Member	Financial
			Tavistock Relationships	Director	Financial
			Homerton University Hospital NHS FT	Assistant Psychologist (Daughter)	Indirect
			Barton House NHS Practice	Registered with GP	Non-financial personal
Dr Mark Rickets	14/01/2020	Member / ICB Co-Chair	NE London CCG	ICP Clinical Chair	Financial
			Homerton University Hospital NHS Foundation Trust	Non-Executive Director	Financial
			Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	Indirect
			GP Confederation	Nightingale Practice is a Member	Non-financial professional
			HENCEL	I work as a GP appraiser in City and Hackney and Tower Hamlets for HENCEL	Non-financial professional
			Nightingale Practice (CCG Member Practice)	Salaried GP	Financial
Ann Sanders	30/07/2021	Member	NE London CCG	Lay Member	Financial
			Ann Sanders Consultancy	Independent Consultant	Financial
Ruby Sayed	19/11/2020	Member	City of London Corporation	Member	Financial
			Gaia Re Ltd	Member	Financial
			Thincats (Poland) Ltd	Director	Financial

			Bar of England and Wales	Member	Non-financial professional
			Transition Finance (Lavenham) Ltd	Member	Financial
			Nirvana Capital Ltd	Member	Financial
			Honourable Society of the Inner Temple	Governing Bencher	Non-financial professional
			Independent / Temple & Farringdon Together	Member	Non-financial professional
			Worshipful Company of Haberdashers	Member	Non-financial professional
			Guild of Entrepreneurs	Founder Member	Non-financial professional
			Bury St. Edmund's Woman's Aid	Trustee	Non-financial personal
			Housing the Homeless Central Fund	Trustee	Non-financial personal
			Asian Women's Resource Centre	Trustee & Chairperson / Director	Non-financial personal
Laura Sharpe	23/04/2021	Member	City & Hackney GP Confederation	Chief Executive	Financial
Sunil Thakker	30/04/2021	Member	NE London CCG	Executive Director of Finance	Financial
Ian Williams	20/03/2020	Member	London Borough of Hackney	Acting Chief Executive	Financial
				Homeowner in Hackney	Financial
			Hackney Schools for the Future	Director	Non-financial professional
			NWLA Partnership Board	Joint Chair	Non-financial professional

			London Treasury Ltd	SLT Rep	Non-financial professional
			London CIV Board	Observer / SLT Rep	Non-financial professional
			Chartered Institute of Public Finance and Accountancy	Member	Non-financial professional
			Society of London Treasurers	Member	Non-financial professional
			London Finance Advisory Committee	Member	Non-financial professional
			Schools and Academy Funding Group	London Representative	Non-financial professional
			Society of Municipal Treasurers	SMT Executive	Non-financial professional
			London CIV Shareholders Committee	SLT Rep	Non-financial professional
			London Pensions Investments Advisory Committee	Chair	Non-financial professional
Jon Williams	10/08/2021	Member	Healthwatch Hackney	Director	Financial
			- CHCCG Neighbourhood Involvement Contract - CHCCG NHS Community Voice Contract - CHCCG Involvement Alliance Contract - CHCCG Coproduction and Engagement Grant - Hackney Council Core and Signposting Grant	Contracts Healthwatch Holds with CCG	Indirect
Tony Wong	04/10/2021	Member	Hackney Council for Voluntary Services	Chief Executive	Financial

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Minutes of meeting held in public on 9 September 2021
Microsoft Teams

Present:

Hackney Integrated Commissioning Board

Hackney Integrated Commissioning Committee

Cllr Anntoinette Bramble	Deputy Mayor & Cabinet Member for Education, Young People & Childrens' Social Care	London Borough of Hackney
Cllr Chris Kennedy	Cabinet Member for Health, Adult Social Care & Leisure	London Borough of Hackney

North East London CCG City & Hackney Area Committee

Henry Black	Acting Accountable Officer	NE London CCG
Dr Mark Rickets	City & Hackney Clinical Chair	NE London CCG / City & Hackney Integrated Care Partnership
Sunil Thakker	Executive Director of Finance	NE London CCG / City & Hackney Integrated Care Partnership
Steve Collins	Director of Finance	NE London CCG
Siobhan Harper	Transition Director	NE London CCG / City & Hackney Integrated Care Partnership

City Integrated Commissioning Board

City Integrated Commissioning Committee

Marianne Fredericks	Member, Community & Childrens' Services Sub-Committee	City of London Corporation
Randall Anderson QC	Member, Community & Childrens' Services Sub-Committee	City of London Corporation

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North East London
Clinical Commissioning Group

Ruby Sayed	Member, Community & Childrens' Services Sub-Committee	City of London Corporation

Integrated Care Partnership Board Members

Ann Sanders	Lay member	NE London CCG
Caroline Millar	Acting Chair	City & Hackney GP Confederation
Catherine Pelley	Chief Nurse (substitute for Homerton Chief Exec)	Homerton University Hospital NHS Foundation Trust
Haren Patel	Clinical Director	Primary Care Network
Honor Rhodes	Associate Lay Member	NE London CCG
Ian Williams	Acting Chief Executive	London Borough of Hackney
John Gieve	Chair	Homerton University Hospital NHS Foundation Trust
Jon Williams	Executive Director	Healthwatch Hackney
Dr Julia Simon	Director of Strategic Implementation & Partnerships (substitute for Homerton Chief Exec)	Homerton University Hospital NHS Foundation Trust
Laura Sharpe	CEO	City & Hackney GP Confederation
Paul Calaminus	Chief Executive	East London NHS Foundation Trust
Paul Coles	General Manager	Healthwatch City of London
Dr Sandra Husbands	Director of Public Health	London Borough of Hackney
Dr Stephanie Coughlin	Clinical Lead: Neighbourhoods & Covid-19 – City & Hackney	NE London CCG
Susan Masters	Co-Director: Health Transformation, Policy and Neighbourhoods	Hackney Council for Voluntary Services

In attendance

Andrew Carter	Director: Community & Childrens' Services Sub-Committee	City of London Corporation
Alex Harris	Integrated Commissioning Governance Manager	NE London CCG / City & Hackney Integrated Care Partnership
Amy Wilkinson	Workstream Director: Children, Young People, Maternity & Families	NE London CCG / City & Hackney Integrated Care Partnership
Diana Divajeva	Public Health Analyst	London Borough of Hackney

Eeva Huoviala	Head of Public Engagement: Patient & Public Involvement	NE London CCG / City & Hackney Integrated Care Partnership
Ellie Duncan	Programme Manager	NE London CCG / City & Hackney Integrated Care Partnership
Helen Fentimen	Member, Community & Childrens' Services Sub-Committee	City of London Corporation
Helen Woodland	Group Director – Adults, Health & Integration	London Borough of Hackney
Jonathan McShane	Integrated Care Convenor	NE London CCG / City & Hackney Integrated Care Partnership
Matthew Knell	Head of Governance & Assurance	NE London CCG / City & Hackney Integrated Care Partnership
Nina Griffith	Workstream Director: Unplanned Care	NE London CCG / City & Hackney Integrated Care Partnership
Rachael Tomlinson	Programme Manager	NE London CCG
Sally Beaven	Engagement & Co-Production Manager	Healthwatch Hackney
Stella Okonkwo	Integrated Commissioning Programme Manager	NE London CCG / City & Hackney Integrated Care Partnership

Apologies

Cllr Chapman

1. Welcome, Introductions and Apologies for Absence

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

1.2. Apologies were noted as listed above.

2. Declarations of Interests

2.1. Susan Masters added that she was a Councillor in Newham however this did not cause any conflicts in relation to items on the agenda.

2.2. The **City Integrated Commissioning Board**

- **NOTED** the Register of Interests.

2.3. The **Hackney Integrated Commissioning Board**

- **NOTED** the Register of Interests.

3. Questions from the Public

3.1. There were none.

4. Minutes of the Previous Meeting & Action Log

4.1. The **City Integrated Care Partnership Board**

- **APPROVED** the minutes of the previous meeting.
- **RATIFIED** the decisions of the previous meeting.
- **NOTED** the action log.

4.2. The **Hackney Integrated Care Partnership Board**

- **APPROVED** the minutes of the previous meeting.
- **NOTED** the action log.

5. ICS Update

5.1. Siobhan Harper introduced the item. Our primary objective was to establish some coherence throughout the transition to the implementation of Integrated Care Systems (ICS) next year and the closing down of the CCG. There were still emerging discussions about how ICS would interact with local place-based partnerships and a number of fora in which this was being discussed. There was also an event upcoming on October 6th which would aim to discuss the development of ICS further.

5.2. A key piece of work would be developing a collaborative and co-operative culture as opposed to a competitive and transactional culture. Place-based partnerships would also have a strong role in connecting communities with the wider health and social care sector.

5.3. Cllr Kennedy added that health inequalities and covid recovery were the main priorities. We needed to therefore place these first and design the governance to make sure that this fits in place. He also added that "place-based" was coterminous with borough-area. Previously the CCGs in NE London had been mergers of several boroughs. Henry Black added that we should be working through what our purpose was and then design the governance around supporting our new ways of working. The ICS would be designed to bring all partners together as equal peers to design more effective ways of doing things.

5.4. Randall Anderson added that the work would need to continue to be at a City & Hackney level as the NEL-level governance was constrained by legislation.

5.5. Helen Fentimen added we needed clarity around what the objectives were for service transition and design. Siobhan Harper added that a lot of this had been set out in the context of the long term plan. We were also picking up issues around inequalities and needed to make sure we focused and honed-in on this from a population health perspective.

- **Item on service transition and design to be brought back to a future ICPB.**

5.6. Mark Rickets added that the challenges were to make sure that the place-based partnerships were working and that issues such as relationships with health and

wellbeing boards were ironed out. This was therefore a parallel piece of work in developing the governance.

5.7. John Gieve noted that we had received our financial settlement. The amount of money received was not the amount needed for it to catch-up on the backlog of care in the service and to simultaneously deal with other pressures. The biggest change currently taking place in terms of national legislation was the move to a more centralized allocation system. He therefore asked what the timetable was for decisions at the NE London level. Furthermore, the ICPB would not just be dealing with additional / extra funding but would be more involved in allocation of existing funding.

5.8. Helen Fentimen noted that City & Hackney was focused on health inequalities and place-based partnerships. However the impact of covid was enormous and much had been pushed back. She was therefore not clear how we could manage old tensions whilst keeping the focus on health inequalities so that they were not merely pushed to the side.

5.9. Laura Sharpe noted that as leaders and clinicians we would need to set a series of principles around this. We should therefore set the high-level principles that would underpin our investment. Furthermore, we would need to be agreeing on a set of prioritisations for which we would also be involving the public. The debate would therefore take a long time and should be started soon.

5.10. Henry Black responded that it was essential for us to prioritise work in a way that was safe and fair but that we also find better and more innovative ways of reducing the burdens placed on the system in relation to the covid backlog. In terms of the financial framework going forward, this would be based on population need and the ability to allocate resources accordingly. The payment-by-results (PBR) system was designed to foster competition, and was not effective in encouraging collaboration.

5.11. The **City Integrated Care Partnership Board**

- **NOTED** the report.

5.12. The **Hackney Integrated Care Partnership Board**

- **NOTED** the report.

6. City & Hackney Co-Production Charter

6.1. Sally Beaven introduced the item. This charter had been underpinned by a piece of work in reviewing the extant 2017 charter, which had concluded that it should be an evolving and live document. The principles of the charter remained broadly the same as in the 2017 charter however there had been updates to the elements of the charter in relation to staff training and induction and in helping organisations capture the public voice.

6.2. The charter was not something that organisations would be forced to sign up to, but the ICPB was being asked to endorse the charter and encourage organisations to agree to. Individual organisations would therefore be given the opportunity to comment on anything that was proposed. The item may therefore need to be brought back to a future ICPB.

6.3. Honor Rhodes added that children and young peoples' voices should not be lost within this, as they could have valuable perspectives on how services should be designed. We needed to therefore think about how we would encourage children to co-design things with us. Sally Beaven added that we may be bringing work on system influencers to governance boards that existed within the ICS structure. Honor Rhodes added that young people need to be referenced specifically within the co-production work.

6.4. Stephanie Coughlin added that she was fully supportive of the principles, however there could be more work in bringing all organisations on board with this work. Different organisations would have their own challenges and we needed to ensure buy-in and engagement, and that organisations were not signing up to things they could not achieve. Sally Beaven responded that the work itself was widely co-produced, however there was more we could do in bringing on board the decision-makers in the respective organisations.

6.5. Randall Anderson noted that he was happy to sign off the charter with the provision that it be brought back to ICPB once it has been to the various partner organisations.

6.6. Jon Williams added that co-production was a very effective way of involving people in local systems because it enabled people to be involved in service production from the beginning. He also added that the backup documents were a big positive piece of this work.

6.7. Mark Rickets added that we should review this after a year. He also asked how the self-assessment tool would be filled-in. Sally Beaven responded that this would be a co-produced part of the process and everyone would be able to discuss the self-assessment going forward.

6.8. Paul Calaminus asked how we would be able to keep an eye on how we were progressing towards co-production. It was therefore important for us to see and learn together how we would build up towards leading, designing and learning together. Sally Beaven responded that the role of the People & Place Group was crucial and would be the primary leadership governance body supporting this work.

6.9. Cllr Kennedy also added that co-production was something that would be happening all the time and should not just be contained within one stream of work.

6.10. Siobhan Harper offered to support this work going through the system. We all needed to support this as a way of working and think about how we would support implementation as a collective endeavor.

6.11. Ann Sanders suggested that the People & Place Group oversee the review of this work.

6.12. The **City Integrated Care Partnership Board**

- **NOTED** the report.

6.13. The **Hackney Integrated Care Partnership Board**

- **NOTED** the report.

7. People & Place Group Update

7.1. Eeva Huoviala introduced the item. She noted that the People & Place Group (PPG) would operate as a sub-committee of the ICPB. There had been a series of development sessions undertaken, and the Group was due to hold its third formal meeting in October. The board would continually develop its arrangements to ensure a wide range of community insight.

7.2. Cllr Kennedy added that we often heard stories of services going badly for residents due to the emotional impact of these situations. However we also needed to understand outcomes in their full breadth. We needed a consistent mechanism to capture these outputs and the ICPB would need to decide what information it wanted to hear on a regular basis.

7.3. Stephanie Coughlin added that she would like to see this brought back to ICPB once we had a clearer idea of how these principles would be implemented in practice, in particular how we would enable clinicians to embed these principles in the work that we do.

7.4. Eeva Huoviala responded that we would be striving towards a wide range of feedback and we were working with Healthwatch on developing that further. We were also beginning to offer people the opportunity to have their voices heard and then to analyse and code that information better. We would therefore be building a database of community insight that could report on what people were saying about services, and a regular report would come to the PPG.

7.5. In terms of making the values & principles a reality, we were currently working on this to make sure that the principles and values were not just abstract but were convertible into tangible work for practitioners.

7.6. Ann Sanders added that the community involvement forum was a place where people could discuss issues in detail. If clinicians, for example, requested information from the public then this could be set up and could then feed information to the PPG.

7.7. Honor Rhodes noted that we should regularly receive reports from all groups in the sub-committee structure.

7.8. Caroline Millar added that we should think about our agendas set out in terms of themes such as strategy, operational, for information and they should be structured as such.

7.9. The **City Integrated Care Partnership Board**

- **NOTED** the report.

7.10. The **Hackney Integrated Care Partnership Board**

- **NOTED** the report.

8. Children & Young Peoples' Emotional Health and Wellbeing Strategy

8.1. Amy Wilkinson introduced the item. She noted that a big focus of the next five years was a move towards resilience and prevention.

8.2. Honor Rhodes thanked the team for the work that they had done in re-developing this strategy since the previous meeting.

8.3. The **City Integrated Care Partnership Board**
- **APPROVED** the strategy and progression to publish and dissemination.

8.4. The **City Integrated Care Partnership Board**
- **APPROVED** the strategy and progression to publish and dissemination.

9. Monthly Finance Update

9.1. Sunil Thakker introduced the item. At M4 City & Hackney was declaring a break-even position. There was a small cost pressure within the acute area of spend. There were however ongoing cost pressures around prescribing and Continuing Healthcare (CHC).

9.2. NE London CCG was working towards a budget just under £2bn and was forecasting a break-even position. There were cost pressures relating to actue prescribing and CHC.

9.3. Cllr Kennedy asked if there was any information about the recently-announced extra funding for hospital discharge. Sunil Thakker said he did not have information about this yet but there was an ongoing review situation. We would also be looking at the second half of the planning cycle from October onwards.

10. Risk Management Update

10.1. Rachael Tomlinson introduced the item. She noted that the report represented a new mechanism of risk reporting and updating, which would be focused on building up a system-based risk register. Only red-rated risks were currently being reported however the ICPB may wish to have certain risks reported to the board.

10.2. Cllr Kennedy welcomed the new approach. He noted that the previous system only really highlighted red risks, and he endorsed the system-based way of reporting.

10.3. John Gieve noted that many of the risks were operational risks, however there were also longer-term strategic risks that arose from changes in financing allocations. We therefore needed a way to balance longer-term strategic risks against the more immediate operational risks. Randall Anderson added that the longer-term strategic risks were not necessarily ones that would arise from the natural workstream reporting process. Rachael Tomlinson added that the ICPB itself could identify risks it wished to see, and we could separate the risk register into operational and strategic risks.

10.4. Siobhan Harper noted that there was further work that could be done to bring risks together as part of a system register as opposed to having risks that would sit on organizational risk registers.

10.5. The **City Integrated Care Partnership Board**
- **NOTED** the report.

10.6. The **Hackney Integrated Care Partnership Board**

- **NOTED** the report.

11. AOB & Reflections

11.1. Cllr Kennedy noted that many comments had been about the ways in which we do our work – we were very much in a state of flux at the moment as a partnership board. We needed to bear this in mind as we further developed our arrangements going forward.

11.2. Honor Rhodes added that we had been giving greater thought to how we did work and how things would be operating going forward. She added she had no current insight into how the Neighbourhood Health and Care Board (NHCB) was going. She requested an update on the NHCB for the next meeting.

- **Update on NHCB to be provided at next ICPB meeting.**

11.3. Siobhan Harper added that we may wish to schedule in a development session for the ICPB in the next few months. Caroline Millar added that she was supportive of the principle of a development session.

11.4. Randall Anderson added that there was a possibility for us to have in-person meetings in future.

11.5. Julia Simon added that the quality of the meeting was very high-quality, as were the papers.

11.6. John Gieve added that City & Hackney was in a good position to act as a London exemplar to how we developed place-based partnerships going forward.

City and Hackney Local Outbreak Board / Integrated Care Partnership Board Action Tracker

Ref No	Action	Assigned to	Assigned date	Due date	Status	Update
ICPBJul-2	Update on investment underpinning inequalities tools and resources to be brought back to ICPB.	Anna Garner	Jul-21	Aug-21	In progress.	
LOBSep-1	Nina Griffith to update the Local Outbreak Board on further outreach work and pop-ups to address the low level of uptake in Local Vaccination Centers (LVS).	Nina Griffith	Sep-21	Oct-21		
LOBSep-2	Nina Griffith to respond to Marianne Fredericks on the status of the Mantle St. Estate pop-up.	Nina Griffith	Sep-21	Oct-21		
ICPBSep-1	Item on service transition and design to be brought back to a future ICPB.	Siobhan Harper	Sep-21	Dec-21		
ICPBSep-2	Update on NHCB to be provided at next ICPB meeting.	Tracey Fletcher	Sep-21	Dec-21		

Title of report:	Report from Tracey Fletcher, ICP System Lead
Date of meeting:	14 October ICPB
Lead Officer:	Tracey Fletcher, Chief Executive, Homerton University Hospital NHS Foundation Trust
Author:	Tracey Fletcher
Committee(s):	ICPB
Public / Non-public	Public

Executive Summary:

The ICP System Lead report will be a standing item on future ICPB agendas. It will provide an update on the movement towards an ICS, notify the board of any upcoming developments of interest and pose questions or challenges for the board when a steer or clarity is required.

Recommendations:

The **Integrated Care Partnership 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	☐	
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

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Communications and engagement:

N/A

Equalities implications and impact on priority groups:

N/A

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

N/A

Report from Tracey Fletcher, ICP System lead

Development of the system team
It was agreed at the Neighbourhood Health & Care Board (NHCB) that the appointment to the planned ICP Delivery lead post will now be pursued. A job description is being established and it is proposed that this will be a joint health and local authority post. SRO roles for Quality and Finance for example will also be identified from across the system over the next two months.

Use of non-recurrent funding for winter planning pressures
It was agreed at the Finance & Planning Committee of the NEL CCG and the NHCB that £600k will be made available from CCG non-recurrent resources for anticipated pressures across all areas of the system for this forthcoming winter. Proposals to utilise this allocation is currently being processed.

Development of the North east London Integrated Care System (NEL ICS)

- The appointment of the NEL ICS Chief Executive is progressing and the shortlisted candidates have been identified. Stakeholder sessions and the panel interview will take place mid-October.
- An ICS Development session was held on Wednesday 6th October which a number of City and Hackney system members attended. This was well attended and the discussion focussed on progressing the establishment of future ICS priorities.
- Work has begun on the development of a Clinical and Practitioner lead model. NEL CCG intends to bring to an end the current contracts that exist for primary care leaders and have asked each ICP area to develop a structure that will serve the locality in the future. Dr Steph Coughlin, System Clinical Lead is leading on this work.

ICPB Development Sessions
At the last ICPB, members asked that we set up a development session to get to a shared understanding of how we will work together as a place-based partnership in future. We are proposing two development sessions, one in November and one in January. It is proposed that these sessions are supported by an external facilitator. Two sessions will allow us to cover more ground in sufficient detail. By holding them in November and January we will also be able to reflect, as a system, on emerging proposals in establishing the North East London ICS and what they mean for our work.

We propose extending the ICPB meetings in November and January by one hour and carefully managing the main agenda so we have two hours for the development conversations in each month. An initial discussion has been held with Ralph McCormack to support the session as a facilitator. He has extensive senior experience in East London done work with the NEL ICS as they get ready for April 2022.

In light of the comments at the last ICPB meeting and conversations with members we propose to cover the following areas across the two sessions alongside emerging proposals from NEL ICS. Please let me know if there are other areas you feel should be discussed at these sessions.

Relationship with North East London ICS
What will be delegated to City and Hackney?
How will the formal delegation take place?
What role do ICPB/NHCB have in deciding how those resources are used?
What is the reporting and accountability relationship between City and Hackney and NEL?

Integrated Care & Partnership Board (ICPB)

How will ICPB develop a vision and strategy for City and Hackney? What will the process be? How do we engage stakeholders and the public? Who will do the actual work?
Are we still proposing a 'mandate' or similar annual communication with NHCB setting out expectations around delivery of the strategy? If so, how will this work in practice?
What decisions will be taken by ICPB/NHCB and how do we avoid everything going to both committees? What decisions are reserved to the Area Committee?
Where does responsibility for assurance around finance, performance and quality sit?
Are we happy with membership and rotating chair arrangement?

Neighbourhood Health & Care Board (NHCB)
How will NHCB develop plans to deliver the local strategy? How will they engage stakeholders and the public?
What other groups will support the work of NHCB? How will the new structure differ from workstreams?

Health & Wellbeing Boards (HWBs)
How will we ensure the various strategies and plans are coherent? Is that one of the roles of the HWBs?
Are we committed to the idea that the HWBs develop an overarching health and wellbeing strategy and the ICPB develops the health and social care element of that?
Are we happy for the HWBs to lead on the development of strategy and monitoring of delivery around wider determinants of health? Do the HWBs need to work differently to carry out these new roles?

Tracey Fletcher
7th October 2021

Title of report:	**Ageing Well**
Date of meeting:	9th September 2021
Lead Officer:	Nina Griffith
Author:	Nina Griffith, Cindy Fischer, Anna Hanbury
Committee(s):	The messages in this paper have been taken to the following Committee's: ● System Operational Command Group - for agreement – 16th September 2021 ● Finance and Performance Subcommittee - for agreement – September 2021 ● Neighbourhoods Health and Care Board – September 2021
Public / Non-public	*[The partner organisations are committed to being as open as possible about all the decisions and actions they take, and reports will be considered to be in the public domain as standard. If there is a reason the contents of the report should not be made public please state below.]* None

Executive Summary:

This paper presents the initial proposals for the use of the Ageing Well Community Service development fund, which the Integrated Care Partnership Board are being asked to approve. These have been to the System Operational Command Group (SOCG), the CCG Finance Sub-committee and the Neighbourhoods health and care board.

City and Hackney have been given £1.1m to invest in community services to support delivery of the NHSE Ageing Well agenda.

Following a bottom up engagement process with a range of clinical and practitioner leads, the following proposals are being put forward:

-Investment in increased therapy and mental health support to care homes
-Introduction of self referral into our community based rapid response service
-Increased mental health support within our community rapid response services
-Increased resources in discharge pathways to support people to get home more quickly and improved assessment

Further work is underway to pilot a model of 'Anticipatory Care' which is delivering community based multi-disciplinary support to people with rising needs. We are holding back £500k of the investment to support this model and will return to ICPB with a proposal

for this later in the year.

Recommendations:

The **City Integrated Care Partnership Board** is asked to:

- Approve the proposals for use of the Community Services Development fund to support the NHSE Ageing Well Agenda

The **Hackney Integrated Care Partnership Board** is asked to:

- Approve the proposals for use of the Community Services Development fund to support the NHSE Ageing Well Agenda

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	X	These investments are for community services as part of ab roader national agenda to shift resources from the acute to the out of hospital sector. They should support inequalities by: -improving services to people in older adults care homes, who often do not receive the same access to certain services as people living at home -addressing unmet need by introducing self referral into our 2 hour community response service
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	X	-All of the proposals support this agenda by providing proactive community services where people live
Ensure we maintain financial balance as a system and achieve our financial plans	X	-The proposals fall within the financial envelope provided by NHSE. If the proposals are successful they should support older adults to remain at home and living independently and reduce inappropriate hospital attendances. The investment is non-recurrent; we will conduct a full evaluation to determine sustainable models of care following the end of the NHSE funding in 2024.
Deliver integrated care which meets the	X	-The proposals include investment in more therapy, mental health and social

physical, mental health and social needs of our diverse communities		work capacity. An expected further tranche of proposals will also request investment in the voluntary sector (as part of anticipatory care). The investment will support integrated models of care in rapid response, enhanced health in care homes and anticipatory care (specific proposal on anticipatory care to follow).
Empower patients and residents	X	-The proposals all support improved independence and functionality for older adults. The introduction of self referral into our two hour community response service specifically empowers residents to source their own support. -We will work with residents and users to ensure that the proposals do meet their needs and promote their independence.

Specific implications for City

All of the service proposals except for one apply to services that are for both City and Hackney residents. We have included one proposal that pertains to discharge services in Hackney. This is because of a specific existing pressure on this service.

The proposals will support the delivery of strengthened community services in the City, which are in line with our broader ambitions around neighbourhoods working.

Fit with CoLC strategic objectives

The City of London Corporation is focused on addressing social isolation in older people as a key determinant of health. Although addressing social isolation is not a specific objective within the NHSE Ageing well asks, we do expect our local two hour rapid response and anticipatory care services to address this. One of our key asks from the investment will be that community services supporting people at home in these two services do assess for and address social isolation where they see it. In practice, this will mean that these services will need to be trained to identify social isolation where they see it, and also to proactively support individuals into the right services that can address this, such as our range of community navigation services. We will include talking social isolation within the evaluation of the two hour response and anticipatory care services.

