Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**City of London Corporation**
Clinical Commissioning Groups	**City and Hackney CCG**
	Tower Hamlets CCG
	Islington CCG
Boundary Differences	**There is only one GP practice within the City, and therefore many of our residents are registered with GPs outside our boundaries and those of the CCG. We are therefore committed to working with neighbouring CCGs in order to meet the needs of our residents.**
Date agreed at Health and Well-Being Board:	**1 April 2014**
Date submitted:	**4 April 2014**
Minimum required value of ITF pooled budget: 2014/15	**£41k**
2015/16	**£776k**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£776k**

b) Authorisation and signoff

City and Hackney CCG	
Signed on behalf of the Clinical Commissioning Group	
By	Paul Haigh
Position	Chief Officer
Date	

Tower Hamlets CCG	
Signed on behalf of the Clinical Commissioning Group	
By	Jane Milligan
Position	Chief Officer
Date	

Islington CCG	
Signed on behalf of the Clinical Commissioning Group	
By	Alison Blair
Position	Chief Officer
Date	

City of London Corporation	
Signed on behalf of the City of London Corporation	
By	Ade Adetosoye
Position	Director of Community and Children's Services
Date	

City of London Health and Wellbeing Board	
Signed on behalf of the Health and Wellbeing Board	
By Chairman of Health and Wellbeing Board	Rev Dr Martin Dudley
Date	

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Provider engagement

On the 12 December 2013 Healthwatch facilitated a consultation event for the purpose of developing the City of London's BCF Plan. The event included both health and social care service providers, and service users. The consultation addressed 4 key themes:

- Care in the right place at the right time
- Joined up care
- Quality of life
- Caring for carers

Service providers were consulted with in order to develop this plan and gave their support for the key priority areas. Providers included:

- Healthwatch
- Hopscotch Asian Women's Centre
- Barbican Tuesday Club
- Crossroads Care Central North London
- City and Hackney Out of Hours AMHP Service
- Health in the City
- Toynbee Hall
- East London Foundation Trust
- Bart's Health NHS Trust
- City 50+
- Elders Voice
- City Estates
- City Health and Wellbeing Board
- City and Hackney Carers Centre

Key issues and proposals from this consultation event have shaped the formulation of this plan.

Senior managers in the City of London met with the CCG and provider hospitals in adjoining CCG areas to scope out the work that will be required to map out care pathways and to agree the need for the Joint Care Navigators (proposed new posts designed to deliver better integration of care), and have secured their agreement to work with us. We meet regularly with the City's Primary Health providers and have consulted with in developing this plan. We have also strengthened our links with Tower Hamlets and Islington CCGs as part of our commitment to ensuring better services for those residents registered outside of the CCG area, including those residents from Islington who are registered with our GP practice.

Both CCGs have signed this plan, signalling their commitment to deliver services across providers across the CCG boundaries. Work is currently ongoing to establish clear data collection in relation to our residents who are registered in Tower Hamlets (approx. 1/7th of our resident population).

The plan has been discussed with Community Nursing who were invited to participate in

our Health Scrutiny Committee to help explore with us the needs of City residents.

We have commissioned the support of a specialist consultancy (Tricordant) to develop the working arrangements to deliver integration from 2014/15 onwards so that we can deliver outcomes in the first year. This will include collaboration across a commissioning and provider landscape of 3 distinct CCGs to simplify care pathways and remove existing barriers of cross boundary commissioning in order to improve patient and carer experience.

Our Adult Wellbeing Partnership Board has partnership oversight of the delivery of the Integrated Care agenda and has a reporting structure into the Health and Wellbeing Board. Chaired by the Director of Community and Children's Services and attended by key strategic partners, it has responsibility for monitoring a number of key strategies across Health, Housing and Social Care including Dementia, Public Health Outcomes, Learning Disabilities, Physical Disabilities, Mental and Emotional Wellbeing, Carers and Homelessness amongst others, and will ensure the delivery of these strategies to support integrated care.