Specific implications for Hackney

All of the service proposals except for one apply to services that are for both City and Hackney residents. We have included one proposals that pertains to discharge services in Hackney. This is because of a specific existing pressure on this service.

The proposals will support the delivery of strengthened community services in Hackney, which are in line with our broader ambitions around neighbourhoods working.

Fit with LBH strategic objectives

London Borough of Hackney have published an Ageing Well Strategy to improve wellbeing, outcomes and quality of life for older people in the borough. This is completely separate to, and pre-dates the NHSE Ageing Well strategy. The LBH strategy looks across the breadth of local services and infrastructure to make Hackney a 'great place to grow old'; whereas the NHSE strategy is focused on rolling out the three specific health services described previously. Although the two agendas have different scopes, there was still an opportunity to use the NHSE monies to progress the LBH Ageing Well strategy where it pertains to Health and Wellbeing of older people.

As part of the strategy development, LBH heard from residents about their concerns and priorities were regarding health and wellbeing. Two of their concerns that could be directly addressed by this work were concern around loss of independence and concern around access to mental health services.

All of the proposals put forward should support improved independence for older people by increasing therapies and social work capacity into our care homes, community rapid response and discharge services. We are also using the investment to put in place older adults mental health expertise within these services, so this should support improved access to older adult mental health, and provide better provision of dementia services specifically.

Patient and Public Involvement and Impact:

Enhanced health in care homes:
-The proposed model is based on a pilot which was undertaken in one of our nursing homes. Residents were surveyed as part of this and inputted into the model of care and findings.

2 hour community response:
-Our 2 hour community response services (which include Paradoc and IIT) have had significant input from residents over the years, including a recent review of Paradoc by Healthwatch. The proposal to introduce self-referral into these services initially came from resident feedback.

Anticipatory care (to follow)
-This work is being led by the neighbourhoods programme. There has been significant input from the Neighbourhoods Resident Involvement Group in how we have developed this model of care.

As part of the implementation all of the proposals will need further engagement to ensure they do meet the needs of users and residents.

Clinical/practitioner input and engagement:

All of the proposals were put forward via a structured engagement exercise with practitioners and clinician.

Communications and engagement:

We will need to work with communications partners to realise the benefits of self referral into two hour response services, and to ensure that it is used by all communities.

There is already significant communications work underway around anticipatory care, through the neighbourhoods programme.

Equalities implications and impact on priority groups:

The proposals should address health inequalities by broadening access to community therapies, social work and reablement to specific cohorts of people that do not currently access these services. A full Equality impact assessment will be undertaken as part of project planning and/or evaluation, however, the following key benefits are expected for certain cohorts:

-Care home residents will get proactive access to therapies and older adults mental health teams. Often these individuals are not supported with a reablement approach. However, even within a care home setting there is opportunity and benefit to improving or maintaining independence for residents.

-Introducing self-referral into our community rapid response service should expand access into this service. This will be fully evaluated to understand if we realise this ambitions. Some communications support will also be needed within certain communities to support this.

Safeguarding implications:

Older adults are often subject to safeguarding concerns.

All of the proposals will strengthen the community support to older adults, and as such should provide services that:

-Better identify safeguarding issues in older adults in their homes (including care homes)

-Provide proactive care to specific cohorts of older adults that support improved outcomes and improved independence

-Work with other services, including social care and the voluntary and community sector to provide joined up physical and community health services and reduce the likelihood of individuals falling between the gaps in services.

Impact on / Overlap with Existing Services:

All of the proposals build on existing work to develop and strengthen models of community

based care in City and Hackney.

Main Report

Please see accompanying paper

Supporting Papers and Evidence:

None - see supporting paper.

Sign-off:

See Committee's identified above.

Hackney

CITY OF LONDON

NHS
City and Hackney
Clinical Commissioning Group

NHSE Ageing Well Programme

1. Introduction

This paper presents the initial proposals for the use of the Ageing Well Community Service development fund, which the Integrated Care Partnership Board are being asked to approve. These have been to the System Operational Command Group (SOCG), the CCG Finance Sub-committee and the Neighbourhoods health and care board.

2. The national context

NHSE have launched the Ageing Well programme which is a multi-year programme which aims to deliver the following three national objectives in every system:

-**Enhanced health in care homes (EHICH)**: Providing proactive primary and community health care services to residents in care homes, including regular MDTs and a weekly primary care round. This has been an NHSE agenda for a number of years so the model of care is well established within primary care. PCNs have been contracted nationally to deliver primary care into care homes following this model since October 2021.

-**2 hour community response**: Delivering a community based rapid response service that will support people in their own homes within two hours of referral. The service should offer fast access to a range of qualified professionals who can address health and social care needs, including physiotherapy and occupational therapy, medication prescribing and reviews, and help with staying well-fed and -hydrated. The service should also support admission avoidance, be available from 0800-2000 each day and take referrals from 111 and 999 as a minimum.

-**Anticipatory care**: Delivering a community based multi-disciplinary service that proactively identifies and supports people in the community (but not in care homes) with more complex needs or at risk of deterioration. The service should be delivered jointly between primary care and community health services as a minimum, though can also involve social care and the voluntary sector. The anticipatory care model is still under development by NHSE, with the expectation that a clearer service model is published later in 21/22, systems are therefore expected to start delivering it in 2022/23.

Resources to deliver

NHSE have committed monies to support delivery of the Ageing well objectives within each system. These monies were originally labelled as Long Term Plan funding, with a funding commitment until 2024. These are as follows:

ICS level project resources

£238k is being made available to NEL ICS to support overall project management – this is non-recurrent in 21/22.

£100k is available to every ICS to recruit an Ageing Well lead if they wish to do so. This is one year fixed term from Q3 21/22 to end Q2 22/23

Primary Care funding through PCN contracts

PCNs have been given resources through a Direct Enhanced services (DES) contract from NHSE to deliver on the EHICH agenda. This has been in place since October 2020. This requires primary

care to deliver a weekly MDT and care home round in the home, as well as responding to urgent needs of residents. It covers CQC registered care homes only, of which there are 16 in City and Hackney. NHSE are currently developing a PCN DES for Anticipatory Care which will be launched in 2022. We do not know if it will bring additional funding. There has also been an expectation that PCNs use the additional roles reimbursement scheme posts to support delivery of these agendas.

Community Services development Fund

A significant amount of money has been committed nationally to invest in community services to support delivery of Ageing Well. This amounts to £9.4m in NEL in 2021/22, with an ongoing funding commitment until 2023/24. Unlike the primary care funding, there is a reasonable amount of flexibility in how these funds are used within community services, although community services have to demonstrate that they meet the Ageing Well asks as a minimum. If these asks are met, systems can decide to invest in other areas. Whilst NHSE have been clear that the money is intended for community services, they have not provided further definition on this, therefore the money could be invested in NHS, voluntary and independent sector community based services.

3. The NEL Position

The Ageing well agenda has been taken on by the Community Based Care (CBC) programme in NEL.

A small group was convened with representation from each borough and community provider to determine how the £9.4m NEL community SDF should be allocated across NEL. It was agreed that the money should be allocated across each borough using the same weighted population scale that NHSE to determine CCG allocations for community services. This takes account of age, sex, deprivation (see https://www.england.nhs.uk/allocations/ for more detail on this).

From this, City and Hackney have been allocated £1.14m in 21/22.

This money will be allocated to each ICP (via the CCG). The CBC programme board will ask for assurance that that Ageing Well asks are delivered, but beyond that will give flexibility to how the money is invested. The proposals presented in this paper have been presented and supported by this group.

4. Use of the Community SDF in City and Hackney

There has been discussion through SOCG for determining how we allocate the community SDF in City and Hackney. Partners agreed some key principles for use of the money as well as a process for how to allocate the monies.

The following principles were agreed:

a. Given the investment is for delivery of the three objectives within the Ageing Well agenda, these should be the priority areas for investment.
b. Given anticipatory care is not yet defined by NHSE, we will hold back a reasonable portion of the money to support any must dos that emerge from NHSE on this agenda.
c. As stipulated by NHSE – the money should be invested in community services. It is for adult services, with a focus on, but not limited to older adults.
d. The money is available until March 2024, so partners will need to make a separate case for any continued investment after this point. We may also agree to fund some projects for a shorter period.

e. The money should support multi-disciplinary working in City and Hackney, and further delivery of our Neighbourhood model.

Based on these, the following process was undertaken in July to August of this year:

I. A stock-take of provision against the NHSE Ageing well asks was undertaken (Appendix A)
II. A bottom up, structured engagement process with community leads and stakeholder partners was run over the summer. This went out to clinical and practitioner leads in community health services, acute services, primary care, mental health, the voluntary sector, adult social work and our local care homes in the City and Hackney. The engagement was to understand if there were any gaps or opportunities, and to enable practitioners to put forwards any specific proposals where they had them.
III. The unplanned care team undertook a data review and benchmarking with other services to understand gaps or opportunities for us. They also considered synergies with existing borough-wide ambitions.
IV. A small group including the Chief Operating Office and Head of Integrated from the Homerton and the Unplanned Care team pulled together the outcomes from the research and engagement, and oversaw the development of the proposals with practitioners. Discussions were held with senior leads across partner organisations to test proposals informally.
V. The proposals were taken to SOCG, the CCG Finance Sub- Committee and the Neighbourhoods health and care board.
    a. SOCG had specific feedback that they could not see how these proposals supported our broader partnership ambitions around integrated care and inequalities. Section 6 describes this in more detail.

5. Proposals for use of Ageing Well Community SDF in 2021

The following is a very high level list of each proposal:

Anticipatory Care

We will hold back £500k to support the anticipatory care service. We will come back in November with a proposal for what is required, once the pilot has completed. We also agreed to invest £50k to support the Anticipatory Care pilot and wider case notes review, to ensure that we do get the required outputs from this exercise.

Enhanced Health in Care Homes

Proactive therapies and mental health support to care homes

The proposed initiative is to provide therapists and older adults mental health professionals to supplement the primary care MDT currently in place in older adults care homes. These teams will provide regular and proactive support to the homes and develop multi-disciplinary personalised care and support planning with each resident. The aim is to improve the transition to the care home environment and improve function and quality of life for residents through collaborative working of health and care professionals. This should support a reablement approach for residents.

Indicative Value - £230k (HUHFT: £132k / ELFT: £98k)

Two hour response

There are a number of proposals that support the community based urgent response objective;

Self-referral into IIT rapid response: Value - £111,000

The proposal is to introduce and promote self-referral into IIT rapid response service. The aim is to broaden access to the service in order to reach the missed opportunity that has been identified in previous audits and maximise utilisation.

Paramedic training: Value - £3,200

Provision of training to upskill Paradoc Rapid Response paramedics to be able to complete a basic mobility, balance, walking aid and equipment assessment as part of their response to a fall.

Improving delivery of discharge to assess and post discharge assessments Value - £160k

Increased capacity in the Integrated Independence Team (IIT) in order to ensure we can deliver a robust Discharge to Assess service and support faster and higher quality assessments for people leaving hospital. The additional capacity includes a therapist and two social workers.

Home Treatment & Reablement: Value - £137k

The proposal is to increase capacity within the Home Treatment and Reablement team to meet the 2 day reablement target and manage increased discharge activity resulting from the Discharge Policy and Operating Model.

This proposal, unlike all of the others, is focused predominately on Hackney residents. This is because of a known, existing pressure on these services which is putting pressure on access to discharge and reablement for some Hackney residents.

The overview of the proposals is with spend shown in Appendix B

Appendix C gives the detail on each of the proposals

A note on the costs

The costings are still indicative and need to be finalised with services, although we will ensure that they still fall within the current umbrella. They are FYE costs. Further work is needed to plan for likely start dates of the services, and therefore the profiling of the costs across this year and next. Based on projects starting mid-year, there will be a large amount of non-recurrent monies available from this year. When this is fully costed, we will determine how this will be used. However, the following are the likely elements that this will comprise:

- Use of non recurrent monies to support project mobilisation and quality improvement
- Use of non-recurrent monies to undertake evaluation to inform longer term decisions
- Use of non-recurrent monies to allow certain projects to run beyond the funding period of Ageing Well, where it is required to support a fuller evaluation

6. How the NHSE Ageing Well Agenda supports our broader partnership aims

This investment has been driven by NHSE with the specific ask that it should support community services to deliver on three specific objectives. However, we have reflected the broader ambitions of the partnership where possible within the context of the NHSE asks. All of the proposals do support and further the implementation of our Neighbourhood model of community based, multi-disciplinary care closer to home.

We have also broadened the definition of two hour community response to include discharge, and will use a portion of the investment to support discharge to assess, access to reablement post discharge and delivery of high quality assessments. We have included additional social work capacity within these proposals to achieve this.

The Anticipatory Care model that we are developing involves health, voluntary sector and social care partners, and consideration of the individuals' wider social needs is a core element of the model. We expect that the proposal in November will include investment in the voluntary sector to enable their involvement in the service.

Priorities for older adults in the City of London and London Borough of Hackney

Both CoLC and LBH see the development of neighbourhood based, multi-disciplinary models of care as a key priority for supporting people with complex and rising needs, including older adults and frailty. The enhanced health in care homes and anticipatory care proposals will progress these priorities.

The City of London Corporation is focused on addressing social isolation in older people as a key determinant of health. Although addressing social isolation is not a specific objective within the NHSE Ageing well asks, we do expect our local two hour rapid response and anticipatory care services to address this. One of our key asks from the investment will be that community services supporting people at home in these two services do assess for and address social isolation where they see it. In practice, this will mean that these services will need to be trained to identify social isolation where they see it, and also to proactively support individuals into the right services that can address this, such as our range of community navigation services. We will include talking social isolation within the evaluation of the two hour response and anticipatory care services.

London Borough of Hackney have published an Ageing Well Strategy to improve wellbeing, outcomes and quality of life for older people in the borough. This is completely separate to, and pre-dates the NHSE Ageing Well strategy. The LBH strategy looks across the breadth of local services and infrastructure to make Hackney a 'great place to grow old'; whereas the NHSE strategy is focused on rolling out the three specific health services described previously. Although the two agendas have different scopes, there was still an opportunity to use the NHSE monies to progress the LBH Ageing Well strategy where it pertains to Health and Wellbeing of older people.

As part of the strategy development, LBH heard from residents about their concerns and priorities were regarding health and wellbeing. Two of their concerns that could be directly addressed by this work were concern around loss of independence and concern around access to mental health services.

All of the proposals put forward should support improved independence for older people by increasing therapies and social work capacity into our care homes, community rapid response and discharge services. We are also using the investment to put in place older adults mental health expertise within these services, so this should support improved access to older adult mental health, and provide better provision of dementia services specifically.

Health Inequalities

The proposals should address health inequalities by broadening access to community therapies, social work and reablement to specific cohorts of people that do not currently access these services. A full Equality impact assessment will be undertaken as part of project planning and/or evaluation, however, the following key benefits are expected for certain cohorts:

-Care home residents will get proactive access to therapies and older adults mental health teams. Often these individuals are not supported with a reablement approach. However, even within a care home setting there is opportunity and benefit to improving or maintaining independence for residents.

-Introducing self-referral into our community rapid response service should expand access into this service. This will be fully evaluated to understand if we realise this ambitions. Some communications support will also be needed within certain communities to support this.

7. Next Steps

The Integrate Care Programme Board are asked to approve these proposals.

If partners agree with these proposals, further work is required to develop clear delivery plans, which will need to include engaging with resident representatives and users, as well as undertaking the relevant Equality Impact Assessments.

A further proposal on Anticipatory Care will be brought back to this board in December.

September 2021

Cindy Fischer

Anna Hanbury

Nina Griffith

Appendix A

High Level Summary of Stock Take

Ageing well ask	National context	Local context
Enhanced health in care homes	The framework is well developed and clearly defined PCNs have been commissioned to deliver EHICH to CQC registered homes since October 2020 NHSE have stated that they may ask for the approach to be rolled out to non-CQC care settings.	-We currently do meet the NHSE requirements. -Each Care home has been aligned to a Neighbourhood -Primary care are delivering the model in our local CQC registered care homes -We have supplemented the national DES with a local enhancement within our older adults CQC registered care homes – this is provided through primary care -We have identified named community services leads attached to each of the care homes -Primary care run MDTs in each care home, community service leads are sometimes invite to attend, however, they do not attend regularly or proactively. There could be an opportunity to: - deliver more proactive therapeutic involvement into care homes, - to potentially also to non CQC registered settings.
Two hour community response	The ask is well defined by NHSe in terms of the service model and the hours of opening. All areas must offer a community based rapid response service that takes referrals from 111/999 and sees people in their homes within 2 hours of referral. NHSe have said that this will be rigorously performance managed from 2022 All providers need to start reporting performance and activity on the Community Services Data Set (CSDS) from 2021/22, this is where performance and activity will be monitored by NHSE. However, there are lots of unknowns such as expected activity levels and the clinical criteria for the services.	-We have rapid response services in place that meet the NHSE requirements – through IIT and Paradoc -Activity in these services is much lower than neighbouring boroughs. -Some work is needed to set up the required reporting against this metric dictated by NHSE There could be an opportunity to support a wider cohort of people or to reduce unnecessary conveyances to hospital

Anticipatory care	The ask is not yet defined by NHSE - although we have a strong indication of what it is likely to include	We are developing our local model – which is in line with what we expect to come from NHSE This is currently being piloted in Springhill Practice. Whilst the pilot will be important to develop the process, the patient sample size is all from one practice, therefore it is too small to determine the likely cohort across the whole borough. Therefore a broader casenotes review will be required to ensure we understand the needs from this service across all of our Neighbourhoods. It will be hard to determine what is needed locally in advance of this pilot completing.

Appendix B

SDF Total allocation 100%: £1,132,496.87

SDF 80%: £905,997.49
100% Transformation SDF: £62,077.16

City and Hackney – Budget Planner

ICPs should be planning to spend at least 80% of overall allocated budget

Area of Investment – UCR / Care /Anticipatory Care	Additional Description	Provider	Quarter for Planned spend 2021-22 Q2-4	KPI/ Outcomes (please put TBC if in planning)	Amount – estimated spend for initiative (tbc including in year spend as proposal developed)
Overarching – reporting	CSDS reporting	Homerton	Q2-4	Meet CSDS reporting requirements	£62,077.16
EHCH	Enhanced MDT in care homes – proactive therapy and Dementia input (2 proposals - £132, 190 + £98,913)	Homerton + ELFT	Q3,4	tbc	£231,103
Urgent community response	Introduction of self referral for 2 hour crisis response - therapy and nursing resource	Homerton	Q4	Tbc	£111,000
Urgent community response	Paradoc paramedic training to cover key functions into evenings	Homerton	Q3,4	Tbc	£3,200
Urgent community response -	Increased rapid response/DSPA capacity to ensure D2A model resilience – including therapist and social workers (will support 2 hour / 2 day response & CHC)	Homerton	Q4	tbc	£158,000
Urgent Community response	Increased capacity for Home Treatment & Reablement team & manage increased discharge activity	Homerton			£136,600
Anticipatory Care	Pilot, audit and discovery phase to inform development of anticipatory care model and determine funding requirements – tbc	GP confederation , PCN's	Q3,4	Tbc	£500,000
Evaluation	Resource to support independent review and evaluation of all initiatives (recurrent utilisation of yearly underspend)	Tbc	Roll over into 2022		tbc (dependent on initiative spends)
				Total (Total at least 80% of overall budget expected to be drawn down by Q4)	£1,139,903 (excluding CSDS 62K & evaluation)

Appendix C

Ageing Well Programme – community service improvement proposals

Area of investment	Enhanced Health in Care Homes
Title	Enhanced health in care homes: Collaborative working to provide multi-disciplinary personalised care and support planning to improve transition to nursing care and quality of life.
Indicative spend	£132,190 (Based on Band 7 indicative 2020/21 costing likely to have 3% increase for this financial year. Includes on costs but no overheads).
Context / service gap	Reablement and rehabilitation is one of the 7 care elements within the Enhanced Health in Care Homes Framework. Currently the primary care led MDTs in care homes do not include proactive input from community therapies. The Adult Community Rehabilitation Team (ACRT) provide intervention in care homes. Referrals are often inappropriate or later than ideal resulting in more complex presentations that could have been avoidable. Evidence shows that proactive MDT intervention can reduce falls and unplanned hospital admissions in mobile nursing home residents. Complex clients are often discharged with detailed care booklets that require support, training and specialist equipment set up to maximise an individual's health and wellbeing in a new environment. A Pilot completed in Mary Seacole Nursing Home Sept 19-Feb 2020. QI approach was used to engage care staff and therapists, service user and family feedback demonstrated improved MDT working, improved referral processes, range of proactive occupational therapy (OT) and physiotherapy intervention (PT) and care home staff training.
Description of initiative	Expansion of the previous pilot. 12 month pilot to include nursing homes within City and Hackney. The capacity, culture and operational processes of each nursing home will vary and may therefore require different engagement and approach. 1. Early Interdisciplinary therapy (OT/PT) assessment for all new residents and regular multi-disciplinary meetings, and regular (6 month) review of current residents are core outcomes. Person centred care and support planning and carer training to be provided by the MDT. 2. The needs of patients are stratified into: a. Assessment and recommendations (EOL); b. Assessment and <2 intervention sessions (new admissions); c. Assessment & training (post hospital discharge (re)settlement); d. Assessment and < 2 intervention sessions (urgent needs/ training) ACRT referral (complex needs for ongoing therapy intervention);

	e. Review of current residents (every 6 months)
Intended benefit / outcome	Overall aim: To improve the quality of life for patients through collaborative working (ACRT, dementia team, GP, geriatrician, nursing home staff) and early access to proactive OT and PT assessment and intervention, training and education. 1. To provide holistic assessment of resident needs upon arrival into a new nursing home setting (within 7 days of admission) 2. To support nursing home staff to develop holistic care plans and meet personalized resident needs through training and support of AHP staff 3. To facilitate communication and training of specialist support plans, including improved transition support from hospital. 4. To minimise secondary complications for complex patients through preventative care planning and training. 5. To improve quality and timeliness of ACRT referrals, prioritisation and responsiveness. 6.To work with activity coordinator to maximise their sessions to meet individuals needs 7. To support patient communication and maximise engagement 8. To pilot Speech and language therapy within the MDT to promote communication and personalisation for patients with impaired communication. 8. Additional unplanned outcomes (such as equipment reviews)
Workforce / resource requirements	• 0.8 WTE Band 7 Occupational Therapist £48,069 • WTE Band 7 Physiotherapist £60,087 • 0.4WTE Band 7 Speech and Language therapist £24,034 • Lap tops/ mobile phones.

Ageing Well Programme – community service improvement proposal

Area of investment	• Enhanced Health in Care Homes • 2-hour Crisis Response
Title	Dementia Service Support
Indicative spend	£98, 913 (includes 20% overhead)
Context / service gap	Clinicians within ELFT and Homerton have identified the need to support work across the system for a well-coordinated and proactive multidisciplinary approach in response to the needs of People with Dementia. The service is consultant-led and delivered by a team of multi-disciplinary staff. All residents with dementia will be supported from diagnosis to end of life. Currently the structure enables one community psychiatric nurse per PCN. EHCH -Dementia is one of the 7 care elements within the Enhanced Health in Care Homes Framework. An additional Community Psychiatric Nurse (CPN) would enable a specialist role within older adults care homes and would work closely with ACRT, other primary care and community services staff (see proposal: *Collaborative working to provide multi-disciplinary personalised care and support planning to improve transition to nursing care and quality of life).* In 2019, the Dementia Alliance funded a train the trainer programme for all social care providers and Acorn Lodge and Beis Pinchos now have their own in-house trainers. The CPN would support the embedding of train the trainer programme within all older adults care homes. Learning Disability and Mental Health care homes also have an aging population and have asked for support and training which hasn't been possible due to lack of resources within the Dementia Alliance. Crisis Response Consultant time is currently limited to planned activity and enhancing the capacity by a session a week would enable the team to build in extra capacity for unplanned activity for greater interface with Paradoc and IIT who lead on the 2-hour response.
Description of initiative	Well-coordinated and proactive approach with multi-disciplinary teams. **Band 7 Dementia Liaison Nurse** 1. Enhanced Health in Care Homes • Lead Dementia Specialist for older adults care homes • Attend MDT and care rounds as required • Facilitate discharge process and follow up of patients post discharge from hospital • Expert adviser for both clinicians and staff of care homes • Support the embedding of train the trainer programme within care homes (older adults, LD & MH).

	2. 2-hour Crisis Response- Urgent care provision and extended support to patients • Receive patients from the crisis response team and follow them up within 24 hours to ensure they are stable, and all care packages are active. • Provide ongoing care and support to minimise hospital admissions • If admission into hospital was inevitable, facilitate patient's discharge and provide post discharge follow up to ensure they settle safely back into the community • Undertake medication review **Consultant**- 1 session per week of clinical time to support the Band 7 nurse and to do clinical reviews of identified patients.
Intended benefit / outcome	A dementia diagnosis supports patients and their relative wishes and can enable access to both treatment and support. Specific outcomes include: • Improved or sustained cognition through pharmacological treatments • Care planning for those who still have capacity to make these decisions • Access to support and signposting e.g. carers assessment and allowance, memory groups • Management of deterioration Collaborative working with care homes, hospitals and primary care should also assist with the following system benefits: • Reduction in hospital conveyance and admission • Reduction in length of stay within hospital • Reduction in re-admission
Workforce / resource requirements	• 1.0 WTE Band 7 Dementia Liaison Nurse • 0.1 WTE Consultant

Ageing Well Programme – community service improvement proposal

Area of investment	Urgent Community Response
Title	Self-Referral into IIT rapid response
Indicative spend	£111,000
Context / service gap	- Volume of 2 hour referrals into IIT community rapid response is low in comparison to similar services across NEL. By contrast IIT 2 hour performance is much higher. - Previous audit suggests small amount of missed opportunity in utilisation of rapid response for ED and Admission avoidance. - 2 hour response standard includes requirement for self-referral – although these can be via 111. However, referrals from 111 into rapid response have always been very low. - Other areas in NEL successfully promote and use self-referral as a route to access rapid response (e.g. BHR) - Although self-referral has been offered to patients known to the service it has not been actively promoted as a route to access this service for first contact
Description of initiative	- Pilot introduction and promotion of self-referral into IIT rapid response
Intended benefit / outcome	- Increase utilisation of community rapid response: o Address unmet need identified o Maximise beneficial impact of rapid response -
Workforce / resource requirements	Additional resource to manage new referrals to the IIT SPA and potential increase in demand resulting from it • WTE Band 6 therapist or nurse - £50,000 • WTE Band 7 therapist or nurse - £61,000

Ageing Well Programme – community service improvement proposal

Area of investment	Urgent Community Response
Title	Paradoc paramedic training
Indicative spend	£3,200
Context / service gap	- IIT has no therapy cover to support ParaDoc (one of our rapid response services) between 8am-10am and 6pm and 8pm at weekends (and bank holidays). - Joint IIT / Paradoc response is particularly effective for response to falls
Description of initiative	- Provision of training to upskill ParaDoc rapid response paramedics able to complete a basic mobility, balance, walking aid and equipment assessment for handover to the IIT rapid response therapists as soon as they come on shift
Intended benefit / outcome	- Improved 2 hour falls response - provision of therapist falls function during extended weekend hours when IIT therapist not working (or unavailable due to ED demand)
Workforce / resource requirements	- Paramedics would need to complete 2 x 4 hours of training with IIT therapist - With 25 paramedics working for ParaDoc, this would result in up to 200 hours in total of training. - 200 hours ParaDoc Paramedic training at Band 6 - £3,200

Ageing Well Programme – community service improvement proposal

Area of investment	2-Hour Community Response
Title	Discharge Single Point of Access (DSPA) and discharge to assess (D2A)
Indicative spend	£158K (includes on-costs but no overheads)
Context / service gap	The Integrated Independence Team (IIT) consists of 4 "strands": Rapid Response, Home Treatment, Reablement and Rapid Care (formerly Discharge to Assess). The service has its own single point of access with new patient assessments booked centrally for clinicians. The Discharge Single Point of Access (DSPA) was originally set up in in response to the Pandemic and as a result of an NHS England directive to support improved discharge planning. A new Discharge Policy and Operating Model came into force in September 2020. As Business as Usual returned, the work of the DSPA, along with expectations from partner agencies in respect of its response times and functioning, has not diminished; however other staff have returned to their pre-pandemic roles, leaving the service clinically understaffed, and held only by IIT. A level of scrutiny and assurance on Discharge to Assess referrals from out-of-borough hospitals has therefore been compromised. The DSPA sits alongside the IIT SPA in order to try and best manage resources. In July 2021, LBH provided £30,000 of non-recurrent funding for the DSPA to employ a Band 6 OT which has to be used by end of March 2022. It was trialled by an agency OT, who was otherwise due to leave the team, for a period of 3 weeks in August, ahead of a new OT being able to commence from October 4th. The qualitative and safety impact this made was significant to the functioning of the service, along with improved patient experience as it facilitated an increased offer of rapid assessment in the home for patients previously unknown who were being discharged same day from out-of-borough, often without any prior inpatient therapy assessment. This post also supports the increase in referrals and assessments required for those needing resettlement interventions, also generated by the Discharge Policy. Increased onus is being placed on D2A in order to ensure inpatient beds are managed and recovery is enabled to maximum effect. The increased demand for rapid home assessment and resettlement, particularly for those referred from out of borough hospitals has already put additional pressure on the Single Point of Access therapists and Social workers. D2A requires timely review of all patients on this pathway, in order to release the resources required, and reduce the need for "Immediate Service Requests" via social care. When initially set up, the IIT had an additional social worker specifically to ensure these reviews took place. When funding for this temporary post was removed in January 2019, the average length of stay (LoS) increased from 13.5 days to 18.8 days within that quarter and has been retained at that level ever since.

	The average LoS for patients on D2A who need to go on to have a long term package of care is now at almost 29 days, due to the need for these patients to have a comprehensive social work assessment. With no additional Social Worker resource having been put back into IIT however, these assessments are often completed only after the higher priority rapid response social work assessments and safeguarding work has been undertaken. As such, funding for a full time social worker is requested to support this D2A stream, to ensure that resources can be best secured for those who need them and support patient flow. **Continuing Heathcare (CHC)** Current targets of NHSE for CHC assessments are 1. <15% of assessments are completed within the hospital and 2. >80% must be completed within 28 days of referral. Following eligibility for CHC, individuals must be reviewed within 12 weeks and then annually thereafter. The 'location' target is in order to ensure that professionals, patients and their family members have a greater sense as to the true needs of the individual concerned, which can often be masked in an unfamiliar and over stimulating inpatient setting. Assessments must be completed by a multidisciplinary team which ideally includes health and social care working together so as to reduce patient complaints and commissioner disputes. Previous local D2A arrangements (pre-pandemic) included funding a CHC D2A nurse but not a CHC social worker. Prior to the pandemic we were able to meet CHC targets. A positive impact of the Discharge Policy has meant we are now completing 0% of assessments within the acute. Our 28-day target predominantly remains met; however, the Integrated Discharge Service can struggle to allocate social workers. In particular, there is no specific social work resource allocated to support CHC reviews where a patients needs have changed and a new assessment is required by a multi-disciplinary team. The CHC Clinical team do seek to plan all reviews, but without having a named social worker to join them it impacts upon their ability to case manage effectively. Once the backlog of reviews, which was largely as a result of the Pandemic, has been cleared, the proposal would be that this social worker post continues to respond to CHC requests, (approx. 2-3 days per week) but is otherwise employed supporting the Discharge to Assess functions within IIT, to secure adequate provision for annual leave etc. It is considered now that the discharge guidance will remain long-term, in part to support The Health and Care Bill 2021, which will need to be implemented from 2022 and with it the creation of a new discharge mechanism between NHS and social care. Critical to the Discharge to Assess model is the timely (re)assessment and review of patients once back home and in their own environment, in line with the personalisation agenda.
Description of initiative	The initiative is to increase the resources within the DSPA / SPA team to manage patient referrals once they no longer meet the criteria to reside in hospital and for

	additional social work capacity to complete social work assessments for patients within IIT, and receiving an interim package of care/placement via D2A. 1. A Band 6 OT to sit within the DSPA to ensure increased scrutiny and response times for D2A 2. A social worker to ensure review and LoS remain at target level 3. A social worker to participate in CHC assessments and reviews within the community (will also support Reablement review)
Intended benefit / outcome	• Patients who no longer meet the criteria to reside in hospital, can be discharged to an appropriate care setting within the same or next day • Location of assessment - <15% of CHC assessments are completed within the hospital • 28-day target - >80% CHC assessments must be completed within 28 days of referral. • Social care and CHC reviews – are conducted within a timely fashion to ensure the package of care is appropriate and cost effective.
Workforce / resource requirements	• 1 WTE Band 6 OT - £50,000 • 2.0 WTE Social Workers - £108,000

Ageing Well Programme – community service improvement proposal

Area of investment	2-Hour Community Response
Title	Home Treatment and Reablement
Indicative spend	£136, 600 (includes on-costs but no overheads)
Context / service gap	The Integrated Independence Team (IIT) consists of 4 "strands": Rapid Response, Home Treatment, Reablement and Rapid Care (formerly Discharge to Assess). Response time for all referrals under the Home Treatment & Reablement Team is 2 working days. The new Discharge Policy and Operating Model came into force from September 2020 in response to the Pandemic, increased the number and complexity of patients referred for rehabilitation within the Home Treatment and Reablement (HTR) pathway of the team by 30%. It is considered now that the guidance will remain long-term, in part to support The Health and Care Bill 2021, which will need to be implemented from 2022 and with it the creation of a new discharge mechanism between NHS and social care.
Description of initiative	The request made is for an additional Occupational Therapist and Physiotherapist within this pathway. By increasing stability with permanent static posts, (when most posts within the service are Band 5 therapists on rotation), flexibility for neuro and generic demand will be increased to meet the sustained increase in numbers and complexity. The additional 0.6 Band 7 requested would be to provide additional leadership within IIT, to support the increased staffing, whilst also increasing both the Speech and Language Therapy (SaLT) and Psychotherapy offer across the service, by 0.4wte and 0.2wte respectively as those disciplines have also seen increased demand in referrals for both rehabilitation and resettlement across the team. This could be met by existing staff increasing their hours. The SaLT will also support D2A.
Intended benefit / outcome	• To enable patients to improve their independence/increase functional abilities. • To reduce the need for inpatient admission by providing urgent intermediate rehabilitative therapeutic care in the home (2-day response) • Reduction in % of service users readmitted to hospital within 30 days of discharge • Proportion of older people (65 and over) discharged from hospital via IIT who remain at home after 91 Days (Target - 91%).
Workforce / resource requirements	• WTE Band 6 therapist (OT) - £50,000 • WTE Band 6 therapist (Physio) - £50,000 • 0.6 WTE Band 7 therapist - £36,600

Title of report:	A proposal to permanently locate the inpatient dementia assessment services at East Ham Care Centre
Date of meeting:	14.10.21
Lead Officer:	Eugene Jones, Director Service Transformation, East London NHS Foundation Trust
Author:	Eugene Jones, Director Service Transformation, East London NHS Foundation Trust
Committee(s):	The following stakeholder forums and committees have/will be receiving this proposal and are being asked to feedback their views which will be incorporated prior to the proposed public consultation. In addition a visit has been conducted by Healthwatch Hackney on the 3rd September to East Ham Care Centre including Cazaubon ward. Dementia Alliance Board and feedback - 8th September Older Persons Reference Group to consider and feedback - 22nd September People and Place Group to consider and feedback - 6th October Health in Hackney (Scrutiny) - 11th October TNW Delivery Group and Area Committee - 14th October Integrated Care Partnership Board - 14th October Tower Hamlets Health scrutiny - 26th October NEL Quality Committee - 10th November City of London Health Scrutiny - 10th November
Public / Non-public	[The partner organisations are committed to being as open as possible about all the decisions and actions they take, and reports will be considered to be in the public domain as standard. If there is a reason the contents of the report should not be made public please state below.] N/A

Executive Summary:

Our proposal is to make permanent the move of Dementia inpatient admission services to Cazaubon ward, East Ham Care Centre; these services moved on an interim basis from Columbia ward, Mile End Hospital in August 2020.

The move of Columbia ward to East Ham Care Centre has provided this opportunity, to create a critical mass of expertise, resources and support for dementia care and the frail elderly. The Cazaubon ward environment supports recovery and the interim move has

already seen improvements in patient outcomes for residents of the City of London, Hackney, Newham and Tower Hamlets. With an increased range of social and clinical interventions and greater stimulation through the activities programme at the centre, staff are able to identify with the patient the type of support they need to return home or in some cases consider residential care arrangements. We have noted a reduced length of stay in hospital since the provision was moved to Cazaubon ward. This is an important opportunity to sustain the improvements that have been made in the health and care for people with dementia and make a positive impact on their mental/physical health and overall well-being.

We intend to engage and consult with stakeholders initially on our plans to make permanent the move of the Dementia inpatient admission services to East Ham Care Centre.

We are developing our case for change describing the proposed model and have developed a draft communications plan (See Appendix 1) in support of this. We will also conduct an Equality Impact Assessment as part of our case for change to help reviewers understand how these proposals impact- positively or negatively on certain protected groups and to estimate whether such impacts disproportionately affect such groups.

We intend to begin the public consultation in early December 2021 and for this to be open and available for feedback for a period of 12 weeks after which it will then conclude. The 2 questions we are intending to have answered in the public consultation, are contained in our report and are also below, we would welcome feedback on our plans, proposed approach and the questions.

1. To what extent do you think the co-location of older persons physical and mental health inpatient services at East Ham Care Centre will provide an improvement to care and treatment for patients with Dementia?

Agree fully Agree partly Disagree partly Disagree fully

2. To what extent do you agree or disagree that this proposal will enhance the overall care and support for patient's carers and their families?

Agree fully Agree partly Disagree partly Disagree fully

Recommendations:

[Recommendations should be clear and not open to interpretation, should always describe the recommended option, including reference to any financial commitment, and, where appropriate, should be split into separately numbered recommendations.]

The **Integrated Care Partnership Board** is asked:

- To **CONSIDER** and provide feedback on our plans, proposed approach and the 2 questions that are intended to be used in the public consultation.

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	☐	
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	Cazaubon ward average Length of Stay –has reduced from 98 to 82 days, patients are being discharged from hospital safely and returning home or into other community support settings on average 16 days earlier, reducing risk and the need for hospital based care and treatment.
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	☒	To create a focus of expertise in one place to develop a bespoke centre of excellence model for the dementia assessment function, within the overall function for frail elderly and dementia services located at East Ham Care Centre that can offer a better therapeutic experience for local people.
Empower patients and residents	☐	

Specific implications for City

[Please make the specific implications of the proposal for City.]

Specific implications for Hackney

[Please make the specific implications of the proposal for Hackney.]

Patient and Public Involvement and Impact:

This change will specifically affect older people with dementia who require admission into hospital and reside within the City of London, and the London boroughs of Tower Hamlets, Hackney, Newham and their families. We have begun a series of engagement events with stakeholders and our proposals have/will be presented at the respective reference and interest groups, that relate to care of the elderly and dementia. Health watch Hackney have visited East Ham Care Centre on the 3rd September 2021 and have provided a report.

Areas of feedback received thus far are incorporated in our 'Frequently asked questions' which is attached as an appendix.

We have also launched a carers questionnaire to establish carers views on the current arrangements within Cazaubon ward and their views of our proposal to make this a permanent arrangement.

In addition 'our case for change' will be made widely available through our public consultation and we have posed 2 questions to understand and receive feedback on our proposed change.

Clinical/practitioner input and engagement:

Clinicians have been involved in the development of this proposal and are fully supportive of the benefits these new clinical adjacencies provide. Clinicians are fully engaged in the environmental development to further improve the ward design and layout to maximise its full potential. The co-located wards and staff (not separate from other specialist older adult and frailty services) provide a critical mass of Cognitive Impairment, Specialist Dementia and Frailty inpatient care. These services are supported by clinical experts from medical, psychological, therapeutic, and nursing professions on the one site. This provides further opportunities to consolidate shared learning, quality improvements and reduce variation leading to better patient outcomes and higher quality care. Extending the range of therapeutic activities (such as counselling; art and music therapy; will help patients relearn everyday living skills) without which it can take longer for patients to recover and return home.

The new service configuration will enable staff to provide the best care possible, with skills and expertise that are of the highest standards. With flexible rotas, that are able to respond to cover during busy times and a working environment that makes it a pleasure to work in, enabling staff to do their best and provide the care to patients of a standard we know they strive for.

Communications and engagement:

[Does this report, or the work described in the document, require communications and/or stakeholder engagement with patient groups, the public or integrated care partners? **Yes**/No. If yes, please explain what communications and engagement has been undertaken or will be undertaken. If no – please state why not.]

A draft communications plan has been developed and is detailed in the main report as an appendix.

Comms Sign-off
Which Communications and Engagement team member has contributed to the communications and engagement thinking which underpins this work?

Janet Flaherty, Head of Communications, East London NHS Foundation Trust
Don Neame, Senior Communications Consultant, North East London CCG

Equalities implications and impact on priority groups:

We intend to conduct a full Equality Impact Analysis as part of our case for change to understand how these proposals impact – either positively or negatively on certain protected groups and to estimate whether such impacts disproportionately affect such groups.

Safeguarding implications:

There are no safeguarding issues identified at present.

Impact on / Overlap with Existing Services:

[Please state how proposals in the report will impact on existing service provision, considering inter-relations between NHS and Local Authority, acute, GP and community services.] The current arrangements have not created any impacts on existing service provision, they have allowed the safe operation of the COVID – 19 free 'Green Zone' at Mile End Hospital and the existing arrangements for community and primary care responsibility are retained by the respective local teams based within the patient's area of origin. The permanent move of these services will enable further development and investment to progress to enhance the already exceptional environment, to fulfil the ambition to create a centre of excellence, this proposal does not identify any new issues in terms of the impact between services and inter-relations.

NHS
East London
NHS Foundation Trust

A proposal to permanently locate the inpatient dementia assessment services at East Ham Care Centre

Report for the Integrated Care Partnership Board

14th October 2021

Eugene Jones

Director Service Transformation

Purpose of the Report

NHS
East London
NHS Foundation Trust

To provide the Integrated Care Partnership Board with a report on

- Our proposal - to permanently locate the inpatient dementia assessment services at East Ham Care Centre
- The experience of service users and carers over the last 12 months following the interim move of the Dementia Assessment Unit, formerly provided within Columbia Ward, Mile End Hospital (MEH).
- The COVID – 19 ‘green’ zone arrangements within Mile End Hospital
- The future plans and next steps for these sites/services and to receive feedback on these proposals.

Introduction

NHS East London NHS Foundation Trust

During 2020, in response to the Covid -19 pandemic a covid free ‘green’ zone was created on the MEH site, designed to keep patients, staff and family/carers safe, reducing the risk of cross infection.

Columbia ward, a 21 bed, Organic (Dementia) Assessment unit, located at MEH, had entry and exit routes accessed through the ‘green’ zone, it was therefore not possible for Columbia ward to remain insitu.

ELFT and partners reviewed the options available to relocate Columbia Ward, seeking a suitable ward environment, to provide, safe & effective care for patients with Dementia

Cazaubon, a vacant ward, situated within East Ham Care Centre (EHCC), was identified, it had the capacity and adequate space with an improved environment, it also provided greater clinical adjacencies, as all the wards for Dementia and frail elderly would now be located at EHCC.

Our proposal

NHS
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NHS Foundation Trust

The move of Columbia ward to East Ham Care Centre has provided the opportunity for more effective clinical adjacencies, achieved through the colocation of the dementia and frail elderly inpatients on one site.

This creates a critical mass of expertise, resources and support of the care of the elderly and frail at this location. Patients can transition from the day hospital to the continuing care ward and if required, transition to the end of life ward within the one site at East Ham Care Centre providing a seamless pathway of care for a patient group for whom change can be unsettling.

We are already seeing the benefit this environment has on patients' recovery meaning they are well enough to go home sooner. This is an important opportunity to improve the health and care of older adults to make a positive difference to the mental and physical health of residents.

We now wish to make this a permanent arrangement with all Dementia inpatient admission services to Cazaubon ward, East Ham Care Centre

About the previous service - Columbia ward, Mile End hospital

NHS East London NHS Foundation Trust

Columbia ward design and layout is no longer compliant with modern mental health building expectations. Whilst single rooms were available there was only 1 bedroom with en-suite facilities. Patients who require admission to hospital because of a mental health problem especially Dementia are extremely vulnerable, can be confused and dis-orientated and are typically admitted for several weeks, they need an environment that will offer privacy and dignity to support their recovery.

Further environmental issues

- Poor natural light leading to a very dark environment
- Space and capacity issues for patients and carers/ and families visiting
- No direct access to outdoor space (all patients required to be escorted into the garden area by staff, limiting access as the ward is based on the top floor,
- Exceptionally hot in the summer due to its top floor position with inadequate insulation

About East Ham Care Centre

East London NHS Foundation Trust

East Ham Care Centre is a purpose-built environment, providing a dementia-friendly layout. Cazaubon ward provides an improved environment (a step up from Columbia Ward), with large en-suite bedrooms, throughout, offering natural light. There is a restaurant on site, free visitor parking and therapy space and private secluded gardens.

The vast majority of care we provide takes place in the community, in or near to people's homes. In some cases care needs to be in hospital, this maybe because a thorough assessment is required, or a crisis has occurred.

In terms of the primary care pathway (including G. P, medical cover) this is unaffected by admission, the arrangements previously in place (within the Borough of origin) resume at the point of hospital discharge.

We have two older adult mental health inpatient wards and one physical health inpatient ward located at the East Ham Care Centre, serving residents of City & Hackney, Tower Hamlets and Newham.

- Fothergill Ward – 32 beds, providing physical health and end of life care
- Sally Sherman Ward – beds, providing Dementia and complex/challenging behaviour
- Cazaubon Ward – 21 Beds, providing organic (Dementia) admission and assessment function (replaced Columbia ward)

The experience of the past 12 months of the Cazaubon ward provision

- Admissions profile
- Pt Length of Stay
- Incidents number and themes
- Friends & Family Test

Columbia and Cazaubon wards comparative admission data

NHS East London NHS Foundation Trust

The need for hospital based care, even for those people with severe mental illness and Dementia has reduced over time, with more care now being delivered in the community. There is still however a requirement for acute and crisis admissions of people with Dementia, especially where the individuals require a period of admission in a safe environment.

The respective admissions profile

Columbia Ward Admissions	2018	2019	Up to August 2020 closure
CITY AND HACKNEY	20	26	18
NEWHAM	15	16	6
TOWER HAMLETS	19	17	17
Total	54	59	41

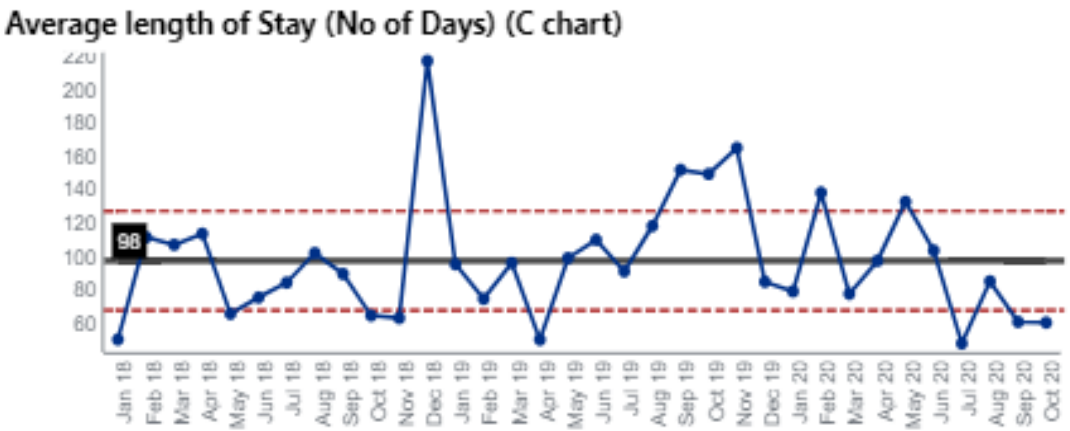
Cazaubon Ward Admissions/Transfers	Transfers following Columbia closure	Admissions August 2020 to date	Total patients cared for since opening
CITY AND HACKNEY	3	7	10
NEWHAM	2	6	8
TOWER HAMLETS	7	7	14
Total	12	20	32

Columbia and Cazaubon Wards – Length of Stay

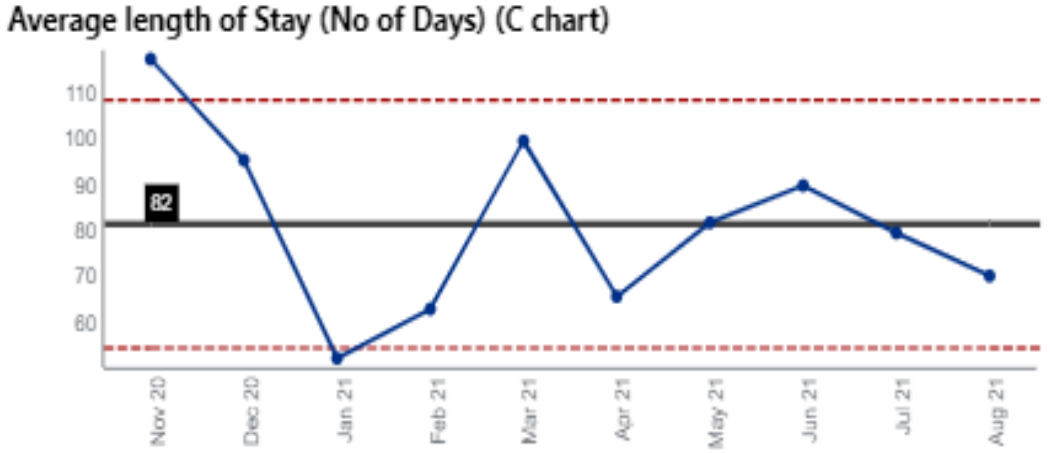
NHS East London NHS Foundation Trust

Length of Stay (the number of inpatient days spent in hospital) is linked to service function, efficiency and quality. Reducing the length of stay in hospital, aims to provide patients with a better care experience and can reduce risk, especially for those who are frail or elderly. Risks can include; Infection - hospital acquired, and other, Falls - unfamiliar hospital surroundings, furniture and fittings, and Cognitive loss - hospital admission disorientation, sometimes not recoverable.

Columbia Ward – Average Length of Stay (No of days) Jan-18 to Oct 2020

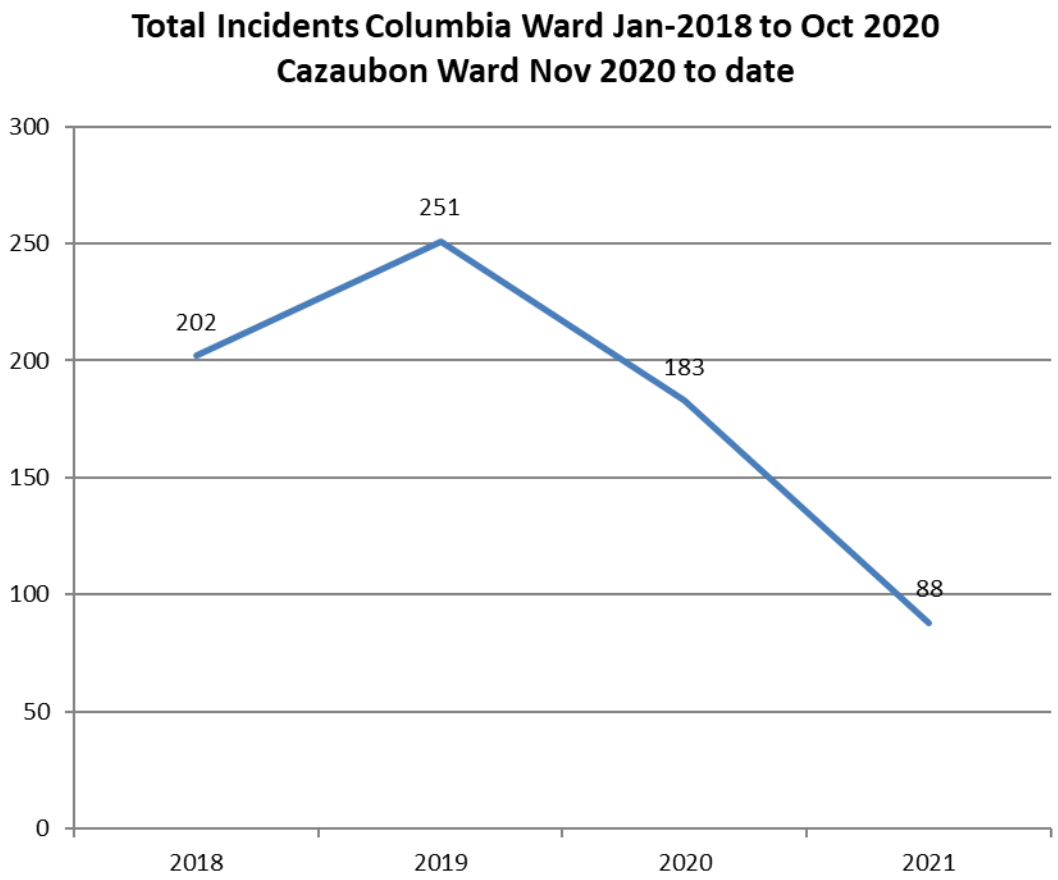


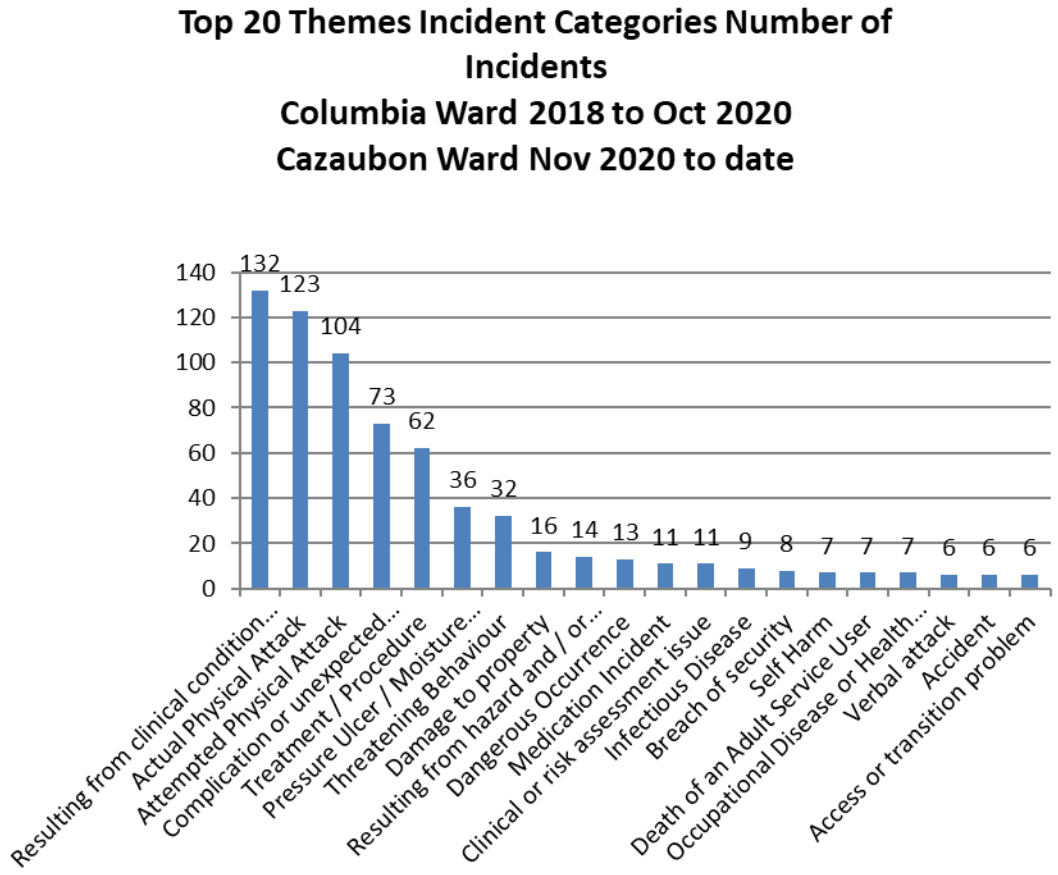
Cazaubon Ward – Average Length of Stay (No of days) from Nov 2020 to Aug 21



Cazaubon ward Length of Stay – Average has reduced from 98 to 82 days

Columbia and Cazaubon Wards – Incidents and Themes





Cazaubon ward has seen a reduction incidents 2020/21

Friends and Family Test results - Columbia and Cazaubon Wards

NHS East London NHS Foundation Trust

The Friends and Family Test (FFT) provides feedback from the people who use our services and their experience. This is used alongside other measures to provide a good overall understanding of what is working well, and what needs improving for service users and their families.