Senior managers from the City have also been involved in consultation events held by Hackney and by the CCG as a number of our schemes will interlink. In January 2014, the Hackney Health and Wellbeing Board invited the City to an extended development event on integrated care and support in Hackney. This was attended by 45 senior colleagues from across the statutory health and social care organisations, public health, NHS England commissioners, the VCS and Healthwatch Hackney. These included the main NHS providers in Hackney plus representatives of the GP Out of Hours provider, City and Hackney Urgent Healthcare Social Enterprise (CHUHSE), their prospective GP Provider Federation (CHUSHE+) and the Tavistock and Portman who provide some community mental health services.

The purpose of this event was to ensure collective understanding of the vision and principles for integrated care and support, reflect on the initiatives and services currently in place and to discuss further the development of the model for integrated care.

The City has its own vision and principles for the delivery of a locality-based model. However, it is essential to shape the development of Hackney services that will impact on our residents, and ensure there is access to the schemes that are being developed jointly with the CCG. Many of the pilot schemes being developed within Hackney will be mirrored in the City, but will be tailored to meet the needs of our residents. This includes the use of out of hours services and the practice based co-ordinated care.

The Neaman Practice (the City GP practice) has been part of a CCG wide clinical audit of recent emergency admissions to hospital of their patients. The learning points and reflections on alternative management arrangements and the opportunities of these integrated care proposals have been discussed both across GP practices in the City and Hackney CCG area and then collectively with the Homerton's Care of the Elderly consultants, social services, adult community nursing and reablement staff. There is strong frontline clinical engagement identifying issues and related improvements we want to make. As such and our clinicians are driving solutions from the "bottom up" - ensuring they are both relevant and locally owned.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Patient, Service user and public engagement

The City has a wide range of stakeholders whose asset base is key to the delivery of our BCF plan. Our consultation events and discussions have reached across this base, engaging our stakeholders both directly and indirectly in the development of our plan.

City of London Joint Health and Wellbeing Strategy 2013

Service users and City of London residents were key participants at the City's BCF plan consultation event facilitated by Healthwatch in December 2013. The event was structured around 4 key theme:

- Care in the right place at the right time
- Joined up care
- Quality of life
- Caring for carers

Service users and residents provided their thoughts and experiences on what worked well and what needed to improve to deliver better person centred and integrated care. There was a clear commitment from the service users to engage in and support change in local systems and services. A summary of feedback from the event is listed in the supporting documentation.

The City's Adult Advisory Group (a consultative body of service users, carers and those who have experienced hospital care locally) were also consulted (on 5 February 2014) to identify their priorities and those of local needs of residents, and identify their vision for seamless services between Health and Social Care. They offered further suggestions that have been included in this draft plan and emphasised the need to have services delivered locally within the City.

The Adult Advisory Group (AAG) meet on a quarterly basis and reports on its activity on an annual basis to the Community and Children's Services Grand Committee and the Health and Well Being Board. The group plays a key role in facilitating opportunities for service users, carers, voluntary organisations, officers and Members to help collectively shape practice and policy in Adult Social Care through a process of consultation and co-production. It reflects the City's on-going commitment to empower service users and ensure they shape our services.

The focus of the AAG includes:

- facilitating opportunities for co-produced policy and practice development;
- updating Members on the transformation of social care and the personalisation agenda;
- updating Members on consultations, guidance and legislative changes in respect of Adult Social Care at national and local level;
- updating members on key issues in relation to safeguarding adults;
- ensuring that adults and older people from socially and/or economically excluded groups are involved in the planning, development and review of services within the City of London Corporation;
- providing opportunities for the representatives of key stakeholder groups to meet together to promote information exchange, networking and disseminate good practice for example representatives from the Safeguarding Adult Board, Older People Reference Group and Commissioning.

Both the Healthwatch and City of London resident newsletters also highlighted the development of the BCF plan and invited the wider public reached by those publications to contact us with their issues and suggestions.

This breadth of consultation identified key areas of strength, and opportunities to improve integration and excellence of services within the City. Key reflections on what works well included:

- social care assessments are good and carried out well
- care and equipment needs are met quickly
- GPs, the police and housing staff have good awareness of people's social care needs and of those that are vulnerable, and they have good links with Adult Social Care services
- there are good events promoting healthier lifestyles
- the Adult Social Care Services Directory is very useful, and
- specialist services such as foot care are good.