The Friends and Family Test

Service Report: Sep 2019 - Aug 2020

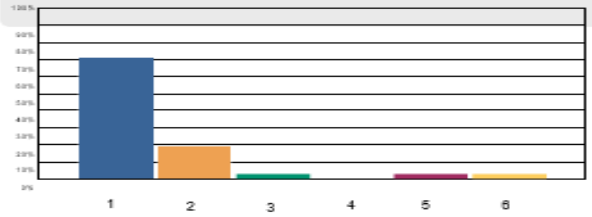
NHS East London NHS Foundation Trust

Service

Columbia Ward

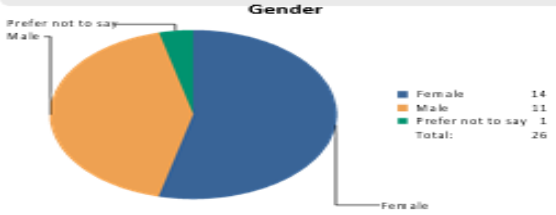
Star Rating	Positive	Negative
★★★★½	90.32%	3.23%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	22	70.97%
2 - Good	6	19.35%
3 - Neither good nor poor	1	3.23%
4 - Poor	0	0.00%
5 - Very poor	1	3.23%
6 - Don't know	1	3.23%

Breakdown



Total Responses

31

The Friends and Family Test

Service Report: Sept 2020 - Aug 2021

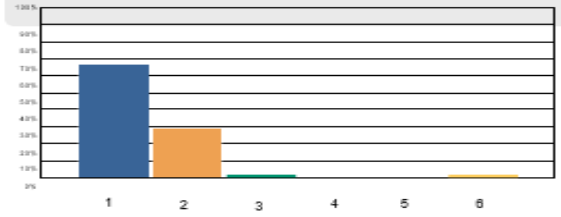
NHS East London NHS Foundation Trust

Service

Cazaubon Ward

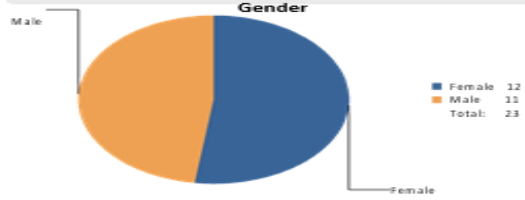
Star Rating	Positive	Negative
★★★★★	95.56%	0.00%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	30	66.67%
2 - Good	13	28.89%
3 - Neither good nor poor	1	2.22%
4 - Poor	0	0.00%
5 - Very poor	0	0.00%
6 - Don't know	1	2.22%

Breakdown



Total Responses

45

Travel & Assistance

We appreciate that for residents and family members of Tower Hamlets and City & Hackney the move of services to EHCC will for some increase the travel distance.

We also understand that Carers and family members may themselves be elderly and/or frail and we wish to reduce the impact of travel for them.

There is free visitor car parking at EHCC, this is not available on the MEH site.

We also have available travel assistance to support carers with the journey to EHCC

The criteria for travel support is assessed against the ability of individuals to use their own or public transport to visit. It is an informal process and based on a discussion with the carer/family member themselves. It is not means tested, there is no additional paper work involved and may include the provision of taxis, payment towards parking or provision of hospital transport.

Travel Assistance - A carers story

NHS East London NHS Foundation Trust

Mrs A was admitted to Cazaubon ward in the summer of 2021, and was a resident from City & Hackney.

Shortly after the admission the ward matron saw Mrs. A with her husband, Mr. A, he appeared frailer and physically less able. He had arranged a taxi to return home that day and whilst waiting at the reception area it was obvious that Mrs. A was worried about him. She was encouraged to wait with him until the taxi arrived.

The following day the ward matron asked Mrs. A if her partner was due to visit. She said that he was only able to use taxi's to visit. A decision was made automatically to fund the cost of future taxi journeys. An agreement was made that Mrs A or her husband would inform the ward administrator when they wished to visit, and a taxi would be booked both ways, paid through the Cazaubon ward account.

They were advised that this service could be provided daily for as long as Mrs A was a patient on the ward. Happily Mrs A has now been discharged home with follow up support from the community health team.

Financial

NHS East London NHS Foundation Trust

There are no direct staffing financial savings expected as a result of this change, the staff team have moved from Columbia ward to Cazaubon ward, with an equivalent staffing model, which not only provides continuity of care, it has also reduced the need for recruitment and ensures a safe staffing model.

There is however a system benefit in terms of costs

- The vacant ward space within East Ham Care Centre placed a considerable revenue cost on the overall Health and Social Care system, who remained liable for the previously vacant (void costs) and unused ward space.

We intend to invest in the environment at Cazaubon ward, East Ham Care Centre to improve this even further with a focus on optimising the ward's full potential, to create the very best of ward environments, the capital cost for this has been estimated at £850,000.

Potential Impact of our proposals - we believe that the proposal has many more advantages than disadvantages.

East London NHS Foundation Trust

Fantastic built environment - *The ward has been designed with the care of older persons and frailty in mind and is light, airy and spacious.*

Improved clinical care - *to help people recover faster and get home sooner. The length of stay has reduced already in Cazaubon ward by 16 days.*

Co-located wards and staff - *(not separate from other specialist older adult and frailty services) providing a critical mass of Cognitive Impairment, Specialist Dementia and Frailty inpatient care and treatment, supported by clinical experts.*

Staffing, Retention and Recruitment - *Enabling staff to do their best and provide the care to patients of a standard we know they strive for, of the highest standards.*

Making best use of Buildings and NHS estate - *The NHS Long Term Plan has called on all NHS trusts to make better use of clinical space and where possible consolidate services to gain benefits*

COVID 19 – Green Zone - *Continued safe service delivery at Mile End Hospital to support those who are clinically extremely vulnerable to COVID- 19 infection across the North East London CCG.*

Potential Impact of our proposals - we believe that the proposal has many more advantages than disadvantages.

NHS East London NHS Foundation Trust

Our proposal would mean longer journeys for some visitors, although for others, it will mean shorter journey times.

Actions in place to reduce impact of disadvantages

- ✓ Continue to improve care in a way that reduces the need for hospital admissions in the first place, enhancing care capacity in existing community mental health services.
- ✓ Provide information about transport and travel options for carers and family visitors and the financial support and assistance that is available
- ✓ Continue to support the use of technology and 'virtual visiting' in addition to face-to-face visits

Stakeholder and Public Engagement - Feedback and Sharing views

NHS East London NHS Foundation Trust

We intend to engage and consult with stakeholders initially on our plans to make permanent the move of the Dementia inpatient admission services to East Ham Care Centre.

We are developing our case for change describing the proposed model and have developed a draft communications plan (See Appendix 1) in support of this. We will also conduct an **Equality Impact Assessment** as part of our case for change to help reviewers understand how these proposals impact- positively or negatively on certain protected groups and to estimate whether such impacts disproportionately affect such groups.

We intend to begin the public consultation in early December 2021 and for this to be open and available for feedback for a period of 12 weeks after which it will then conclude. The 2 questions we are intending to have answered in the public consultation, are below, we would welcome feedback on our plans, proposed approach and the questions.

1. To what extent do you think the co-location of older persons physical and mental health inpatient services at East Ham Care Centre will provide an improvement to care and treatment for patients with Dementia?

Agree fully **Agree partly** **Disagree partly** **Disagree fully**

2. To what extent do you agree or disagree that this proposal will enhance the overall care and support for patient's carers and their families?

Agree fully **Agree partly** **Disagree partly** **Disagree fully**

We would value your feedback and specifically on our plan and proposals
and the 2 questions we are proposing for the public consultation

Further opportunity to feedback on our proposals, via email please forward to Eugene.jones2@nhs.net.

NHS
East London
NHS Foundation Trust

A proposal to permanently locate the inpatient dementia assessment services at East Ham Care Centre

Report for the Integrated Care Partnership Board

14th October 2021

NHS
East London
NHS Foundation Trust

Contents

1. Introduction

The response to Covid-19, has created the need for emergency transformation of Healthcare services to protect patients and the public.

In response to the Covid -19 pandemic a covid-free, 'green' zone was created on the Mile End Hospital site. The Green Zone ensures that those people in the clinically extremely vulnerable groups (see below) can continue to access and receive treatment from the NHS services at Mile End Hospital. It has been designed to keep patients, staff and family/carers safe, reducing the risk of cross infection.

The cohort of patients at risk 'clinically extremely vulnerable' is described by NHS England as:

- Those undergoing active treatment for specific cancers
- Those with an underlying haematological malignancy or inherited blood disorder
- Those living with a solid organ transplant
- Those on current immunosuppression at a level thought to engender risk
- Pregnant women with associated cardiac disease

Columbia ward, a 21 bed, Organic (Dementia) Assessment unit, located at Mile End Hospital, had entry and exit routes accessed through the 'green' zone, it was therefore not possible for Columbia ward to remain in situ.

East London NHS Foundation Trust and partners reviewed the options available to relocate Columbia Ward, seeking a suitable ward environment, to provide, safe and effective care for patients with complex Dementia.

Cazaubon, a vacant ward, situated within East Ham Care Centre, was identified, it had the capacity and adequate space with an improved environment, it also provided greater clinical adjacencies, as all the wards for Dementia and frail elderly would now be located at East Ham Care Centre.

The emergency transformation and urgent service change of location of Columbia ward was approved on an interim basis in June 2020.

Columbia ward moved from Mile End Hospital to Cazaubon ward at East Ham Care Centre in August 2020 on an interim basis.

We are now wishing to progress the interim move of Columbia ward to Cazaubon ward and make this a permanent move.

2. Columbia Ward at Mile End

Columbia ward design and layout is no longer compliant with modern mental health building expectations. Whilst single rooms were available there was only 1 bedroom with en-suite facilities. Patients who require admission to hospital because of a mental health problem especially Dementia are extremely vulnerable, can be confused and dis-orientated and are typically admitted for several weeks, they need an environment that will offer privacy and dignity to support their recovery.

Further environmental issues

- Poor natural light leading to a very dark environment
- Space and capacity issues for patients and carers/ and families visiting
- No direct access to outdoor space (all patients required to be escorted into the garden area by staff, limiting access as the ward is based on the top floor,
- Exceptionally hot in the summer due to its top floor position with inadequate insulation

3. East Ham Care Centre

The vast majority of care we provide takes place in the community, in or near to people's homes, our aim is for care as much as possible to be delivered in these community settings by community and mental health teams. In some cases care cannot be provided in the community, this maybe because a thorough assessment needs to be undertaken, a crisis has occurred or a relapse of an illness. We have two older adult mental health inpatient wards and one physical health inpatient ward located at the East Ham Care Centre, serving a population across North East London CCG, serving residents of City & Hackney, Tower Hamlets and Newham.

- Fothergill Ward – 32 beds, providing physical health and end of life care
- Sally Sherman Ward – beds, providing Dementia and complex/challenging behaviour
- Cazaubon Ward – 21 Beds, providing organic (Dementia) admission and assessment function (replaced Columbia ward)

East Ham Care Centre has extensive gardens and unlike the Mile End Hospital site, the gardens are private and for the sole use of East Ham Care Centre residents and their carers, the gardens are well maintained with adequate private and seating space and are used frequently.

There is an activity centre at East Ham Care Centre which runs from Monday to Friday every week and includes weekly music therapy and dance therapy sessions. Patients also have access to faith and fellowship services, including multi-faith prayer meetings each week, and a sensory room.

4. Columbia and Cazaubon wards comparative data over the last year

Admission Profile

The community services have developed over recent years to provide a fully functioning offer for people who would have previously been admitted to hospital, the charts below identify the reducing trend in admission profile across all areas from 2018. The need for hospital based care, even for those people with severe mental illness and Dementia has reduced over time, with more care now being delivered in the community. There is still however a requirement for acute and crisis admissions of people with Dementia, especially where the individuals are, for example, a danger to themselves and require a period of admission in a safe environment.

Columbia Ward Admissions	2018	2019	Up to August 2020 closure
CITY AND HACKNEY	20	26	18
NEWHAM	15	16	6
TOWER HAMLETS	19	17	17
Total	**54**	**59**	**41**

Admissions to Columbia ward up to its closure in August 2020

Cazaubon Ward Admissions/Transfers	Transfers following Columbia closure	Admissions August 2020 to date	Total patients cared for since opening
CITY AND HACKNEY	3	7	10
NEWHAM	2	6	8
TOWER HAMLETS	7	7	14
Total	**12**	**20**	**32**

Admissions to Cazaubon ward from August 2020 to date.

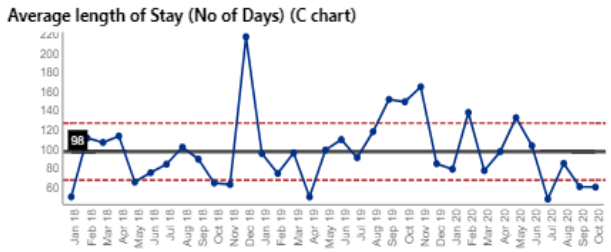
Length of Stay

Length of Stay (the number of inpatient days spent in hospital) is an important indicator, linked to service function, efficiency and quality. Optimising the period of care provided in hospital by reducing the length of stay, aims to provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay.

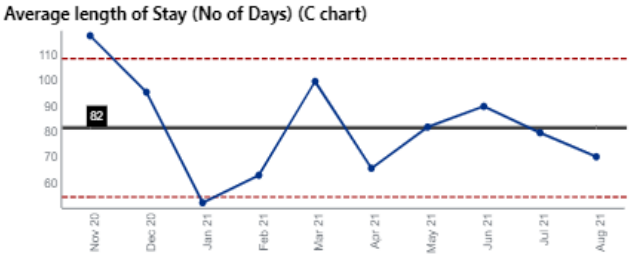
Spending a long time in hospital can lead to increased risk, especially for those who are frail or elderly. These risks can include; Infection - hospital acquired, and other, Falls - unfamiliar hospital surroundings, furniture and fittings, Poor sleep patterns – that can impact on overall health and well being and Cognitive loss - hospital admission creates disorientation, sometimes this is not recoverable.

By ensuring patients return to their usual place of residence, or another care setting, as soon as it's safe to do so following hospital admission we reduce these potential risks.

Columbia Ward – Average Length of Stay (No of days) Jan-18 to Oct 2020

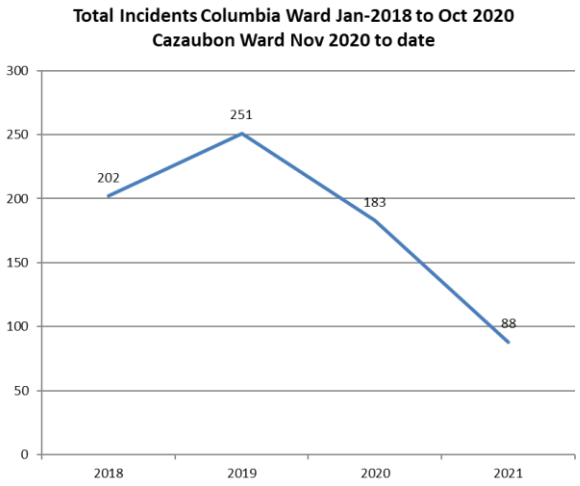


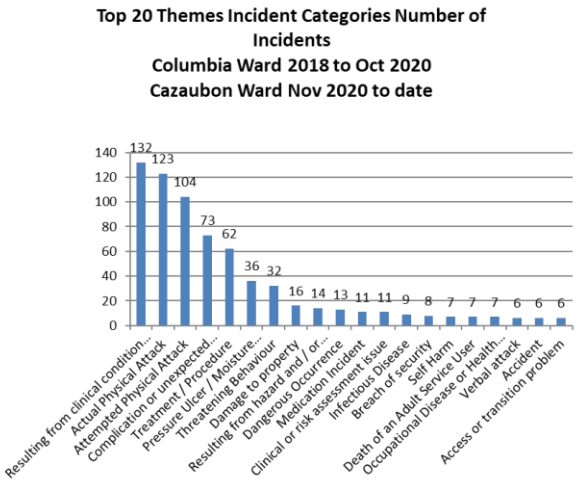
Cazaubon Ward – Average Length of Stay (No from Nov 2020 to date



Cazaubon ward Length of Stay (LOS) – Average LOS has reduced from 98 to 82 days, patients being discharged from hospital returning home or into other community support settings ***16 days earlier*** *on average.*

Incidents from 2018 to date – Columbia and Cazaubon wards





Cazaubon ward has seen a reduction of incidents since opening in 2020/21

5. Listening to patients, carers and our staff - What people have said

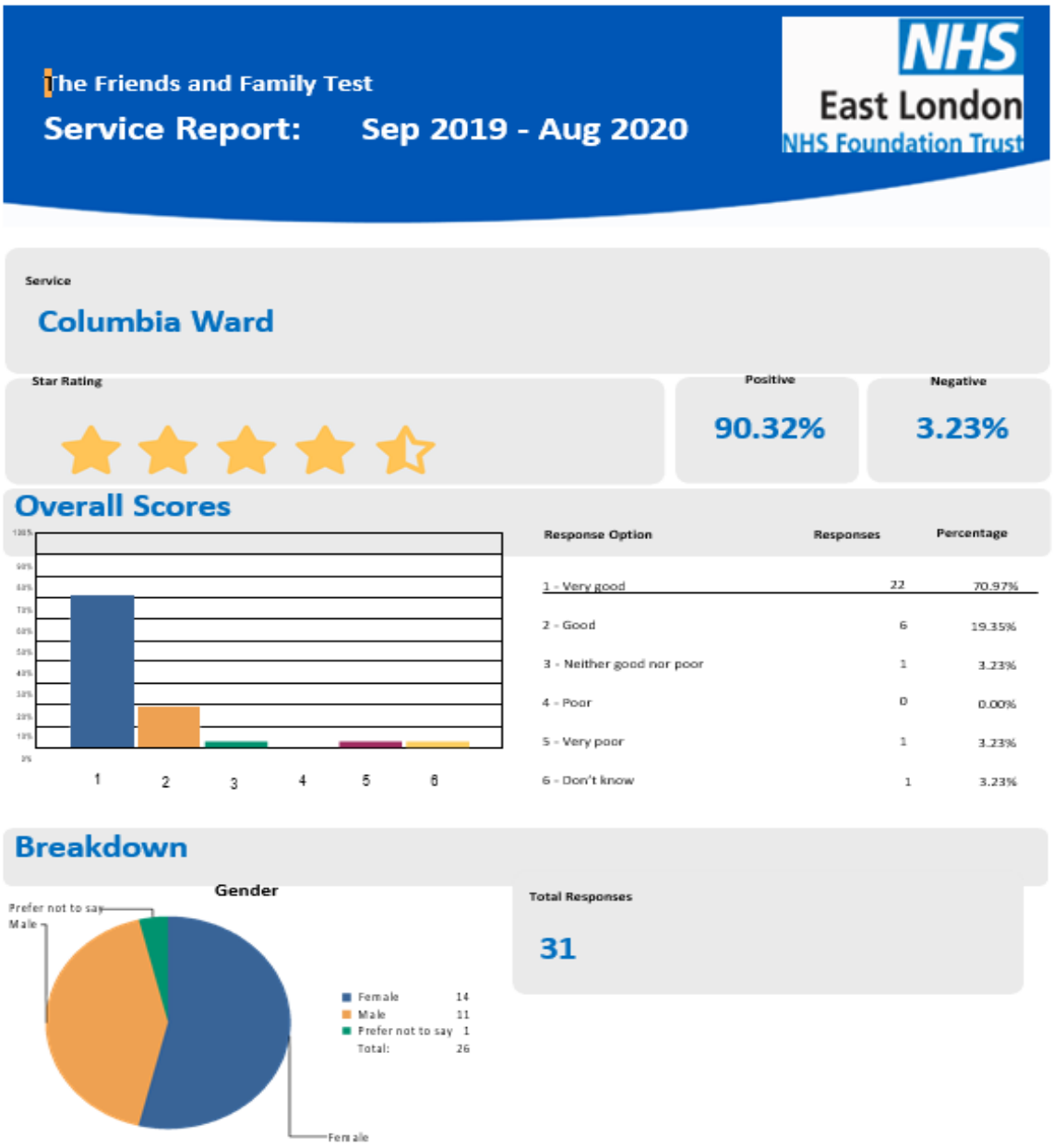
What is the Friends and Family Test (FFT) and comparative data Columbia and Cazaubon wards

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

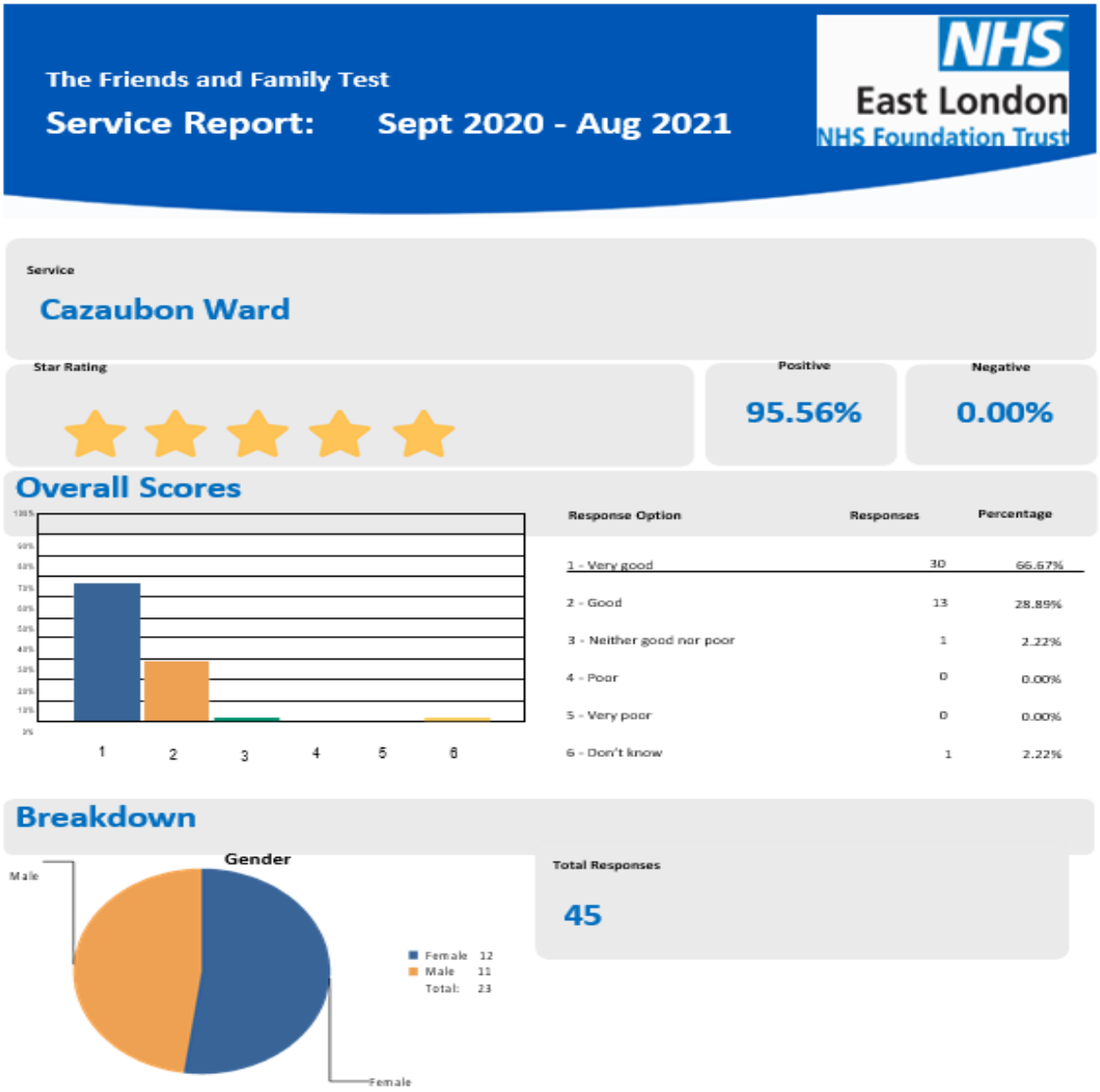
We use it alongside other experience measures to give us a good overall understanding of what is working well, and what needs improving for service users and their families.

Service users and carers have helped design the questions.

Friends and Family Test overall results - Columbia Ward 2019- 20



Friends and Family Test overall results – Cazaubon Ward 2020- 21



The friends and family results whilst very positive within Columbia ward in 2019-20 have increased by a further 5% in 2020-21 based on the experience of patients and in some cases their carers of Cazaubon ward over the last 12 months.

Carers and family

East London NHS Foundation Trust recognises the importance of providing accessible services for patients and the continued contact of family and carers. Support from loved ones whilst someone is an inpatient is a key component in their journey of recovery.

We appreciate that for residents and family members of Tower Hamlets and City & Hackney the move of services to East Ham care Centre will for some increase the travel distance and for others the journey will decrease. We also understand that Carers and family members may themselves be elderly and/or frail and we wish to reduce the impact of travel for them. There is free visitor car parking at East Ham Care Centre, this is not available on the Mile End Hospital site. We also have available travel assistance to support carers with the journey to East Ham Care Centre.

The criteria for travel support is assessed against the ability of individuals to use their own or public transport to visit. It is an informal process and based on a discussion with the carer/family member themselves. It is not means tested, there is no additional paper work involved and may include the provision of taxis, payment towards parking or provision of hospital transport.

A Carers story

Mrs A was admitted to Cazaubon ward in the summer of 2021, and was a resident from City & Hackney.

Shortly after the admission the ward matron saw Mrs. A with her husband, Mr. A, he appeared frailer and physically less able. He had arranged a taxi to return home that day and whilst waiting at the reception area it was obvious that Mrs. A was worried about him. She was encouraged to wait with him until the taxi arrived.

The following day the ward matron asked Mrs. A if her partner was due to visit. She said that he was only able to use taxi's to visit. A decision was made automatically to fund the cost of future taxi journeys. An agreement was made that Mrs A or her husband would inform the ward administrator when they wished to visit, and a taxi would be booked both ways, paid through the Cazaubon ward account.

They were advised that this service could be provided daily for as long as Mrs A was a patient on the ward.

Happily Mrs A has now been discharged home with follow up support from the community health team.

For the Charadi and Hasidic Jewish communities who cannot use public transport during Shabbat, we are looking into the possibility of overnight accommodation to enable them to visit family members on Fridays and Saturdays on foot.

We have been talking with families seeking their views on behalf of their loved one and we have established a **carer's questionnaire**, this will be provided during September to receive feedback directly from family and carers, in addition to any individual discussions.

We have also reached out and engaged with **Health watch Hackney** to create a further channel to receive feedback on behalf of patients, carers and families on their experience. Health watch Hackney have visited the East Ham Care Centre and wards during September 2021 and have provided a report of their recent visit.

Our Staff

The staff team transferred from Columbia ward to Cazaubon ward to maintain care continuity, we have engaged staff and their representatives regarding this proposal, these discussions have provided an open and honest dialogue, this has been received positively by staff, who are receptive and understanding of the need to agree a permanent arrangement.

Clinical staff have been fully engaged in a series of discussions to enhance the environment within Cazaubon ward and the quality of patient care provided.

There has been no material change in either staff absence or staff turnover.

We intend to engage staff formally through a consultation process to understand their needs, wishes and future aspirations in terms of clinical settings and workplace.

6. Financial

There are no direct staffing financial savings expected as a result of this change, the staff team have moved from Columbia ward to Cazaubon ward, with an equivalent staffing model, which not only provides continuity of care, it has also reduced the need for recruitment and ensures a safe staffing model.

There is however a system benefit in terms of costs

- The vacant ward space within East Ham Care Centre placed a considerable revenue cost on the overall Health and Social Care system, who remained liable for the previously vacant (void costs) and unused ward space.

We intend to invest in the environment at Cazaubon ward, East Ham Care Centre to improve this even further with a focus on optimising the ward's full potential, to create the very best of ward environments, the capital cost for this has been estimated at £850,000.

7. Our proposal

To make permanent the move of Dementia inpatient admission services to Cazaubon ward, East Ham Care Centre; the services moved on an interim basis from Mile End Hospital in August 2020.

We are not proposing any significant changes to the way care is provided on Cazaubon Ward but we expect that we will continue to develop further quality improvement in the new unit to enhance care with more therapeutic activities available in a fit for purpose unit.

East Ham Care Centre is a purpose-built environment, providing a dementia-friendly layout. Cazaubon ward provides an improved environment (a step up from Columbia Ward), with large en-suite bedrooms, throughout, offering natural light. It is dementia friendly, there is a restaurant on site, there is therapy space and private secluded gardens and activity areas, the environment uses effective colour and design with dementia patients in mind.

The move of Columbia ward to East Ham Care Centre has provided the opportunity to maximise the benefit and consolidate the different clinical and care streams of the older adult inpatient pathway. These new clinical adjacencies, achieved through the colocation of the dementia and frail elderly inpatients on one site, allow for smooth transition between settings for a patient group for whom change can be unsettling.

This proposal also creates a critical mass of expertise, resources and support of the care of the elderly and frail at this location. Patients can transition from the day hospital to the continuing care ward and if required, transition to the end of life ward within the one site at East Ham Care Centre providing a seamless pathway of care.

The interim move of services to Cazaubon ward from Mile End Hospital has already seen improvements that need to be sustained and made permanent to fulfil our ambition to create a centre of excellence. We are already seeing the benefit this environment has on patients' recovery meaning they are well enough to go home sooner.

This is an important opportunity to improve the health and care of older adults who may require admission into hospital and live in City, Hackney, Newham and Tower Hamlets, to make a difference to the mental and physical health of residents.

8. Potential impact of our proposals

Overall, we believe that the proposal have many more advantages than disadvantages.

Advantages of the permanent location of services at Cazaubon ward

Fantastic built environment

The ward has been designed with the care of older persons and frailty in mind and is light, airy and spacious, the circular design provides opportunity to explore and wander safely without creating feelings of frustration.

- Every patient that requires admission will have their own individual bedroom, single bedrooms, designed specially around care needs, providing privacy and dignity and allowing for mixed sex accommodation in line with national standards and priorities for mental health care.

- Therapeutic and rehabilitation areas (to practice daily living activities such as using a kitchen safely) and dedicated space for visitors.

- Ground floor, single storey accommodation with attractive, easily accessible garden areas designed to provide patients with places for relaxation, socialising and activities

- En-suite bathrooms as well as larger assisted bathroom areas for patients with additional needs or disabilities.

- Dedicated indoor and outdoor space for visitors, and a restaurant that visitors and patients can use, serving cooked food for patients, family and carers.

- Designed to ensure optimal lines of sight for staff, reduce blind spots, and have anti-ligature (ligature light) features to help keep patients safe.

- Designed to put in place infection control measures with ease

Improved clinical care delivered co-located in one place

Expected to help people recover faster and get home sooner. The length of stay has reduced already in Cazaubon ward by 16 days with the aim to reduce the average length of stay even further.

- Co-located wards and staff (not separate from other specialist older adult and frailty services) providing a critical mass of Cognitive Impairment, Specialist Dementia and Frailty inpatient care and treatment with support from clinical experts, medical, psychological, therapeutic, and nursing professions on one site.

- Opportunities to consolidate shared learning, quality improvements and reduce variation leading to better patient outcomes and higher quality care

- Develop further research and innovation in this specialist area

- Improved Care and Treatment pathways (a holistic approach to Mental Health and Physical Health) within the comprehensive East Ham Care Centre model

- Increased range of services- that can flex and are responsive to need, delivering a sustainable, high quality, cost effective model going forward

- Therapies - Providing high quality therapies, including arts, physio, speech and language and occupational therapies across depts.

- Joined up and integrated services, working in harmony (Mental & Physical Health services) complementing community care across our area.

- Providing a range of therapeutic activities (such as counselling; art and music therapy; and help with relearning everyday living skills) without which it can take longer for patients to recover and return home.

Staffing, Retention and Recruitment

Staff working in unison to provide the best care possible, with skills and expertise that are of the highest standards.

- Flexible rotas, that are able to respond to cover during busy times
- A working environment that makes it a pleasure to work in (poor environments are harder to attract and retain staff) with high job satisfaction, opportunities to train and develop and increase staff morale
- Enabling staff to do their best and provide the care to patients of a standard we know they strive for.

A Centre of Excellence - Making best use of Buildings and NHS estate

This model has already been adopted in relation to physical health services, with the acceptance that not every borough needs its own renal unit, or cardiac unit. The NHS Long Term Plan has called on all NHS trusts to make better use of clinical space and where possible consolidate services to gain benefits through having one set of running costs.

- To create a focus of expertise in one place to develop a bespoke centre of excellence model for the dementia assessment function, within the overall service model for frail elderly and dementia services located at East Ham Care Centre, that can offer a better therapeutic experience for local people.

COVID 19 – Green Zone

- Continued safe service delivery at Mile End Hospital to support those who are clinically extremely vulnerable to COVID- 19 infection across the North East London CCG

Disadvantages of the permanent location of services at Cazaubon ward

- Our proposal would mean longer journeys for some visitors, although for others, it will mean shorter journey times. (Travel Analysis in Appendix 2).

Actions in place to reduce impact of disadvantages

- Continue to improve care in a way that reduces the need for hospital admissions in the first place, enhancing care capacity in existing community mental health services.

- Provide information about transport and travel options for carers and family visitors and the financial support and assistance that is available

- Continue to support the use of technology and 'virtual visiting' in addition to face-to-face visits

9. Evaluation - Service Monitoring and Governance

We will continue to work together with service users and carers to ensure that our proposals, as they develop, are in line with their ambitions and hopes.

In order to understand the impact of the change and mitigate/respond to any unintended consequences we intend to continually review and consider the views of patients and their families, feedback from health and social care partners including adult social care over the coming months. We intend to continue working with partners, local healthwatch's, service users and carers to review this change to evaluate the following measures to understand over time.

- Length of Stay (Trend)
- Staff turnover (monthly – 12 month rolling)
- Staff absence rate (monthly)
- Incidents number and themes (trend)
- Patient experience and Friends & Family responses
- Staff experience
- Travel assistance monitoring/provided
- Reviewing any delays in discharge and identifying causation

10. Stakeholder and Public Consultation – Feedback and Sharing views

We intend to engage and consult with stakeholders initially on our plans to make permanent the move of the Dementia inpatient admission services to East Ham Care Centre.

We are developing our case for change describing the proposed model and have developed a draft communications plan (See Appendix 1) in support of this. We will also conduct an **Equality Impact Assessment** as part of our case for change to help reviewers understand how these proposals impact- positively or negatively on certain protected groups and to estimate whether such impacts disproportionately affect such groups.

We intend to begin the public consultation in early December 2021 and for this to be open and available for feedback for a period of 12 weeks after which it will then conclude. The 2 questions we are intending to have answered in the public

consultation, are below, we would welcome feedback on our plans, proposed approach and the questions.

The service change questions we are proposing to include within the public consultation are summarised below

1. **To what extent do you think the co-location of older persons physical and mental health inpatient services at East Ham Care Centre will provide an improvement to care and treatment for patients with Dementia?**

Agree fully **Agree partly** **Disagree partly** **Disagree fully**

2. **To what extent do you agree or disagree that this proposal will enhance the overall care and support for patient's carers and their families?**

Agree fully **Agree partly** **Disagree partly** **Disagree fully**

11. Next steps

After the consultation closes, we will provide a report for the stakeholder and health and scrutiny committees, to formally review our plans and the feedback we have received from the public consultation.

We expect that the timeframe to provide this feedback will be from March 2022.

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Appendix 1

Communication and Engagement Plan

DRAFT

Proposal to Permanently Locate the East London Inpatient Dementia Assessment Unit at East Ham Care Centre, Newham

The Cazaubon Unit has been the temporary home of the Inpatient Dementia Assessment Unit formerly based at Columbia Ward, Tower Hamlets. This is a short-stay unit for people who cannot be fully assessment in a community setting.

Audience

This change will specifically affect older people in The City of London, and the London boroughs of Tower Hamlets and Hackney, and their families so information about the change needs to reach older people interest and voluntary groups, the wider public who may need this service in the future, and health and social care staff who will need to liaise with the unit at the point of discharge.

This cohort of the population may not be high users of digital platforms but this should not be assumed so the communication channels employed should be broad and varied. It is also hard to predict if face-to-face engagement will be the safest option towards the end of the year so any meetings envisaged will need to take this into account.

Content/Key Messages

- Explanation of the reason for the move and location
- Explanation of what the unit offers and the benefits and synergies of being co-located with other services for older people
- Highlight that support for carers and families is a strength of the Centre as demonstrated in feedback
- Strong emphasis on the social needs of patients, stimulation and activities
- Culturally sensitive care provided supporting religious and cultural needs
- Steps that the centre can take to support travel, parking and continuous contact between the patient and their family and friends
- Emphasis on rehabilitation and aftercare to ensure patients feel safe and confident when they return home to where they live

Channels

Online

ELFT website – intro, context, Q&As, online questionnaire, contact us information
Social media – highlight consultation is underway and how to have your say
Stakeholder bulletins
Council platforms
ICS website

Printed Information

Consultation document
Summary of consultation document - easy read, Turkish, Somali, Bengali
Questionnaire – printed version and online
ELFT's quarterly magazine, Trusttalk
City Resident Newsletter
Hackney Gazette – press release and information about how to participate
Hackney Citizen – press release and information about how to participate
East London Advertiser
Tower Hamlets Residents News channels
Newham Recorder
Newham Voices

Face to Face Communication – if COVID appropriate

Be guided by Healthwatch and Age UK. Provide a speaker and join existing meetings to discuss

> Hackney Older People's Reference Group
> Tower Hamlets Older People's Reference Group
> Newham Older People's Reference Group
> Age UK
> Mind in Hackney, and Tower Hamlets and Newham
> Connect Hackney
> CVS – Lunch Clubs
> Carers Groups
> Alzheimers Association
> ELFT older peoples patient and carers groups

Public Meeting/Drop-in – if COVID appropriate

Day time as will be dark in the evenings
Central accessible borough locations

ELFT Community Mental Health staff

Encourage conversations with existing patients and carers
Staff to share summary document and questionnaire

These channels are not exhaustive but an outline of the ways ELFT will engage with older people and their representatives. We would value the input of partners to assist us in reaching the broadest audience.

Travel Analysis – Tower Hamlets Residents

Tower Hamlets travel to Mile End/ East Ham	Current Travel to Mile End Hospital **Driving**	Current Travel to Mile End Hospital **Public Transport**	Future Travel to East Ham C.C **Driving**	Future Travel to East Ham C.C **Public Transport**
Stouts Place	13 mins	24 mins	34 mins	41 mins
St. Katherines Dock	16 mins	24 mins	32 mins	38 mins
Docklands	15 mins	36 mins	28 mins	56 mins
Island	13 mins	37 mins	25 mins	52 mins
Aberfeldy	14 mins	30 mins	24 mins	36 mins
Strudley Walk	12 mins	16 mins	21 mins	25 mins
Ruston Street	10 mins	23 mins	27 mins	37 mins
Spitalfields	12 mins	17 mins	43 mins	33 mins

Travel Analysis - City & Hackney Residents

City & Hackney travel to Mile End/East Ham	Current Travel to Mile End Hospital **Driving**	Current Travel to Mile End Hospital **Public Transport**	Future Travel to East Ham C.C **Driving**	Future Travel to East Ham C.C **Public Transport**
Abney House	25 mins	45 mins	38 mins	60mins
Green Lanes	32 mins	50 mins	45 mins	60mins
Southgate Road	19 mins	40mins	50 mins	55 mins
Half Moon Court	25 mins	30 mins	40 mins	52 mins
Broadway Market	12 mins	30 mins	36 mins	48 mins
Lower Clapton Road	23 mins	40 mins	31 mins	60 mins
Wick Road	15 mins	40 mins	30 mins	49 mins
Mandeville Street	31 mins	49 mins	35 mins	64 mins
Egerton Road	30 mins	45 mins	43 mins	57 mins
Criplegate	20 mins	22 ins	45 mins	40 mins
Aldersgate	21 mins	20 mins	46 mins	38 mins
Portsoken	14 mins	19 mins	40 mins	38 mins

Travel Analysis – Newham Residents

Newham travel to Mile End/ East Ham	Current Travel to Mile End Hospital **Driving**	Current Travel to Mile End Hospital **Public Transport**	Future Travel to East Ham C.C **Driving**	Future Travel to East Ham C.C **Public Transport**
Stratford & New Town	14 mins	25 mins	12 mins	31 mins
Little Ilford	25 mins	51 mins	11 mins	22 mins
Royal Docks	17mins	45 mins	14 mins	38 mins
Beckton	23 mins	58 mins	15 mins	40 mins
Canning Town North	17 mins	30 mins	11 mins	30 mins

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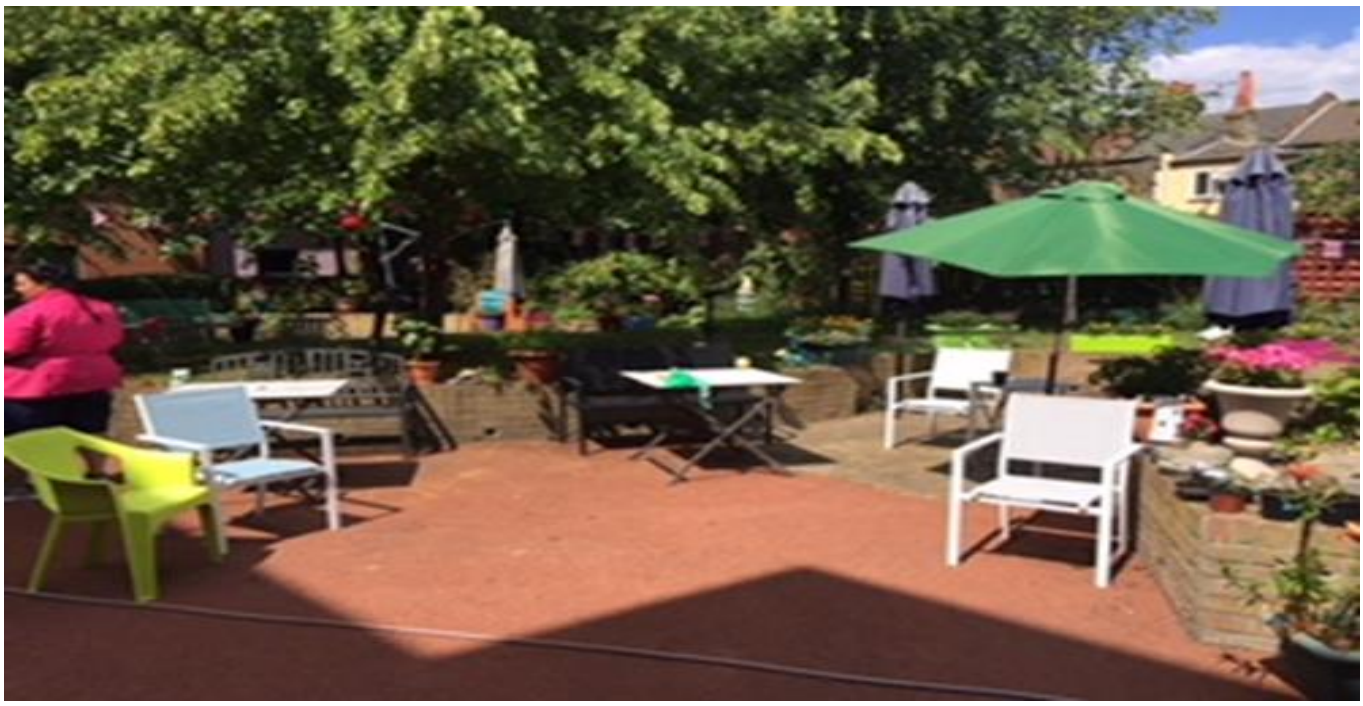
Appendix 3

Images of East Ham Care Centre

Main Entrance – East Ham Care Centre

Atrium Design with cascade of light

Activity Room and access to outside space East Ham Care Centre



Sensory Room and ward layout East Ham Care Centre

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A proposal to permanently locate the inpatient dementia assessment services at East Ham Care Centre

Creating a Centre of Excellence

FREQUENTLY ASKED QUESTIONS

Here we have listed some questions and answers received through stakeholder engagement regarding the change of location for the East London Inpatient Dementia Assessment Unit formerly located at Columbia Ward, Mile End Hospital, (Tower Hamlets) and now based at Cazaubon ward, East Ham Care Centre (Newham).

When and Why did Columbia ward move?

Columbia ward moved from Mile End Hospital in August 2020, this was in response to the Covid -19 pandemic. An urgent requirement for a covid-free, 'green' zone was needed on the Mile End Hospital site. The Green Zone ensures that those people in the clinically extremely vulnerable groups can continue to access and receive treatment from the NHS services at Mile End Hospital. It has been designed to keep patients, staff and family/carers safe, reducing the risk of COVID – 19 infection.

What types of patients are admitted to Cazaubon Ward?

The Ward provides assessment and treatment for people experiencing complex mental health problems associated with degenerative brain disorders such as dementia from Tower Hamlets, City and Hackney and Newham. Each patient receives a thorough assessment of their needs from a wide range of health professionals. Along with input from families, the aim is to provide person centred care by building an understanding of a person's life history in order to meet their individual needs.

How long do people stay on the ward?

It varies but on average, around six weeks.

How will the ward cater for male and female patients?

Cazaubon ward has designated male and female areas, and all of the bedrooms are single and have en-suite facilities to promote privacy and dignity.

Why can't each borough have it's own ward?

This is specialist inpatient unit, the number of people admitted at any one time from City & Hackney, Newham and Tower Hamlets is comparatively small (averaging 5 or 6 patients) it is not possible to staff a ward at borough level for such a small number of patients. Cazaubon ward serves all three boroughs and we have in the Trust other specialist units that provide care and support for a wider geographical area such as; Leadenhall Ward for older people with a functional mental illness, the Coborn Adolescent Mental Health Unit, Rosebank ward, Female Psychiatric Intensive Care.

What other examples are there of specialist services centrally located?

A number of other NHS inpatient specialist services (not provided by ELFT) that serve all of east London also operate in this way. Eg. Specialist eye care (Moorfields), renal unit (Tower Hamlets), cardiology (St Bartholomews, City of London) – all holding outpatient clinics locally - but with inpatient facilities located in one of the east London boroughs to make the best use of resources.

What is the overall impact of this move on patients care and their perception of care provided which Columbia ward couldn't provide?

We are providing equivalent care at ward level in Cazaubon ward, the staff team have transferred with the ward, the main differences are the proximity to colleagues providing specialist and complex dementia care (Sally Sherman ward) and physical healthcare (Fothergill Ward) for the frail elderly all based in the same building providing opportunities for greater seamless working. In addition the improved physical environment, based on the ground floor, access to natural light via the atrium design with access to private gardens, a design specific to older persons care.

What has Cazaubon provided differently from Columbia ward to make this move impactful- how has this impacted on patients' outcomes?

We are continuing to collect relevant data, with a number of outcomes yet to be fully evaluated to measure overall impact but from a patient perspective both the Patient Reported Experience Measures (PREMs), & Friends and Family Test (FFT) have both seen improvements in rating.

Could reduced admissions and Length of Stay be related to COVID -19

While the pandemic had impacted on hospital admissions across all areas, the improved pathway in Cazaubon ward has led to reduced hospital Length of Stay. We are continuing to strive to reduce any unnecessary delay in discharge form hospital

Will all older people's mental health wards be at East Ham Care Centre?

No. Older people with a functional mental illness, such as depression, who need to be cared for in hospital will continue to be cared for on Leadenhall Ward in the Tower Hamlets Centre for Mental Health at Mile End Hospital.

Will all staff transfer to the Cazaubon Ward? Are there to be any job losses?

All staff have transferred to Cazaubon ward. We value all our skilled staff and do not anticipate any reduction in staff.

Is travel support provided for service users, carers and relatives travelling to Cazaubon ward and at what point do carers have information about the travel assistance programme?

When we admit anyone to the ward, we discuss the visiting arrangements and transport needs with carers and family members at the beginning. The criteria for travel support is assessed against the ability of individuals to use their own or public transport to visit. It is an informal process and based on a discussion with the carer/family member themselves. It is not means tested, there is no additional paper work involved and may include the provision of taxis, payment towards parking or provision of hospital transport.

What about parking at East ham Care Centre?

There is Free parking available on site at East ham care Centre.

What about the impact on carers who are frail and will have additional journey time?

We are aware that travelling further could add to the stress of carers who are frail themselves when visiting their loved one. The ward organises the taxis which includes the use of black cabs for wheelchair users and by offering private transport and on-site parking, we hope visits will happen smoothly and without undue stress. During the coronavirus pandemic, we have learned to be creative in enabling carers and patients to stay in touch by using technology too, such as I-pads.

How will you gather feedback on carers experience of travelling to East Ham

When we admit someone, we know we are not just caring for one person; we are caring sometimes for two or more. Our staff come to know carers very well and check-in with them to ensure they feel supported. We have established a carers questionnaire to specifically focus and gather feedback on the new location and travel impact for carers.

What arrangements are in place for the Chardi Jewish Community in north Hackney who cannot travel on the Sabbath?

We are aware of the specific needs of this community, we have identified hotels in the vicinity of East Ham Care Centre that can be walked to on Shabbat to enable visits of their loved one.

Travel Assistance - how many people have actually made use of that and how many have actually been funded?

We are currently gathering transport analysis in terms of usage, we anticipate that because of visiting restrictions in place due to COVID -10 this is likely due to be lower than expected.

What will the additional funding for the environment at Cazaubon ward be used for, how will it enhance the environment?

Additional funding will be used to create clinical areas to receive direct admissions safely in order to respond to infection control measures, environment developments to improve safety; ligature assessment and review, a new therapy room, digital upgrades, including Wi-Fi, space for visitors to be received onto the ward.

Will there be a reduction in the current number of beds?
There are no proposals to reduce beds.

Is this proposal saving money?

This proposal is about improving quality and access to the best care possible. There are no direct savings as result of this change, there are however potential indirect savings through the more effective use of the available estate and buildings.

How will the Cazaubon ward services connect with mental health, community and primary care services?

The inpatient services located at East Ham Care Centre would form part of our comprehensive offer, and be supported by, and complement, the local borough based community mental health and community health provision across City & Hackney, Tower Hamlets and Newham as well as the local Primary Care and G.P services.

When will the decision be made regarding Cazaubon and the permanent arrangements?

We will be receiving initial feedback through stakeholder engagement up to November 2021, this will then be incorporated into a wider public consultation that we intend to launch in December. We are anticipating that a decision can be made on future arrangements on or around March 2022 after all the engagement processes have been fulfilled.

What are the next steps?

We intend to engage and consult with stakeholders initially on our plans to make permanent the move of the Dementia inpatient admission services to East Ham Care Centre.

We are developing our case for change describing the proposed model and have developed a draft communications plan. We will also conduct an Equality Impact Assessment as part of our case for change to help reviewers understand how these proposals impact- positively or negatively on certain protected groups and to estimate whether such impacts disproportionately affect such groups.

We intend to begin the public consultation in early December 2021 and for this to be open and available for feedback for a period of 12 weeks after which it will then conclude.

After the consultation closes, we will provide a further report to formally review our plans and the feedback we have received from the public consultation.

We expect that the timeframe to provide this feedback will be from early March 2022.

How can I get involved?

Involvement from all stakeholders is welcomed.
Opportunities to share insight, ideas and opinions will be shared and promoted through social media, the media, partner organisations, open invitations and through a dedicated section on the ELFT website which will include a portal to submit questions and queries.

Title of report:	**Neighbourhoods - Progress in 2021/22 and Future Plans**
Date of meeting:	14 October 2021
Lead Officer:	Nina Griffith
Author:	Mark Golledge
Committee(s):	The messages in this paper have been taken to the following Committee's: ● Neighbourhoods Steering Group - for agreement - 13th July 2021 ● System Operational Command Group - for agreement - 29th July 2021 ● Finance and Performance Subcommittee - for agreement - 26th August 2021
Public / Non-public	Public

Executive Summary:

The purpose of this paper for the Integrated Care Partnership Board (ICPB) is twofold.

The first is to provide ICPB with an update on progress against the commitments for the Neighbourhoods Programme in 2021/22. The paper describes progress being made against the six priorities agreed for 2021/22 with ICPB Members and specifically details work being undertaken on evaluation and communications.

The second is to outline to ICPB the longer-term sustainability plans for Neighbourhoods. Work funded through the programme is designing new Neighbourhood-based service models to support residents across City and Hackney. In October/November plans are intended to be submitted detailing proposals for resident involvement, community and voluntary sector engagement alongside plans for the remaining transformation projects that will be progressed in 2022/23.

Recommendations:

The **City Integrated Care Partnership Board** is asked:

- Review progress across the programme that is being made in 2021/22 and note activities being undertaken on evaluation and communications in particular (given interest from ICPB members previously).

Hackney

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NHS North East London Clinical Commissioning Group

- Note the Sustainability Plans for Neighbourhoods and proposals that will come back to ICBP in November for:
    - Proposed sustainable Neighbourhood models for resident involvement (Healthwatch), community engagement (HCVS) and community pharmacy
    - Programme funding to support remaining projects in 2022/23 to determine and implement Neighbourhood models.

The **Hackney Integrated Care Partnership Board** is asked:

- Review progress across the programme that is being made in 2021/22 and note activities being undertaken on evaluation and communications in particular (given interest from ICPB members previously).
- Note the Sustainability Plans for Neighbourhoods and proposals that will come back to ICBP in November for:
    - Proposed sustainable Neighbourhood models for resident involvement (Healthwatch), community engagement (HCVS) and community pharmacy
    - Programme funding to support remaining projects in 2022/23 to determine and implement Neighbourhood models.

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	X	A key part of our approach to Neighbourhoods is enabling a greater focus on prevention and addressing local health inequalities. This includes putting a greater emphasis on community navigation (non-medical support). There is work that primary care with system partners will need to deliver this year on health inequalities.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	X	Neighbourhoods is bringing together proactive models of care and support that are wrapped around each Neighbourhood. This will enhance multi-agency working and support from residents and deliver care closer to home.
Ensure we maintain financial balance as a system and achieve our financial plans	X	As we see more resources come into the community whether through recruitment to new roles, through links with voluntary

		sector provision or a closer link from specialist services with community-based teams we would like to see this delivering more effective community based care.
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	X	Neighbourhoods is focused on delivering integrated and coordinated care and support for residents. This includes but extends beyond just physical health. The wider engagement of both voluntary sector organisations as well as wider council services remains key to achieving the overall vision.
Empower patients and residents	X	Healthwatch have led work across Neighbourhoods and with the Neighbourhoods Resident Involvement Group to develop a charter for co-production and community involvement. Programme leads involved in Neighbourhoods have been undertaking sessions jointly with residents on how to embed this way of working in redesign work.

Specific implications for City

Much of the redesign work taking place across community services (whether it is recruitment to additional roles in primary care) or reconfiguration of services such as community nursing or mental health will be for City of London residents.

The City of London Corporation has continued to play an active role in the programme to shape strategic and operational plans.

The priorities and projects described are as relevant for City of London as they are for Hackney.

Specific implications for Hackney

The new care models being developed are relevant for Hackney. This includes specific work led by LB Hackney (in areas such as adult social care and children's services) as well as work being undertaken by partners that will benefit City residents. The new models of care described within the proposals already (and will continue) to involve a range of Hackney services.

Patient and Public Involvement and Impact:

The Neighbourhoods Resident Involvement Group continues to play an important role within the overall programme. This group brings together residents and is supported by Healthwatch.

The wider work being undertaken by Healthwatch and HCVS has similarly played an important role over the last year through the delivery of the Neighbourhood Conversations which are increasingly involving residents.

Many of the Neighbourhood service models being introduced have been based on wide ranging resident and patient involvement including work in community nursing, mental health and adult social care.

Clinical/practitioner input and engagement:

This is a system wide programme with partners owning the programme collectively.

Clinical input and engagement remains a key part of the programme. Proposals provided by individual partners have been shaped by practitioner engagement within individual services.

Communications and engagement:

The paper outlines plans that are being taken forward for both resident and practitioner communications.

We are planning to deliver a series of outputs both for residents and for those people that work in City and Hackney which explains the work underway and the difference we hope that this new way of working will have.

Equalities implications and impact on priority groups:

Helping to address inequalities (both of access to services and of outcomes) is a key purpose for Neighbourhoods. Neighbourhoods are about bringing together services (including voluntary and community sector) to work with residents to improve outcomes for populations of 30-50,000 people.

Specific work will be taken forward by Primary Care (PCNs) with their system partners over the course of this year to identify and address specific identified health inequalities. This will draw on intelligence and insight already gathered.

Safeguarding implications:

The original vision for Neighbourhoods was developed out of a need to improve multi-agency working in relation to safeguarding. This remains a core focus of the programme and the multi-agency working that has been increased through the programme has had a specific safeguarding focus.

Impact on / Overlap with Existing Services:

Neighbourhoods is about improving multi-agency working between community-based services (such as voluntary sector, mental health, social care) as well as blurring the lines with specialist support services. In addition, the focus of Neighbourhoods remains to improve services and support being delivered to residents in the community.

Main Report

Please see accompanying paper

Supporting Papers and Evidence:

None - see supporting paper.

Sign-off:

See Committee's identified above.

Hackney

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North East London
Clinical Commissioning Group

Title: Neighbourhoods: Progress in 2021/22 and Future Plans

From: Nina Griffith
Author: Mark Golledge
Date: August 2021

Integrated Care Partnership Board is asked to:

- Review progress across the programme that is being made in 2021/22 and note activities being undertaken on evaluation and communications in particular (given interest from ICPB members previously).
- Note the Sustainability Plans for Neighbourhoods and proposals that will come back to ICBP in November for:
    - Proposed sustainable Neighbourhood models for resident involvement (Healthwatch), community engagement (HCVS) and community pharmacy
    - Programme funding to support remaining projects in 2022/23 to determine and implement Neighbourhood models.

1. Purpose

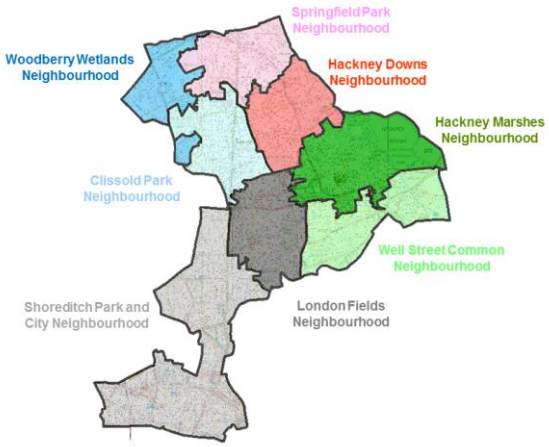
1.1. The purpose of this paper for the Integrated Care Partnership Board (ICPB) is twofold.

1.2. The first is to provide ICPB with an update on progress against the commitments for the Neighbourhoods Programme in 2021/22 *(sections 3, 4 and 5 below)*. The paper describes progress being made against the six priorities agreed for 2021/22 with system partners and specifically details work being undertaken on evaluation and communications.

1.3. The second is to outline to ICPB the longer-term sustainability plans for Neighbourhoods *(section 6)* including plans that will be submitted in October / November detailing sustainable Neighbourhood models alongside plans for the remaining transformation projects in 2022/23.

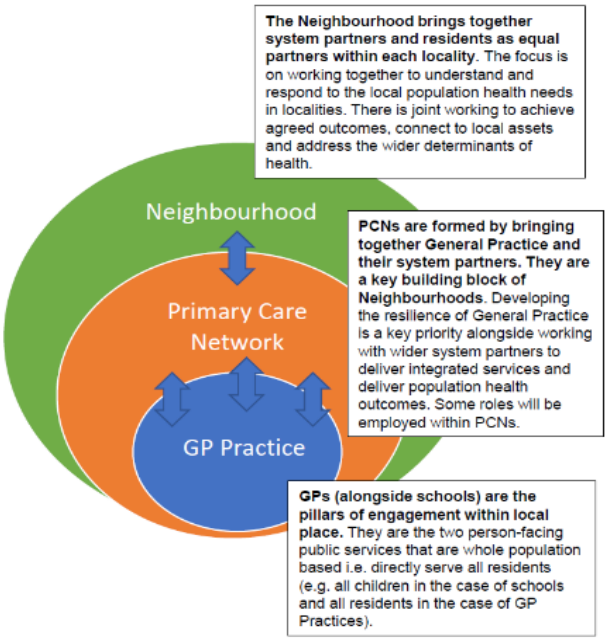
2. Neighbourhoods - A reminder

2.1. Neighbourhoods is our major transformation programme across City and Hackney for the redesign of community services locally. The programme is provider led.



2.2. Neighbourhoods are critical to the delivery of integrated care and provide the geography around which we are aligning many of our health and care services. They are crucial in working together as system partners to address health inequalities.

2.3. We are already bringing together these services, supporting multi-agency working and adopting a more strengths-based approach that focuses on what matters to residents. As a local system we want 'place' rather than 'organisation' and 'conversation' rather than 'referral' to be the currency of integrated service provision locally. We want to ensure that residents receive care and support that is closer to home, based on what matters to them and in a way which means they do not have to tell their story multiple times.



2.4. Neighbourhoods is the way in which we want to bring all system partners together as equal partners to meet the population health needs within each local area. Primary Care Networks (already configured around the 30-50,000 footprint) are the key primary care building block of the Neighbourhood.

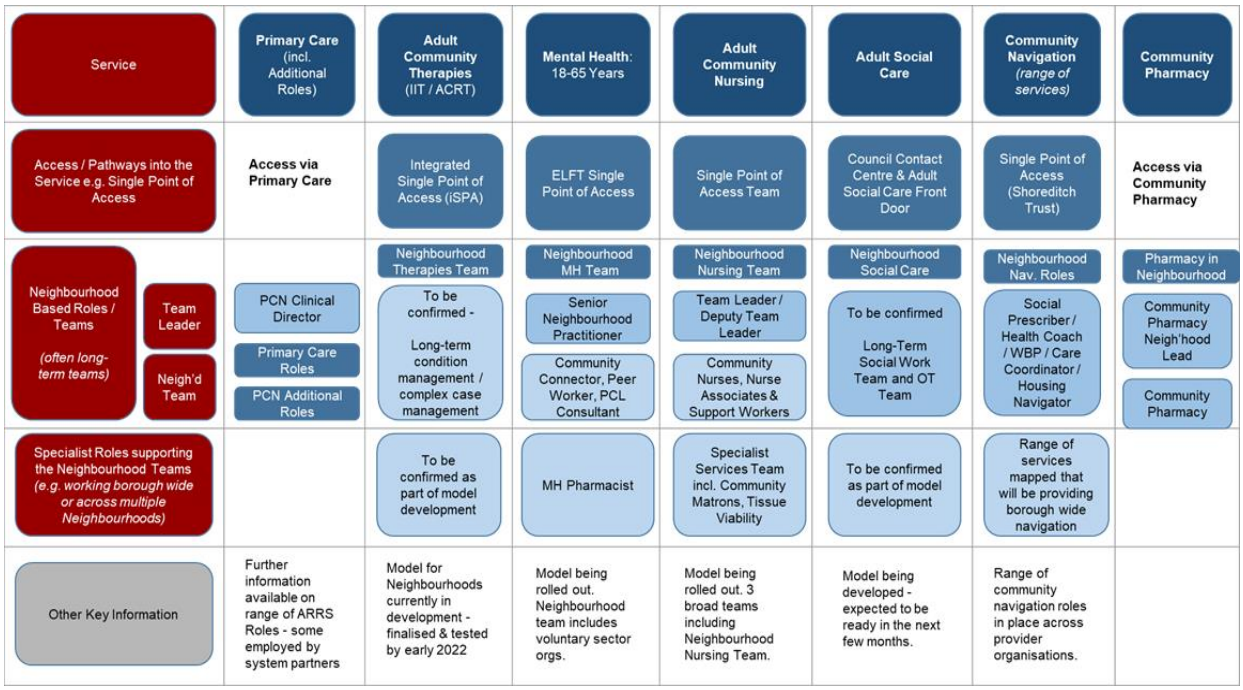
3. A Summary of Progress - 2021/22

3.1. The transformation programme is redesigning the ways that community services are delivered across City and Hackney. 12 system partners are being funded through the programme to develop and implement new models of care and support for residents.

3.2. In 2021/22 the programme is receiving £1.144m (including additional activities funded by reserve totals bringing the total amount to £1.285m). A more detailed breakdown by providers and funding is available in the Appendix.

3.3. 6 priorities have formed the basis of activities in 2021/22. These were agreed with ICPB earlier in 2021 and progress against these areas is summarised in the Appendix. A quarterly review of progress with all partners continues to take place with providers across the programme via the Neighbourhoods Steering Group.

3.4. We are now seeing multi-disciplinary teams forming within the 8 Neighbourhoods providing support to residents. In practice this means an increasing number of practitioners working with residents within an individual Neighbourhood, delivering services closer to home and providing the opportunity for better coordination of care and support.



High level summary of redesign work underway in services including creation of Neighbourhood-based teams..

3.5. For example, Primary Care (through Primary Care Networks) are bringing in new services through Additional Roles in areas such as health coaching, first contact physiotherapists and clinical pharmacists; Mental Health are finalising the rollout of Neighbourhood-based Mental Health teams (including primary care and voluntary sector) and other community partners are implementing Neighbourhood models including Adult Community Nursing, Adult Community Therapies (Integrated Independence Team and Adult Community Rehabilitation Team) and Adult Social Care.

3.6. Improvement work is also being undertaken to improve access and pathways into services and enable more responsive services. For many services this includes an improved single point of access to make it easier to refer residents for support and reduce duplication and hand-offs to teams. Importantly, it is also intended to improve access into non-medical support for residents ("community navigation").

3.7. Work is also underway to align many of our community navigation providers around the Neighbourhoods. Roles such as social prescribers, health coaches, Wellbeing Practitioners and housing navigators (via Engage Hackney) are now supporting residents across a Neighbourhood. Shoreditch Trust are currently facilitating an Information Hub to help improve access to

these roles and also facilitating networks within Neighbourhoods that bring together these frontline wellbeing roles.

3.8. As practitioners now start to come together within each of the Neighbourhoods workforce development and OD (priority 3) will become more important. Work has been undertaken across providers on Neighbourhood (i.e. multi-agency) workforce priorities and will be discussed with the Workforce Enabler (Training Hub) in September. A key part of Neighbourhoods remains around the cultural changes between teams and with residents.

4. Evaluation

4.1. Individual services have established / are in the process of establishing their own evaluation frameworks for the redesign work being described above. Mental Health have developed this and Adult Social Care and Adult Community Nursing are currently developing these (other services will follow). These frameworks focus on a broad range of areas including patient experience, patient self-reported outcomes as well as measures focusing around timeliness of care delivery.

4.2. Cordis Bright are also supporting evaluation work across the Neighbourhoods Programme as a whole. This work is being overseen by the City and Hackney Evaluation Steering Group (as well as the Neighbourhoods Steering Group). The focus of the work is three-fold:

- **To develop a theory of change and evaluation framework for our integrated care model for older adults**. Called 'anticipatory care' (and part of our ageing well ambitions) this work is delivering a more proactive and multi-disciplinary approach to care and support for older adults with moderate or severe frailty. It is aiming to keep people well, at home and independent for longer. Cordis Bright has now completed this work.

- **To undertake a stock-take of Neighbourhoods and produce a set of recommendations to help shape the future direction.** This work is currently underway (and due to be completed in October 2021) and is being undertaken through focus groups (x4), 1:1 interviews (x25) and an e-survey across practitioners (currently 140 responses). The recommendations will inform plans for 2022/23 (see below).

- **To develop an overall theory of change and evaluation framework for Neighbourhoods**. This work is scheduled to take place after the stock-take report (above) is completed and due to be completed by December 2020. The expectation is that individual services (e.g. adult community nursing) develop their own approach to evaluation, but this will be undertaken across the programme as a whole.

5. Communications and Neighbourhoods

5.1. When presenting the request for funding in 2021/22 a request from some members of ICPB was to undertake work across the programme to "launch" Neighbourhoods and improve communications both with residents and with practitioners.

5.2. The specification for this work has been developed across provider organisations, with residents (via the Neighbourhoods Resident Involvement Group) and with the input of the Communications Enabler. Approval has been given for this to be funded via the Communications Enabler funding and has received support from the Board.

5.3. This work is underway and two local organisations have been appointed to support with a range of outputs as described below.

- *Creation of an overarching Neighbourhoods website for practitioners and for the public (mainly static information)*
- *Production of 2 videos which describes Neighbourhoods and what this means in terms of health and care (one for residents and one for practitioners)*
- *Real life (anonymised) case studies which explain the impact of Neighbourhood-based working for residents*
- *A press release to "launch" Neighbourhoods to residents*

5.4. Work is now commencing on this with a small group of residents, frontline practitioners, Primary Care Networks supporting the development of this work with the 2 external agencies. It is expected that this work will continue with the majority of outputs being finalised by January 2022. The Communications Enabler will be kept updated with progress.

6. Neighbourhood Project Sustainability

6.1. The Neighbourhoods Programme is being funded through the Better Care Fund (BCF). It is being used across the programme as transformation funding facilitating redesign work across 12 organisations in City and Hackney that provide community-based services. In the majority of these organisations the funding is being used for project / practitioner capacity to both carry out redesign work and then support implementation of new models (e.g. adult social care).

6.2. When the request for Neighbourhoods funding was presented to ICPB for 2021/22 there was an ask that the sustainability strategy for all projects was made clear. Many partners are now at the point in the programme where they are finalising proposed new Neighbourhood service models (in the case of adult community nursing and mental health have already been confirmed and are being implemented).

6.3. As service models are implemented and become business as usual the level of resourcing through the BCF will reduce for Neighbourhoods. This reduction will be seen from 2022/23 but there will be a need for some continued non-recurrent funding in 2022/23 to enable finalisation of remaining service models (where they are not yet confirmed) and support implementation of the new service models that are agreed and to implement these.

6.4. Partners have been asked to aim for October/November for presentation of these. The service models that are being finalised are:

- **Neighbourhood Community Involvement (HCVS and Healthwatch)** - Proposals are anticipated from HCVS and Healthwatch based on the VCS Neighbourhood pilot in Well Street Common, the Neighbourhood Conversations and Healthwatch work with Volunteer Centre Hackney on Neighbourhood Community Development. This will be formed of two separate but connected proposals.

- **Community Pharmacy (Local Pharmaceutical Committee)** - 8 Community Pharmacy leads have been funded since the Neighbourhood Programme inception. These lead roles have supported coordination amongst Pharmacies in their individual Neighbourhood and have an externally facing role with wider PCNs.

- **Adult Social Care (LB Hackney)** - Plans are being reviewed for the redesign in adult social care. Initial plans to merge the Information and Assessment and Long-Term teams have been changed with plans now to keep these teams remaining as separate functions. The intention is still to progress with redesigning the service so that the long-term team and Occupational Health team casehold on a Neighbourhood-basis.

6.5. From a financial perspective, these models will fall into one of three areas:

a. *There will be some proposals (e.g. Adult Social Care) where existing recurrent funding streams are in place and the proposed service model will remain cost neutral.*

b. *There will be some proposals which already have recurrent funding streams in place but the proposed new service model will come with additional cost pressure. It will be for system partners to review the cost/benefit of these proposals (based on the business case submitted) and make a decision as to whether any additional cost should be funded.*

c. *There will be some proposals (e.g. Healthwatch, HCVS and Community Pharmacy) that do not have existing recurrent funding streams in place and the proposed model will come at a cost. It will be for system partners to review the cost/benefit of these proposals (based on the business case*

submitted) and make a decision as to whether this additional cost should be funded. It is envisaged that this could be funded via the Better Care Fund using the amounts already invested in the Neighbourhoods Programme.

6.6. **We are therefore working on the basis of proposals coming from Hackney CVS (community engagement), Community Pharmacy and Healthwatch (resident involvement) in October/November.**

6.7. **This will be alongside a request for non-recurrent Neighbourhood Programme funding for 2022/23 to ensure that the remaining projects can finalise and implement their Neighbourhood service models.** This non-recurrent request for 2022/23 is expected to include:

- Residual funding for Adult Community Nursing and Mental Health to embed their new Neighbourhood structures
- Funding for Adult Community Therapies to finalise their new service model (planned by January 2022) and support implementation.
- Development of the Long-Term Condition (Planned Care) Neighbourhood Model in 2022/23.
- Support to establish the model for Neighbourhood Governance / Partnerships (proposed model by June 2022).
- Completion of children and young people Neighbourhood improvement projects.
- Continued funding for the City of London Corporation to support the Neighbourhoods Programme.
- Some non-recurrent coordination programme funding for the Central Neighbourhoods Team.

6.8. The timescales for submission of all the proposals outlined above are planned as follows:

Board	**Meeting Date**
Neighbourhoods Steering Group (to be called 'Neighbourhood Providers Alliance Group')	Tuesday 12th October 2021
System Operational Command Group (to be called City and Hackney Delivery Group)	Thursday 21st October 2021
Neighbourhoods Health and Care Board	TBC (date being confirmed)
CCG Finance and Performance Sub-Committee	Thursday 28th October 2021
Integrated Care Programme Board (ICPB)	Thursday 11th November 2021

Appendix: Detailed Progress - At Quarter 1 2021/22

The funding position for Neighbourhoods is described below at Quarter 1 2021/22. The Better Care Fund allocation for 2021/22 is £1.144m. Funding which includes activities funded via reserve totals is £1.285m.

As at Quarter 1, the programme is projecting an underspend of £34k for the full year. The underspend is due to slightly later than planned recruitment across a number of services and some planned activities not yet taking place due to COVID. This excludes any block arrangements (for Homerton and ELFT) and excludes a Primary Care Network Organisational Development (OD) fund which has been allocated to them for their collective and individual development.

	2021/22 Funding					
		Annual Budget £	YTD Actual (Q1 2021/22) £	2021/22 Forecast Outturn £	2021/22 Under/ (Overspend) £	2021/22 Under/ (Overspend) Excluding Block Arrangement - NHSE/I Guidance
	Neighbourhoods Funding 2021/22 (Incl. agreed Non Recurrent funding from Reserve.)	**£1,285,475**				
	Expenditure					
1	Homerton University Hospital (Adult Community Nursing & Therapies)	£146,837	£18,254	£143,665	£3,172	
2	East London Foundation Trust (Mental Health)	£158,151	£37,363	£127,439	£30,712	
3	London Borough of Hackney (Adult Social Care)	£157,306	£38,360	£157,239	£67	£67
4	Office of PCNs *(part of GP Confederation billing - note VAT not included)*	£94,500	£7,735	£84,261	£10,239	£10,239
5	City of London	£20,000	£5,000	£20,000	£0	£0
6	Healthwatch Hackney	£60,000	£13,330	£59,266	£734	£734
7	Hackney CVS	£229,283	£43,456	£226,245	£3,038	£3,038
8	Community Pharmacy	£55,200	£10,450	£47,454	£7,746	£7,746
9	Planned Care (CCG)	£47,307	£11,827	£47,307	£0	
10	Children, Young People and Families (LBH)	£81,406	£1,478	£69,004	£12,402	£12,402
11	Central Neighbourhoods Team (HUH)	£187,710	£31,293	£164,974	£22,736	
12	PCN Clinical Directors *(part of GP Confederation billing - note VAT not included)*	£47,775	£5,551	£22,318	£25,457	£0 Funding ringfenced
	Sub Total cost	**£1,285,475**	**£224,096**	**£1,169,171**	**£116,304**	**£34,227**
	Surplus/(Deficit)	**£0**	**£224,096**	**£1,169,171**	**£116,304**	**£34,227**

Progress against each of the funded projects (at Quarter 1 2021/22) is provided below. Projects have been RAG assessed by providers.

Project RAG rating based on the following:	**Green:** Project underway, milestones on track and no major issues to delivery	**Amber:** Project underway, some milestones delayed, some minor issues to delivery	**Red:** Project either not yet commenced or underway but with major issues to delivery. Support required.

PRIORITY 1 To take a more proactive and joined up approach to supporting City and Hackney residents with rising needs *(Supports PCN Maturity Matrix - Integrating Care)*	**Supporting Children (0-5s)**	**Amber RAG**	• Workshop held with system partners to inform work for 0-5s. • **Woodberry Wetlands:** Improvement project underway in Woodberry Wetlands with MATs and multi-agency working with primary care. Recommendations to be formed in Q2 for spreading to other MATs across City and Hackney. • **All areas:** Improvement project underway in respect of GP link meetings (with health visiting, maternity) to improve multi-agency working for 0-5s. • Specific task groups formed to support the project work identified above.	**Facilitated by**: Children and Young People's Workstream
	Supporting Young People (6-19s)	**Amber RAG**	• Workshop held with system partners to inform work for 6-19s. • **All areas:** Links made between GPs and Schools - 9 GP surgeries signed up to be part of the pilot. Session being held with Headteachers as part of the pilot in early September for integrated working. • Wider session with all Headteachers planned for October.	
	Mental Health in Neighbourhoods	**Green RAG**	• **All areas:** Neighbourhood Mental Health Teams continuing to be rolled out. • Work underway to review and develop an ELFT Single Point of Access (previously CHAMRAS service). • Susan Study stepping in temporarily into the Operational Lead role for Neighbourhoods. Each Neighbourhood managed by a a Senior Neighbourhood Practitioner (although Community Connectors have links back into their organisations). • Work underway with PCNs on ARRS roles for Mental Health.	**Facilitated by**: East London Foundation Trust with input from system partners
	Long-Term Conditions and Community Gynaecology	**Amber RAG**	**Community Gynae Pilot (Hackney Marshes):** • Second phase of the pilot in Q1 2021/22 focused on establishing community based and virtual clinic activity (7 face-to-face clinics at Lea & Lower Clapton seeing 37 patients), 3 virtual group consultations in menopause (attended by 14 patients) and 2x GP education sessions based on case discussions. To continue development in Q2 and monitoring taking place. **Long-Term Conditions:** • Proposal developed for Neighbourhood-based Renal Pilot (Neighbourhood tbc). Diabetes virtual engagement event held in Hackney Marshes to replicate learning from Community Gynae event. • In Q2 pilot of asthma virtual event in August 2021, develop plans for Renal Pilot with Barts and complete stroke patient engagement.	**Facilitated by**: CCG Long Term Conditions Team with input from system partners

	Anticipatory Care and Ageing Well	**Amber RAG**	• **Springfield Park:** Pilot launched focusing on supporting patients with moderate frailty. • Development of person-centred care and support plan and pathway for the work. • Work underway with CEG to support recording of information within EMIS as part of the pathway. • Work underway to recruit to care coordinator to be able to assist the pilot. • Desk-based audit of moderate and severe frailty to commence in Q2 - will be undertaken across all PCNs to help inform future model for anticipatory care.	**Facilitated by**: Homerton University Hospital with input from system partners including adult social care

PRIORITY 2 To continue to redesign services that will make up Neighbourhood based blended teams to support residents identified in priority 1 *(Supports PCN Maturity Matrix - Integrating Care)*	**Adult Community Nursing Neighbourhoods Model**	**Green RAG**	• **All areas:** Consultation completed with staff on the new Nursing structure & significant staff feedback. • Senior managers in post for Neighbourhood team, specialist team and single point of access team. • New Community Matron model goes live from 2nd August (will take 6-8 weeks to implement). • New service hours go live on 13th September - comms being sent to patients and partners. • Remodelling of RiO underway to support data collection. KPIs for the new Nursing team to be agreed. • London Fields & Shoreditch Park will be the first team to split into Neighbourhood teams in September - remaining Neighbourhoods in October.	**Delivered by:** Homerton University Hospital
	Adult Community Therapies Neighbourhood Model	**Amber RAG**	• **All areas:** Development of proposed service model for Adult Community Therapies underway. • Engagement workshops with staff (IIT & ACRT) completed - including discussions on plans for an integrated single point of access and prospective audit for mapping demand across the service. • KPIs / measures identified for Adult Community Therapies as part of the redesign work. • Next quarter involves logistical planning to setup and pilot the integrated single point of access (will be integrated across IIT/ACRT/IDS).	**Delivered by:** Homerton University Hospital
	Adult Social Care (LBH) Neighbourhoods Model	**Amber RAG**	• **All areas:** Updated Neighbourhoods model which include caseholding teams for Long-Term & OT teams. • This will be a separate front door team into the Council and Information and Assessment Team in ASC. • Review of data underway to understand capacity and demand for Long-Term and OT teams. • Work next quarter to support the new model including finalising staffing and demand. • Work to take place to improve front-door activity including a more strengths-based approach.	**Delivered by:** LB Hackney

	Neighbourhoods Home Care Model (LBH)	**Green RAG**	• **London Fields & Shoreditch Park and City:** Kicked off a pilot to deliver more outcomes based support planning in home care with 9 residents - evaluation to commence in Q2. • All home care agencies now attended Neighbourhood MDMs and being invited as standard for residents in receipt of home care • Home care recommissioning - significant consultation to inform redesign has taken place led by Healthwatch Hackney. Co-production group in process of being established.	**Facilitated by:** LB Hackney
	Community Pharmacy Model	**Amber RAG**	• **All areas:** 6 of 8 Neighbourhood Pharmacy leads currently in post (recruitment to commence where there are 2 vacancies in Clissold Park and London Fields). • Joint working between Clinical Pharmacists and Community Pharmacists taken place in Springfield Park. • Principally most work taking place on GP Community Pharmacy Consultation Service & preparing for Covid booster/flu season.	**Delivered by:** Local Pharmaceutical Committee
	Community Navigation Neighbourhoods (Funded separately)	**Amber RAG**	• **All areas:** Work paused on single navigation referral form so that further feedback from primary care can be gained. • Neighbourhood Navigation Networks (bringing together Wellbeing roles) underway in 2 Neighbourhoods. • Business case work due to recommence for community navigation and supporting investment. • GP Confederation aligning Wellbeing Practitioner roles to 6 Neighbourhoods.	**Facilitated by:** Central Team & Public Health

PRIORITY 3 To provide coaching and OD support to Neighbourhood based	**Neighbourhoods OD and Coaching Plan** *(relevant to but not funded through Neighbourhoods)*	**Amber RAG**	• **All areas:** This project was originally proposed to be led by the Workforce Enabler • Presentation planned to the workforce enabler in September to assist with future plans for workforce development and OD. • Early discussion being held with Neighbourhoods Steering Group on this in August to inform the September presentation. • LB Hackney have established their own Organisational Development Board - it will be important for the Workforce Enabler to link with the LBH OD Board. • The LB Hackney work includes considerations of work around inclusive leadership, relational working and trauma informed approaches.	**Facilitated by:** With Workforce Enabler

teams that enhance trust and supports collaborative working *(Supports PCN Maturity Matrix - Integrating Care)*	**MDT Coaching and Training** *(funded by Training Hub but relevant to Neighbourhoods)*	**Amber RAG**	• **All areas:** Melanie Strachan now in post (shared between Central Neighbourhoods Team and Office of PCNs) and will support in taking forward the external coaching and OD support for MDTs. • This is with funding that was received from the Training Hub. • The specification has been drafted on this and over the next few weeks we will be re-engaging partners on this with a view to re-commissioning that work. • This will support MDT working within Neighbourhoods.	**Facilitated by:** Central Neighbourhoods Team
	Neighbourhood/ PCNs staff engagement events	**Red RAG**	• **All areas:** Given COVID and in light of capacity challenges within the team this has now yet been arranged. • Further discussions needed as to whether and when we should be considering whole staff engagement events e.g. reinstating previous Quadrant Meetings. • There may be benefit in waiting until later in the financial year when many of the roles will have been aligned around the Neighbourhoods. • This will need to be a collaborative piece of work between Central Neighbourhoods Team, PCNs (including PCN Development Managers) and system partners. • We would want this to take place across all Neighbourhoods.	**Facilitated by:** Office of PCNs/Central Neighbourhoods Team
	Neighbourhood inductions for Neighbourhood Teams (to voluntary sector)	**Amber RAG**	• **All areas**: As part of plans for 2021/22 HCVS have offered to arrange for inductions for practitioners and voluntary and community sector organisations into the Neighbourhoods (ahead of the Neighbourhood Conversations). • Take up has so far been low but we should encourage more of a focus in Q2 and there will be more opportunity as teams are aligned to the Neighbourhoods. • Further promotion on this will be undertaken throughout the course of 2021/22.	**Led by:** Hackney CVS

PRIORITY 4 To establish meaningful and sustainable approaches to resident involvement and integration of VCSE services in a Neighbourhood where both feel connected and have influence. *(Supports PCN Maturity Matrix - Engaging with People and Communities)*	**Neighbourhoods Resident Involvement and Model Development**	**Green RAG**	**a). Piloting the rollout of Community Influencers to complement existing engagement forums:** ● **Shoreditch Park and the City:** Linking of Community Influencers into Community Forum. Write up of Community Influencer pilot underway and will be shared with partners. ● **Shoreditch Park and the City:** City of London focusing on resident engagement to inform the Health and Wellbeing Strategy (Volunteer Centre Hackney won the bid for this contract based on the learning from the Hoxton Community Influencer Pilot). **b). Embedding co-production across the Neighbourhoods programme:** ● **All areas:** Co-production workshop held with NRIG and service providers to produce a co-production toolkit. NRIG sharing this to help refine content for overall Co-Production Charter for City and Hackney. **c). Identify existing resident involvement and channels of involvement within Neighbourhoods and work with partners to develop proposals for future involvement approaches:** ● **All areas:** Commenced review of a diverse resident engagement channels working with colleagues from NHS Community Voices, HCVS, ELFT, Healthwatch CoL, PCNs and more informal resident groups. ● The review of resident engagement channels and associated interviews will inform development of a Neighbourhood resident involvement model (planned for October).	**Led by:** Healthwatch Hackney and City of London
	Voluntary and Community Sector Neighbourhoods Involvement and Model Development	**Green RAG**	**a). Continued delivery of Neighbourhood Conversations across Neighbourhoods:** ● **All Neighbourhoods (except 2 below with other structures):** Neighbourhood Conversations held including discussions with residents around long COVID and community navigation. ● HCVS and Healthwatch working to increase resident involvement in Neighbourhood Conversations (e.g. working with Engage Hackney) - PCNs promoting and sharing information. ● **All areas:** Ongoing monitoring and support of small grants forums (£1,000 to 11 organisations to deliver activities across all Neighbourhoods). ● **All areas:** Bespoke equality, diversity and inclusion training carried out - raised awareness of discrimination, unconscious bias and practical ways to support diversity and equality. **b). Continued development of the partnership approach developed in Well Street Common / Shoreditch Park and the City:** ● **Well Street Common:** Ongoing support for "Well-Being Partnership" and Well Street Common Core Group. Mental Health Working Group now in place in Well Street with regular engagement with PCN to improve engagement. ● **Shoreditch Park and the City:** Shoreditch Trust and Social Innovation for Change facilitating forum design sessions. Plans to finalise co-produced local governance structure for Shoreditch Park and the City in Q2.	**Led by:** Hackney CVS

PRIORITY 5 Test and begin to establish both operational team working (for Neighbourhood blended teams) and strategic partnership arrangements in each Neighbourhood *(Supports PCN Maturity Matrix - Integrating Care)*	**Development of Strategic Partnership (Governance arrangements) in the Neighbourhoods**	**Amber RAG**	• Session held with partners in July to develop an approach for bringing together a strategic partnership group (e.g. Neighbourhoods Delivery Group) in each of the 8 Neighbourhoods. • **Well Street Common / Shoreditch Park and City:** The intention is to co-design this in Well Street Common followed by Shoreditch Park and the City before developing a model across all Neighbourhoods. • Some challenges around understanding / commitment to this but will need to be worked through as this gets off the ground.	**Facilitated by:** HCVS working with Office of PCNs and Central Neighbourhoods Team
	Workforce development at an operational level within Neighbourhoods		• This is covered in priority 3.	**Facilitated by:** Office of PCNs in collaboration with Central Neighbourhoods Team

PRIORITY 6 Put in place arrangements needed to improve our knowledge of local health outcomes and inequalities and work together to address these with PCNs *(Supports PCN*	**Neighbourhoods Population Health Plan Development Plans**	**Red RAG**	• **All areas:** There was a commitment in the request for funding for 2021/22 to develop a simple population health plan with each of the 8 Neighbourhoods. • This is likely to be dependent on the formation of the Neighbourhood Partnerships (e.g. Neighbourhoods Delivery Group) defined in Priority 5. • No work has yet commenced on this - and will be dependent on some available project resource within the Neighbourhoods.	**Facilitated by:** Individual Neighbourhoods (with input from Population Health Enabler)
	Support PCNs with Health Inequalities DES	**Commencing**	• From October PCNs (via the National Contract) are expected to identify and engage a community experiencing health inequalities to co-design and intervention to address the needs of this population. • By February 2022 PCNs must have finalised their plans to tackle the unmet needs of the selected populations and deliver the plan from March 2022. • System partners will be working with PCNs on implementing this.	**Facilitated by:** Office of PCNs in collaboration with Central Neighbourhoods Team

Maturity Matrix - Data and Population Health Management)	**Population Health Academy - Wave 3** (Hackney Marshes)	**Green RAG**	• **Hackney Marshes:** Partners made a commitment as part of Neighbourhood Plans for 2021/22 to support engagement in the NHSE/NHSI Population Health Academy. • This is a 20 week programme facilitated by NHSE/I and Optum to develop population health approaches in the PCNs. • Hackney Marshes has been selected as the PCN to be involved from City and Hackney (one PCN per ICP). • This is important as it will help us develop and embed a population health approach across all local areas in the future. • Work will need to be undertaken with Hackney Marshes PCN to ensure that wider system partners are engaged in the programme as it progresses.	**Facilitated by:** NHSE/I with PCNs and other system partners to be confirmed Christine Sanders is contact for Hackney Marshes: christine.sanders2@nhs.net

Title of report:	Consolidated Finance (income & expenditure) 2021/2022 Month 05
Date of meeting:	14 October 2021
Lead Officer:	Sunil Thakker, NE London CCG
Author:	Fiona Abiade for Integrated Commissioning Finance Economy Group
Presenter:	Sunil Thakker, Executive Director of Finance, NE London CCG Ian Williams, Acting Chief Executive, London Borough of Hackney
Committee(s):	City Integrated Commissioning Board Hackney Integrated Commissioning Board Transformation Board
Public / Non-public	Public

Executive Summary:

At M5, City & Hackney Integrated Care Partnership (CH ICP) reported a breakeven position. At month 05 NEL CCG have reported a break-even, year to date and H1 forecast position (budgets have been set for the first 6 months of the financial year (H1) across the three integrated care partnership systems for NEL CCG).

At month 5, LBH is forecasting an overspend of £3.7m after the application of one-off funding of £3.5m. This compares to a 2020/21 outturn position of £8.6m overspend (this included £6.5m of which was attributed to Covid-19 expenditure).

At Month 5, the City of London Corporation is forecasting a year end adverse position of £0.2m and a YTD position of £0.6m favourable. The forecast over spend is being driven by Child Social Care and Older people

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	☐	
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	

Hackney

CITY OF LONDON

NHS North East London Clinical Commissioning Group

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

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Equalities implications and impact on priority groups:

N/A

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

N/A

Sign-off:

London Borough of Hackney: Ian Williams, Acting Chief Executive, London Borough of Hackney

City of London Corporation: Mark Jarvis, Head of Finance

NHS North East London Clinical Commissioning Group, City and Hackney Integrated Care Partnership and North East London Health and Care Partnership: Sunil Thakker, Executive Director of Finance

Hackney

CITY OF LONDON

NHS North East London Clinical Commissioning Group

Hackney

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NHS
North East London
Clinical Commissioning Group

NHS
North East London
Clinical Commissioning Group

City and Hackney Integrated Care Partnership
London Borough of Hackney
City of London Corporation

Integrated Finance Report

Month 5 (August 21-22)

Hackney

CITY OF LONDON

City and Hackney

City and Hackney ICP– Position Summary Month 05 2021-22

- The financial regime that was introduced in 2020/21 as a response to managing Covid-19 costs, continues in 2021/22 with NEL system having been allocated a revised financial envelope for the six-month period from 1 April to 30 September 2021. This is referred to as H1. There is an expectation that NEL as a system achieves a breakeven position within the envelope provided.
- By mutual agreement between partners and on a net neutral basis, we are able to amend the default organisational positions by re-distributing system funding, if this required as a system to achieve break-even (see Table1).

As part of the elective recovery work, CH ICP will formalise any agreed backlog/waiting list clearance and service transformation schemes with the Homerton and ELFT with the financial implications in delivering these factored into the reported position.

Schemes such as ACRT Waiting List Clearance, Covid Rehab & Recovery Services and Pathway Homeless Hospital Discharge Team are some of the main schemes that are being progressed.

STP held funds such as SDF, Covid, MH and Growth monies will be allocated in due course with relevant efficiency schemes identified in order that NEL STP deliver the agreed plan for H1.

Table1.	NEL Plans - May 2021			Provider Plans - May 2021	
	Surplus/ (deficit) Before Covid Fund	Apply Covid Fund	System Position	Improvements	Position After improvements
	£'000	£'000	£'000	£'000	£'000
BHRUT	(37,788)	16,000	(21,788)	13,000	(8,788)
Barts	(60,984)	38,000	(22,984)	14,900	(8,084)
ELFT	(7,700)	4,300	(3,400)	3,400	0
Homerton	(8,050)	4,331	(3,719)	3,719	0
NELFT	(537)	395	(142)	142	(0)
Provider Total	**(115,058)**	**63,026**	**(52,032)**	**35,161**	**(16,871)**
NEL CCG	(10,000)	10,000	0		0
Balance be allocated	0	13,878	13,878		13,878
System Position - before Contingency	**(125,058)**	**86,904**	**(38,154)**	**35,161**	**(2,993)**
ICS Reserve - not committed	(10,000)	10,000	0		0
Further CCG NR Action to support system					2,993
System Position - Including Contingency Surplus/(Deficit)	**(135,058)**	**96,904**	**(38,154)**	**35,161**	**(0)**

City and Hackney ICP– Position Summary Month 05 2021-22

C&H ICP Financial Summary - H1 2021-22	H1 - April 21 - Sept 21 £'000	M5 YTD Budget £'000	M5 YTD Actual £'000	YTD (Under)/ Overspend £'000	Forecast Actual £'000	Forecast (Under)/ Overspend £'000	RAG	Forecast Improvement/ Deterioration vs M4 £'000
In Area Acute Trusts	106,407	89,172	89,172	0	106,407	0		0
Out of Area Acute Trusts	20,411	17,009	17,009	0	20,411	0		0
Other Acute	7,136	5,947	6,114	167	7,383	248		24
Subtotal Acute	**133,953**	**112,128**	**112,295**	**167**	**134,201**	**248**		**24**
Mental Health Services	39,407	32,839	32,839	0	39,407	0		0
Community Health Services	27,582	23,042	23,499	457	28,229	647		(128)
Continuing Care	9,571	7,976	7,976	0	9,571	0		(236)
Other Non Acute	1,096	914	914	0	1,096	0		0
Efficiencies	(766)	(638)	(1,171)	(533)	(1,452)	(686)		(462)
Subtotal Non Acute	**76,892**	**64,133**	**64,057**	**(76)**	**76,852**	**(39)**		**(826)**
Prescribing	14,058	11,715	12,081	366	14,497	439		439
Primary Care Services	8,568	7,140	7,340	200	8,768	200		200
Primary Care Co-Commissioning	27,048	22,404	22,404	0	27,048	0		0
Subtotal Primary Care	**49,674**	**41,260**	**41,825**	**566**	**50,313**	**639**		**639**
NHS Property Services	497	415	415	0	497	0		0
Programme	3,248	2,708	2,708	0	3,248	0		0
Subtotal Other	**3,746**	**3,122**	**3,122**	**0**	**3,746**	**0**		**0**
Total Programme	**264,265**	**220,643**	**221,300**	**657**	**265,112**	**847**		**(163)**
Corporate	2,758	2,298	2,298	0	2,758	0		0
Total Corporate	**2,758**	**2,298**	**2,298**	**0**	**2,758**	**0**		**0**
Grand Total	**267,023**	**222,941**	**223,598**	**657**	**267,870**	**847**		**(163)**
Total Resource Limit	**(267,023)**	**(222,941)**	**(222,941)**	**0**	**(267,023)**	**0**		**0**
Surplus/Deficit	**(0)**	**0**	**657**	**657**	**847**	**847**		**(163)**
Expected HDP reimbursement to be validated by NHSEI	**0**	**0**	**(657)**	**(657)**	**(847)**	**(847)**		**163**
Adjusted Surplus/Deficit	**(0)**	**0**	**0**	**0**	**0**	**0**		**0**

At M5, City & Hackney Integrated Care Partnership (CH ICP) reported a breakeven position.

Acute:

- City and Hackney ICP is reporting a breakeven position in respect of its Block contracts with NHS Organisations.
- 'Other Acute' is reporting an over performance forecast of £248k which is driven by higher than expected spend with the non-contracted acute providers and the London Independent Hospital (a BMI hospital).
- The forecast position has deteriorated by £24k on month 4-this is being driven in most part due to increased activity at BMI hospital.

Non-Acute, Mental Health and Community Services:

- CHS is over spent by £457k YTD, this is due to HDP expenditure, for which, funding is expected to be reimbursed by NHSEI.
- CHS block contracts with NHS providers, CHC and all other non-acute areas are reporting a break-even position.
- Efficiencies reported are non-recurrent means to ensure CH ICP maintains its balanced position. Any adverse/favourable movements in the portfolio will be managed via this arrangement.

Primary Care:

- Prescribing YTD overspend is reported at £366k. The impact of high cost of drugs from previous year has continued in the current year leading to an increased run rate above plan.
- Primary Care services is reporting a YTD overspend of £200k resulting from Covid surge costs – Pharmacy extended hours, LBH Covid weekend event and GP Covid clinics, funding is expected to be reimbursed by NHSE.

Corporate

- Running Costs, programme projects and Property services, all are reporting a break-even position with NHSP True up costs expected to materialise with regards to 2020/21.

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

City and Hackney ICP – Risks and Mitigations Month 5 21-22

H1 Summary at M5				
Description	**Recurrent £'000**	**Non Recurrent £'000**	**Net Risk/ (Mitigations) £'000**	**Deterioration/ (Improvement) from last month**
ERF Income	0	0	0	0
QIPP/CIP delivery	0	0	0	0
SOCG delivery plan	800	600	1,400	0
Vaccination costs	75	75	150	0
Deficit management	0	1,452	1,452	686
Other	173	146	319	16
Neighbourhood Health & Care transformation funds	0	1,200	1,200	0
Total Risks	**1,048**	**3,473**	**4,521**	**702**
Service Development Fund (SDF)	0	0	0	0
Referral to Treatment (RTT)	0	(1,566)	(1,566)	0
Hospital Discharge Programme (HDP)	0	(750)	(750)	0
Continuing Health Care & Learning Disability	0	(1,110)	(1,110)	(303)
Primary Care	0	(1,435)	(1,435)	0
Acute Other	0	(67)	(67)	0
Prescribing	0	(342)	(342)	(0)
Estates - NHSP	0	(514)	(514)	(10)
Other smaller Balance sheet gains	0	(690)	(690)	40
Total Mitigations	**0**	**(6,473)**	**(6,473)**	**(272)**
			(1,953)	**430**

- Risks and Migrations for H1 have been identified by analysing the accruals brought forward from 2020/21 (and other prior years) against known commitments to date (M5).
- Where there are disputes outstanding against accruals, these have been **risk rated** to arrive at the potential mitigation available to CH ICP. The adverse movement from last month of £430k relates to the management of overspends in Acute NCAs and Prescribing, off-set by favourable gains in CHC and LD.
- There is a NEL wide detailed review of brought forward mitigations being undertaken to identify one off benefits to ICPs and the system. Whist the figures presented here have been risk rated there can be further risks when we move into H2 with the restart of efficiency savings. The NEL CCG expectation is to break-even, with plans being carefully considered and deployed to ensure financial resilience/balance recurrently.
- ERF income loss (-), non-delivery of efficiency targets (-) and any SDF funds (+) will be managed via the STP and therefore risk rated to zero in this table.

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

North East London (NEL) CCG– Position Summary Month 05 21-22

NEL Monthly Finance Report - Month 5 Financial Control Report - 31st August 2021	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	H1 Budget £'000	H1 Actual £'000	H1 Variance £'000
Total In Sector Acute Trusts	756,320	756,320	0	897,407	897,407	0
Total Out of Sector Acute Trusts	67,289	67,289	0	80,747	80,747	0
Total Other Acute	74,523	80,084	5,562	88,626	94,842	6,216
TOTAL ACUTE	**898,132**	**903,694**	**5,562**	**1,066,779**	**1,072,996**	**6,216**
Total Mental Health	164,725	164,725	0	193,776	193,774	(2)
Total CHS - Provider	141,147	147,986	6,839	170,384	178,975	8,591
Total Continuing Care	68,440	67,495	(945)	80,343	81,484	1,140
Total Other Non Acute	58,300	58,401	101	68,326	69,288	962
TOTAL NON ACUTE	**432,612**	**438,607**	**5,995**	**512,829**	**523,521**	**10,692**
Total Primary Care	137,576	142,370	4,794	165,411	170,189	4,778
Total Primary Care Co-Commissioning	140,624	140,624	(0)	168,749	168,749	0
TOTAL PRIMARY CARE	**278,200**	**282,994**	**4,794**	**334,160**	**338,937**	**4,778**
Running costs - Staffing and Non Pay	11,263	11,522	336	13,516	13,516	0
CSU SLA	4,762	4,503	(334)	5,714	5,714	(0)
CCG Reserve	12,857	(8,300)	(21,157)	15,212	3,229	(11,983)
Unidentified Efficiencies	(12,446)	(638)	11,808	(13,609)	(13,609)	(0)
TOTAL Running Costs & Central Reserves	**16,435**	**7,087**	**(9,347)**	**20,833**	**8,850**	**(11,983)**
TOTAL EXPENDITURE	**1,625,379**	**1,632,381**	**7,004**	**1,934,601**	**1,944,304**	**9,703**
HDP/Covid Costs to be reclaimed	0	0	(13,248)	0	(15,029)	(15,029)
ERF Non NHS to be reclaimed	0	0	(2,646)	0	(3,292)	(3,292)
HDP Covid Funding Received	0	0	6,244	0	6,244	6,244
ERF Non NHS Funding Funding Received	0	0	2,646	0	2,374	2,374
Revised Variance	**0**	**0**	**(7,004)**	**0**	**(9,703)**	**(9,703)**
Revenue Resource Limit	0	0	0			
Programme	(1,443,184)	(1,443,184)	0	(1,728,194)	(1,728,194)	0
Retrospective Top Up	(25,546)	(25,546)	0	(18,428)	(18,428)	0
Admin	(16,025)	(16,025)	0	(19,230)	(19,230)	0
Primary Care Co-Comm	(140,624)	(140,624)	0	(168,749)	(168,749)	0
Revenue Resource Limit Total	**(1,625,379)**	**(1,625,379)**	**0**	**(1,934,601)**	**(1,934,601)**	**0**
In Year Surplus / Deficit	**0**	**7,002**	**(0)**	**(0)**	**0**	**0**

- At month 05 NEL CCG have reported a break-even, year to date and H1 forecast position.
- Budgets have been set for the first 6 months of the financial year (H1) across the three integrated care partnership systems for NEL CCG.
- The total month 5 budget for NEL CCG is £1,625m, with a H1 budget £1,947m.
- Although the reported position is break even at Month 5, delivery of the position is reliant on the use of non-recurrent mitigations (£25.3m) and Covid contingency funds (£2.7m), to offset identified budgetary pressures of £28m.
- Of the £28m non-recurrent mitigations required, £14m was expected within the H1 plan.
- Budgetary pressures in Independent Sector (IS) contracts, prescribing and Continuing Healthcare (CHC) have increased the mitigation requirement over and above planned levels.

London Borough of Hackney – Position Summary at Month 05 2021-22

2021/22 Budget	Service Area	Forecast Budget Variance before one-off funding	One-off funding usage	Forecast Budget Variance after one-off funding	Change in Variance from last month	How much of spend/reduced income is due to Covid19
6,070	Care Management & Adult Divisional Support	457	(177)	280	(33)	-
9,135	Provided Services	573	(38)	535	5	681
44,216	Care Support Commissioning	4,380	(1,500)	2,880	752	340
7,884	Mental Health	945	-	945	(2)	-
18,234	Preventative Services	(1,041)	(54)	(1,095)	(134)	126
11,622	ASC Commissioning	1,365	(1,675)	(311)	(35)	-
97,161	**Adult Social Care subtotal**	**6,678**	**(3,444)**	**3,234**	**553**	**1,147**
34,890	Public Health	10	(10)	-	-	-
466	Hackney Mortuary	432	-	432	-	410
35,356	**Community Health subtotal**	**442**	**(10)**	**432**	**-**	**410**
132,516	**AH&I Total**	**7,121**	**(3,455)**	**3,666**	**553**	**1,557**

London Borough of Hackney – Position Summary at Month 5 2021-22

- At month 5, LBH is forecasting an overspend of £3.7m after the application of one-off funding of £3.5m. This compares to a 2020/21 outturn position of £8.6m overspend (this included £6.5m of which was attributed to Covid-19 expenditure).

- Covid-19 continues to present a significant financial risk to the LBH forecast for 2021-22 with the costs resulting from actions undertaken to limit the spread of infection. In recognition of this risk, the local authority provided corporate growth of £3m to offset increased costs attributed to Covid-19 within Adult Social Care. However, the reduction of NHS funding from being fully funded to 6 weeks funding (subsequently further reduced to 4 weeks from Qtr 2) for hospital discharge care packages has led to a £3.2m reduction in Covid-19 funding this year. The estimated net cost of the pandemic for the directorate above the level of corporate and grant funding received is a net cost of £1.55m this financial year. The remaining £1.7m overspend is predominantly driven by care package costs driven by growth in client numbers and increased complexity of care needs.

- This financial year, Adult Social Care received a further £1.2m of Infection Control and Rapid Testing Funding for care homes to fight Covid-19. Our role in this is primarily one of passporting the funding and so the allocation we received cannot be viewed as further assistance to mitigate the financial pressures we are under.

- The cyber attack continues to have a significant impact on a number of key systems across the local authority. There is a clear project plan to restore the social care system, and the service is working with ICT, finance and performance to ensure that we restore the system and take opportunities to build back better.

- Forecast positions in relation to each division are set out below:

- **Public Health (PH)**: Public Health is forecasting a breakeven position, this includes the delivery of planned savings of £217k. The Public Health (PH) grant increased by approximately 1m in 2021/22, although £775k of the total increase relates to the funding allocated for PrEP related activity, as this was previously funded via a separate grant in 2020/21. The 2021/22 grant will continue to be subject to conditions, including a ring-fence requiring local authorities to use the grant exclusively for public health activity which may include public health challenges arising directly or indirectly from Covid-19.

- The Covid-19 pandemic has seen a significant increase in Public Health activities specifically around helping reduce the spread of the virus in the local area, whilst still continuing to ensure other non-covid,demand-led services such as sexual health continue to be managed.

- **Adult Social Care (ASC):** The revenue forecast for Adult Social Care is £100.4m against a net budget of £97.2m, resulting in a £3.2m overspend (3.3%). Covid-19 related expenditure accounts for £1.15m of the reported budget overspend.

- The overall position for Adult Social Care last year was an overspend of £6.9m (this included £5.1m attributed to the Covid-19 pandemic). The revenue forecast includes significant levels of non-recurrent funding including iBCF (£2m), Social Care Support Grant (£6.3m), and Independent Living Fund (£0.7m).

- **Care Support Commissioning** (external commissioned packages of care) contains the main element of the overspend in Adult Social Care, with a £2.9m pressure against the £44.22m budget. This is primarily due to:

  - Physical & Sensory Support is forecasting an overspend of £0.55m, whilst Memory/Cognition & Mental Health ASC (OP) has a further budget pressure of £0.5m. Cost pressures being faced in both service areas have been driven by the significant growth in client numbers as a result of hospital discharges, and includes £1.5m of one-off funding towards the increased level of care packages in 21/22
  - The Learning Disabilities (LD) is forecasting an overspend of £1.65m (£0.88m in July-21). There continues to be pressures driven by the increasing complexity of care needs for new and existing clients coupled with inflationary pressures requested by care providers. The gross forecast spend on care packages in Learning Disabilities is £33.8m (£32.7m in July-21). This month we have seen a significant increase in the LD position primarily as a result of one service user transitioning from Children services with a care package cost of c£500k, this has been partially offset by an indicative joint-funded contribution of £150k.

- The **Mental Health** service is provided in partnership with the East London Foundation Trust (ELFT), and is forecasting an overspend of £0.95m (£0.95m in July-21). The overall position is largely attributed to an overspend on externally commissioned care services, and as part of the cost reduction plans, Adult Services and the ELFT will work closely to forensically review care packages within the service to seek a reduction of at least £350k this financial year.

- **Preventative services** is forecasting an underspend of £1.1m and is primarily attributable to the interim bed facility at Leander Court (£0.58m) and Substance Misuse (£0.2m) linked to lower than expected demand for rehab placements. The underspend is offsetting the overall overspend on care package expenditure which sits in Care Support commissioning.

City of London Corporation – Position Summary at Month 05 21/22

				YTD Performance			Forecast Outturn		
	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Variance £000's	**Prior Mth** Variance £000's
Budgets	Comm'ned & *DD	Adult Social Care	3,085	1,136	1,027	109	2,917	168	-
		Occupational Therapy	301	125	101	25	263	38	-
		Public Health	1,314	329	(196)	524	1,314	-	-
		Child Social Care	1,244	555	684	(129)	1,544	(300)	-
		Older People	1,543	635	547	88	1,690	(147)	-
Grand total			**7,487**	**2,781**	**2,164**	**617**	**7,728**	**(241)**	**-**

***** DD denotes services which are Directly delivered .

* Budgets include iBCF funding - £313k

***** Comm'ned = Commissioned

- At Month 5, the City of London Corporation is forecasting a year end adverse position of £0.2m and a YTD position of £0.6m favourable.
- The forecast over spend is being driven by Child Social Care and Older people - £447k adverse. . These budgets are very volatile and a small change in client numbers / circumstances can have a major impact on the budget. The over spends have been partially mitigated by under spends in Adult Social Care and Occupational therapy- £207k
- The budgets reflect the pre-existing integrated services of the Better Care Fund (BCF). These budgets are forecast to break even at year end.
- No savings targets have been set against City budgets for 2021/22

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

Title of report:	Risk Register
Date of meeting:	October 2021
Lead Officer:	Siobhan Harper
Author:	Matthew Knell
Committee(s):	N/A
Public / Non-public	Public

Executive Summary:

The following report highlights the current high level (red rated) risks within health for the City and Hackney system.

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	☐	
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

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Communications and engagement:

N/A

Equalities implications and impact on priority groups:

N/A

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

N/A

Background and Current Position

11 red rated risks have been escalated to the ICPB in October 2021 and the following register provides further details on these risks.

One risk has dropped from a red rating (16) in September 2021 to an amber rating (1) this month (PC6, regarding COVID outbreaks at care homes and commissioned placements for residents with a learning disability). This risk is included in this month's report for the ICPBs information and will not appear from next month onwards, unless it moves back into a red rated status.

One new red rated risk (15) is included in this month's report – CYPMF6, regarding levels of childhood immunisations in the borough that may lead to outbreaks of preventable disease that can severely impact large numbers of the population. This risk was not escalated in September 2021 but will be included in future reports while it remains in a red rated status.

All risks have been reviewed and updated since the ICPB last received this report in September 2021 and risks not specifically mentioned have not seen changes in score.

Across the 7 workstream and team risk registers that the following risks have been drawn from, there are currently 17 amber risks rated at 12 (this is the highest amber score before a risk becomes red rated) – none of these risks have increased in score since September 2021.

NHS
North East London
Clinical Commissioning Group

Risk Management Report for ICPB

October 2021

City and Hackney

Risk Update

- The risks reported in the following risk register, follow on from meetings with risk owners to discuss the current risks in place and the changes in the reporting. The majority of these meetings were held with CCG staff, though some meetings were also held with members of staff from Hackney Local Authority, City of London Corporation and the Homerton University Hospital NHS Foundation Trust.

- Moving forward we are looking adopt a more system based approach and risk owners have been encouraged to share the current risk registers across the system and at relevant meetings. Further information on risks can be requested by the ICPB.

- The risks included in this report are those red risks which could impact on the wider system, lower level risks in the amber and green range are being managed at work stream and programme level.

- The template being used shows the risk, current and target scores alongside completed and outstanding mitigations. Each month risk owners will be asked to review these as well as include an update on the work taking place.

- Future risk reports will also show any movement in risks which the ICPB needs to be aware of.

Changes to risks

The information below highlights any changes to risks which have been previously been reported to the ICPB.

Risk	Changes in score	Changes in mitigations
PC6, risk of COVID outbreaks at care homes and commissioned placements for residents with a learning disability	Scored at 16 in September 2021 Reduced to 10 in October 2021 	By Nov all staff at care homes will be double vaccinated; business continuity plans where staff are not. Vaccinations being encouraged for Staff and Residents. four out of 5 homes have >75% double vaccination rate (1 is at 57%). Regular testing in place. Standard Operating Procedures in place to address outbreaks. Arranging Restore2mini training to identify deterioration. The risk mitigation has achieved its target score - Option to close this risk now with consideration of bringing back pending winter issues.
CYPMF6, risk that low levels of childhood immunisations in the borough may lead to outbreaks of preventable disease that can severely impact large numbers of the population	Scored at 15 in September and October 2021, excluded in error from previous months report 	Not applicable

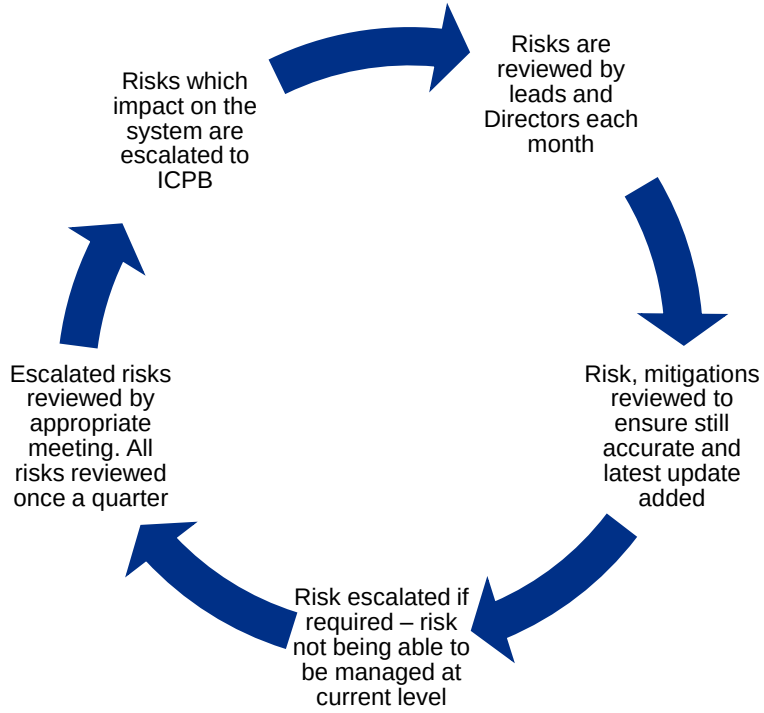
Across the 7 workstream and team risk registers that the following risks have been drawn from, there are currently 17 amber risks rated at 12 (this is the highest amber score before a risk becomes red rated) – none of these risks have increased in score since September 2021.

Monthly risk cycle - CH ICP, NEL CCG

This slide is included for information of the monthly process for review and discussion of risk.

Each month:

- Risk owners will be asked to review their risks to ensure the risk is up to date – an email reminder will be sent out to all leads
- Risks can also be taken to other groups and sub-committees for review and discussion if this will enable the risk to be more widely understood and managed
- Risks can be updated at any point following discussions with owners and at meetings
- There will be one primary owner of the risk on the register; however as this is system focussed risk it is envisaged the owner will liaise with others across the system
- Governance team will review the registers, and update information to be sent to the NEL CCG corporate risk register as part of the internal processes.



ID no.	Date raised	Raised by (individual/ committee/ programme)	Initial risk score	Risk description	Previous rating	Current rating			Target rating	Target completion date	Completed mitigating actions	Mitigating actions still to be completed	Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details	Updates/ comments - *add in month/year of update*	Close Down Status
						Likelihood	Impact	Risk Score (1-25)											
PC5	Feb-21	Planned care team	20	Increase in mortality for residents with a learning disability as a result of COVID (increase in Learning Disabilities Mortality Review (LeDeR) Programme reporting)	20	4	5	20	15	Apr-22	Vaccine offer and support to take it up - vaccine programme.	Infection control and self care resources for patients and their carers - constantly updating as online information and with changes to guidance. Get data from G.P on vaccination rates. Staff training to be in place to be able to recognise signs of illness in patients . Leder reviews in place (and learning from these). work being done to increase vaccination update in staff and those supporting learning disabled users.	Charlotte Painter	Penny Heron	ICPB / SOCG / HNCB			Sept 2021 - Vaccinations programme: Current rates of double vaccinations is 67% in C&H for this cohort. The Integrated Learning Disability Service continues to proactively followup with patients on it's caseload via welfare checks. For patients not on the service caseload, Primary Care are conducting checks, such as Annual Health Checks. GPs have clear guidance for identifying patient via CEG searches and protocol for what to discuss with patients when they are contacted. Resources have been promoted by the council and CCG- a new winter planning handbook will be shared with patients. Ongoing monitoring of LeDeR reporting. If vaccination rate increases, option to review risk score.	
PC6	Feb-21	Planned care team	16	Risk of COVID outbreaks at care homes and commissioned placements for residents with a learning disability	16	2	5	10	10	Apr-22	Vaccination of residents in care homes / Regular Testing/ Infection protection and control training and SOPs for care / share winter planning handbook	Support Resources for patients, staff and carers. Winter planning promotion in addition to the handbook. Ongoing work to promote vaccines uptake for staff - linking in LBH and public health and undertaking quality assurance.	Charlotte Painter	Penny Heron	ICPB / SOCG / HNCB			Sept 2021 - Mandatory vaccinations programme for staff. By Nov all staff at care homes will be double vaccinated; business continuity plans where staff are not. Vaccinations being encouraged for Staff and Residents. four out of 5 homes hvae >75% double vaccination rate (1 is at 57%). Regular testing in place. Standard Operating Procedures in place to address outbreaks. Arranging Restore2mini training to identify deterioration. The risk mitigation has achieved its target score - Option to close this risk now with consideration of brining back pending winter issues.	
PC7	Feb-21	Planned care team	16	Medium to long term health impact of Covid and Covid related suspension of usual care on people with Long Term Conditions. This may be due to failure to present to health care settings; reduction in proactive monitoring and care or difficulty in accessing services due to restrictions. Likely to have a significant adverse impact on especially vulnerable groups including those in deprived socio-economic groups, people with LD and people from BAME backgrounds. This may become a "rising tide" of people with worsening health outcomes and complications of diseases such as diabetes.	16	4	4	16	9	Apr-22		Develop data reporting and modelling to assess need / Engage patients to collate qualitative feedback / Review services briefs to understand how this need can be me / Review of LTC dashboard data at the end of Q1 to understand the level of recovery work that is able to be completed in PC.	Charlotte Painter	Charlotte Painter / Laurie Sutton Teague	ICPB / SOCG / HNCB			Ongoing monitoring in place to support planning for medium-long term. Development of data models will be scheduled for later in the year to understand the quantitative impact. Engagement and Listening Events also planned to be scheduled for later in the year to gain a qualitative understanding of local need. This will also focus on LTC recovery and how to manage the situation post-COVID. LTC contract 21/22 targets agreed, highlighting priroty areas to address allout from COVID, particularly for vulnerable groups. Unclear how mitigations are being affected by capcity in primary care, LTC dashboard data due to be reviewed once available at the end of the month.	
PC8	Feb-21	Planned care team	20	Impact of COVID on the health of the rough sleepers and asylum seeker populations	20	4	5	20	9	Apr-22		Ongoing accommodation offer / Outreach services from council and ELFT / Out of Hospital Discharge Pathway / Vaccination implementation	Charlotte Painter	Cindy Fischer				Rough Sleeper and Health Partnership Group in place to oversee response. ELFT Outreach Service providing outreach clinics to accommodation for rough sleepers and asylum seekers. Proactive outreach being undertaken by LAs to ensure rough sleepers are offered accommodation. All asylum seekers have been registered at Hoxton/Greenhouse. Asylum Seeker hotel was stood up in July 2020. DOTW, ELFT and Hoxton supported providing initial health assessment and registering patients through outreach clinics and primary care follow-up. Vaccination clinics have been provided by Excel team, Dr Rhiannon England and Find&Treat. F&T use a peer vaccinator and outreach model and will provide multiple visits to sites. The ELFT Outreach Team contract extension ends in September. Current discussions underway with ELFT and CCG colleagues regarding potential 2.5 year contract.	
PC9	Feb-21	Planned care team	20	NCSO- Limited stock availability of some widely prescribed generics significantly drove up costs of otherwise low cost drugs. The price concessions made by DH to help manage stock availability of affected products, were charged to CCGs - this arrangement (referred to as NCSO) presents C&H CCG with an additional cost pressure. As a result of EU exit, there is risk of transport delays of medicines which could lead to limited stock availability of medicines (which could further drive up the cost of commonly prescribed drugs).	20	4	5	20	9		QJPP efficiencies to aid financial balance		Siobhan Harper	Rozalia Enti				The NHS has put measures in place to help ensure stocks continue to be available even if there are transport delays. The national recommendation is that medicines should be prescribed and dispensed as normal and that medicines should not be stockpiled, the MMT has already shared the message regarding appropriate prescribing and ordering of medicines to prescribers and patients (through Healthwatch Hackney) during the first wave of the COVID-19 pandemic – Spring 2020 and again in Nov/ Dec of 2020. For 2020/21, as of January 2021 prescribing data is only available for April -October 2020. Based on the 7 months data, the estimated annual cost pressure for NCSO is £567,214 in addition to a cost pressure of £367,788 for the associated cost pressure of increased Drug Tariff pricing for drugs prescribed. An additional cost pressure from increased costs of category M products as a consequence of DH announcement to claw back £15M per month from CCGs by increasing the cost of these drugs from June 2020. The estimated cost impact for C&H CCG for this clawback is £412,090 over June2020 to March 2021. Previous low scores was due to it these cost pressures being fully mitigated by QJPP savings delivered, each year to 2019/20, by the Meds Management team in conjunction with practices. So in previous years prescribing budget has always remained break even or underspent. An additional prescription cost factor arising from Covid pandemic is that there appears to be much higher compliance with medicines or at least with having prescriptions being dispensed with upto 30% higher rates of prescriptions dispensed.	
PC11	Feb-21	Planned care team	20	No decision has been made by government about the continuation of discharge to assess funding from April 2021 onwards. Systems should therefore assume that individuals discharged from hospital from 1 April 2021 onwards who require care and support will need to be funded from locally agreed funding arrangements which will have an impact on CCG Continuing Healthcare, and Adult social care budgets. Without a clear process, this could have a detrimental impact on hospital discharge.	20	4	4	20	8			Review Services without Prejudice arrangement that was in place with the Local Authorities prior to when Covid central funding became available. / The Hospital Discharge to Assess processes must continue with any funding arrangements managed separately so that no delays to discharge occur.	Charlotte Painter	Cindy Fischer				The Government confirmed that there will be central funding to support discharge to assess; this will be up to 6 weeks of care during quarter 1 and up to 4 weeks during quarter 2. There is still no national decision regarding funding for Q3-4. The CCG and Local Authorities are in discussion about funding options but there are different opinions across the LA's. We are requesting a position from finance and will explore a way forward as an ICP as part of our BCF planning.	
Primary Care - PRC1	Apr-18	Primary Care Enabler Group	16	New "digital first" practices have the potential to financially destabilise local primary care by attracting a healthier cohort of patients	16	4	4	16	TBC	TBC	• Ongoing monitoring of current numbers registering with other video providers • All practices offering consultations online • All practices offering video consultations (actual volume low) • City & Hackney providing high level of extended access weekday evenings and weekends • Duty Doctor contract in place to meet same day demand • Contract in place with GPC on demand management and digital working • Digital clinical lead in post • Practice triage champions in place • NEL online registration live in majority of practices, with remainder offering a similar service through alternative means	• Practices continue to be offered support to move to a total triage way of working (to increase capacity) • Six practices are actively taking up the support package; more being encouraged to follow suit • Champions sharing knowledge with PCN member practices in three PCNs; more to follow • PCNs continue to be supported through the GPC contract to develop PCN level digital plans • GPC QI team continue to offer support to practices to run digital related QI projects • Practices to audit their websites under the CCE contract to ensure all access options are really clear • Practices to undertake demand and capacity analysis through CCE contract	Richard Bull	Richard Bull	Primary Care Enabler Group Board (PCEGB)		Escalation not required (drop down box to left not working)	2nd September 2021: • Website self-assessment tool and demand capacity resources for practices to use under the CCE contract being signed off at 9th Sep PCEB • Practices encouraged to complete survey in relation to NEL Digital First Programme scale procurement of OC tools	
CYPMF6		CYPMF Strategic Oversight Group	15	Risk that low levels of childhood immunisations in the borough may lead to outbreaks of preventable disease that can severely impact large numbers of the population	15	3	5	15	4	TBC	1. Robust governance established across the Partnership with A.) a fortnightly COVID 19 Childhood Imms Task group with PH, CCG, HLT and Interlink members, B.) a C&H monthly steering group that also manages the flu strategy, and C.) a quarterly wider partnership oversight group with NHSE/PHE that will oversee the 2 year childhood imms action plan. 2. CCG NR investment in childhood immunisations - contract with GPC through which additional clinics and 'event' clinics are held in NE Hackney 3. Utilise NHSE training, data and shared learning opportunities	Continue to work with CEG / NHSE regarding improvements in data collection to support timely delivery; recruit to NR funded imms coordinator / programme manager posts ; restart the GPC delivered children's centre service for NE Hackney; develop our approach to vaccine hesitancy with a focus in NE Hackney with learning applied across C&H	Amy Wilkinson	Amy Wilkinson / Sarah Darcy	CYPMF SOG	Y	ICPB	Impact of further deterioration in coverage in Covid not yet redressed; use of NR funding planned, expected to mobilise end of Q2 / Q3	
CYPMF11		CYPMF Strategic Oversight Group	15	Potentially significant increased demand for CAMHS support throughout the impending phases of the pandemic, at specialist and universal level for children and families. As the pandemic has continued, we have seen increased pressure on T4 beds, and increasing crisis and ED presentations, which is also reflected across NEL and London. Many services are seeing a large risk in the number of referrals, particularly Tier 3 CAMHS, Eating Disorders and Crisis.	15	5	3	15	9		There are a large number of developments in place in order to support CAMHS work, these are included in the CAHMS surge planning document. However, some of these are detailed here - CAMHS Alliance Support has been redeployed to support critical care. - HUH CAMHS to receive enhanced funding for additional senior clinician capacity plus enhanced duty system. - introducing enhanced LBH and Off Centre clinical offer to support surge in CAMHS crisis. - Maintain Crisis service operation 9am -9pm 7 days per week beyond April 2021. - CAMHS Disability has implemented a Duty System including weekly meeting with CAMHS Alliance colleagues to consult on referrals. First steps have adopted to on line with groups and online resources. - WAMHS/MHST has continued to deliver a range of services to meet needs faced by schools, pupils and parents	There are a number of developments underway to support CAMHS work, these are included in the CAHMS surge planning document. However, some of these are detailed here - Crisis eservice operation to be extended from the current 9am - 9pm to cover up to midnight. - Proposal to introduce Intensive Community Support Team (Tier 3.5) for CYP with highly complex needs preventing crisis presentations and unnecessary admission – currently under review by LBH. - Expanding existing Eating Disorders Service by 40% to cover increase demand / rapid deployment underway.	Greg Condon / Sophie McElroy	Dan Burningham / Amy Wilkinson	CYPMF SOG	Y	ICPB	There is still a surge in CAMHS with a growing backlog and waits. CAMHS T4 beds are saturated, however we are no longer seeing young people aged 16-17 in the adults beds. There is currently a regular discharge and flow group in place that is looking at bed blocking. We are also working with NEL LA collaborative to set up an in-housing placement hub for CYP with complex needs that include mental health. The investment round for 21/22 has been completed and this is currently being mobilised which will help alleviate some of the demand. However the new investments in CAMHS are small compared to the 50% increase seen (CED 15% increase) to demand.	

ID no.	Date raised	Raised by (individual/ committee/ programme)	Initial risk score	Risk description	Previous rating	Current rating			Target rating	Target completion date	Completed mitigating actions	Mitigating actions still to be completed	Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details	Updates/ comments - *add in month/year of update*	Close Down Status
						Likelihood	Impact	Risk Score (1-25)											
UPC8	Jun-20	Workstream	20	Risk that there is an increase in non-elective acute demand - either driven by a return to normal levels of admissions or a further peak in covid demand.	16	4	4	16	12		SOC are overseeing a range of plans to strengthen community support including Neighbourhood MDTs and Primary Care Long Term Condition Management / Working with 111 to improve usage of admission avoidance pathways through SDEC and ACPs - Pathways put in place, ongoing reporting and monitoring occuring via NHSD and 111 reports Review and development of 111 CAS and onward UEC pathways is key objective of the new NEL System Resilience and SDEC subgroups - working with partners to understand and optimise patient flow and manage demand across the system, away from hospital whenever possible/appropriate.	- Implementation of ED direct booking via EDDI to smooth demand - SOC are overseeing a range of plans to strengthen community support including Neighbourhood Multi-Disciplinary Teams and Primary Care Long Term Conditions Management - Working with 111 to develop admission avoidance pathways through SDEC and Appropriate Care Pathways	Nina Griffith	Nina Griffith / Anna Hanbury	SOCG / NEL UEC Sub-Group	Y	To be included in report to the ICPB as high level system risk	Work with 111 and Primary care to understand and increase utilisation of 111 bookable appointments in GP practices, hubs and wider primary care community. Ensuring sufficient urgent primary care capacity available to meet demand. SDEC - pathway for direct booking from 111 in 2 priority SDEC pathways agreed and work underway to implement. Further work underway to scope increased SDEC offer including frailty. Urgent community response - working with providers to ensure delivery of the 2 hour standard including direct referral from 111/999 to support management of appropriate patients in the commnity. Reconfiguration work required to pilot direct booking from 111 into Paradoc,is now underway. Continued work to increase utilisation of both core ParaDoc and ParaDoc Falls service by 999, 111, primary care and telecare. 1 October Update - All system partners are working to identify and mitigate key risks in their areas as we approach winter. This includes joint-COVID and Flu plans system-wide.	
MH2	01-Sep-21	Primary Care Mental Health Alliance	20	Since the pandemic primary care practices have found it difficult to delivery SMI physical health checks alongside other priorities such as vacinnation. With the blood bottle shortage this looks unlikely to change. The risk is the City and Hackney ICS will fail to reach its SMI physical health check target and that health risks in the SMI cohort will go undetected and that planning to improve health will not take place.	15	4	4	16	12	Jan-21		1. We are ordering POC test kits for six GP practices with the largest SMI populations. 2. We are increasing the capability of ELFT to undertake physical health checks by introducting POC into the EIS teams and also changing to ELFT HCA contract to include home visits and outreach work for people who have not had a health key elements of the health check completed in over two years. 3. To support this CEG will do searches to identify this at risk cohort.	Dan Burningham	1. Amaia Portilli, 2. Cath Mcelroy 3. Jo Tissier	The Primary Care Mental Health Alliance				
MH3	01-May-21	City Suicide Prevention and Response Group, Suicided Prevention Stekeholder Group, Andrew Horobin (ELFT)	20	Since the pandemic there has been a rise adult experiencing a mental health crisis demontrated by increased crisis line calls, increased suicidal presentations and suicides.	20	4	5	20	12	Jan-21		1. Increase City of London Street Triage hours. 2. Increase ELFT crisis line capacity. Work with HLP and NEL to develop a NEL wide crisis line that links to 111.3. Improve prevention work around vulnerable groups e.g homlessnes and substance misuse.	Dan Burningham	1. Claire Giraud 2. Andrew Horobin 3. Jennifer Millmore	The Mental Health Co-ordinating Committee				

Integrated Commissioning Glossary

ACEs	Adverse Childhood Experiences	
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.
COPD	Chronic Obstructive Pulmonary Disease	
CS2020	Community Services 2020	The programme of work to deliver a new community services contract from 2020.
DES	Directed Enhanced Services	
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.
IPC	Integrated Personal Commissioning	
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.
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	
LBH	London Borough of Hackney	Local authority for the Hackney region
LD	Learning Difficulties	
LTC	Long Term Condition	
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.
MI	Myocardial Infarction	Technical name for a heart attack.
	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.
PD	Personality Disorder	
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.
SOCG	System Operational Command Group	An operational meeting consisting of system leaders from across the City & Hackney health, social care and voluntary sector. Chaired by the Chief Executive of the Homerton Hospital. Set up to deal with the immediate crisis response to the Covid-19 pandemic.
SMI	Severe Mental Illness	
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.
VCSE	Voluntary Community and Social Enterprise	