Areas identified where the City could improve included:

- more information about where to get help and what help is available – especially in an emergency
- ensuring information should be more widely available and available to those who might be partially sighted, or for those who may need information in other languages
- providing residents and agencies with more opportunities to share information and to help shape services
- providing more services that are close to where residents live, and giving greater freedom to the choose which hospital they use
- where we provide equipment, service users want us to check if their needs have changed or if better equipment might have become available
- improving hospital discharge and avoiding delays and timing that can make it difficult to arrange care, and
- delivering support for those with dementia at an earlier stage.

This plan responds directly to our service user feedback and the priorities they raised.

Service users told us their priorities:

Service user priority	How this plan responds to the priority
Seamless services without gaps in provision or in the knowledge of people's issues, or delays in providing support or equipment	We are mapping the "care pathways" that City residents follow to make sure all of them deliver a better patient experience and better outcomes.
A single named professional to help co-ordinate care at home or on discharge from hospital, and to help navigate the way through services	We have created two new posts in our Adult Social Care team that will work flexibly with the hospitals and GPs that City residents use to co-ordinate and link-up services and improve the process of hospital discharge through the use of a single care plan that follows service users in and out of the acute system.
Information and records to be readily available to, and shared between, health and social care professionals	We are reviewing the systems that hold health and care information so that we can improve the processes of communication and data sharing. A new recording system is in place within Social Care and will be modified to include NHS identifiers. A project work stream has been established to conduct a review of IT systems and interoperability with Health. This will recommend next steps in delivering integrated systems.
Better communication between services	The new Joint Care Navigator posts will

such as GPs and hospitals – especially when you are being discharged home	facilitate discharge and provide a single point of contact for the service user between Health and Social Care
More individualised support, advice and information for carers - such as helplines, support groups, respite breaks and practical help	We are undertaking a review of the support and advice we give to carers to make sure it meets their needs. A Service Directory has been developed in Adult Social Care that is given to all service users and carers. This is being developed electronically alongside our Family and Youth Information Services. Health Services will be incorporated into the directory.
Services available around the clock	We will be enhancing our out of hours provision through the use of Paradoc and Paradoc Nursing to prevent unnecessary admissions to hospital where needs can be met by a GP or a nurse attending a City resident.
A "well-being MOT" to assess your needs and the support you need to stay well	Developing 'Care Plans' that are led by GPs, and which are developed and delivered by multi-disciplinary teams.
Support to avoid and tackle social isolation	Reviewing the work and role of the community based groups we commission to make sure they are meeting users' needs and helping us tackle social isolation and deliver better, and timelier, care and support. Social Prescribing and volunteering activities such as befriending will help to minimise the impact of social isolation as will the work around our Dementia Strategy.
Hospital discharge that is timely, has care in place whatever the day or time you leave hospital, and is not delayed by waits for medication or transport.	The new Joint Care Navigator posts will facilitate discharge and provide a single point of contact for the service user between Health and Social Care

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Report to Health and Wellbeing Board requesting a bid for s256 monies for 2	As part of the model for integrated care, it was identified that 2 posts would be

posts	integral to discharge arrangements and to provide navigators for residents being discharged from hospitals in Hackney, Islington and in Tower Hamlets. NHS England funding was secured for 18 months for these two posts amounting to £175k. JDs are currently being drafted within the intention of the posts being recruited to in 2014/15.
Project scope – Integrated Care project	Tricordant have been working closely with our colleagues in Hackney for the last 2 years on intermediate care and more recently on integrated care. We have invited them to assist us with developing our Adult Wellbeing Partnership Board arrangements and to scope the current services and the One City model for care and support.
Consultation event summary	A summary of the consultation event undertaken on the 12th December 2013 with service providers and residents and facilitated jointly by Healthwatch and the City of London. This summary sets out what our residents want from integrated care.
CCG Project scope for deep dive in relation to IT	The CCG have commissioned Tricordant to establish how our information systems can be better aligned or integrated and to review our information sharing agreements.
CCG strategic plan	The CCG strategic plans for 2 years and for 5 years.
Joint Strategic Needs Assessment (JSNA)	Assessment of the physical and mental health and wellbeing needs of individuals and communities in the City and Hackney
Joint Health and Wellbeing Strategy	Sets out the Health and Wellbeing Board's priorities based on the identified needs in the JSNA and these are included in this plan.
City and Hackney Integrated Care Stocktake report	A report to inform the development of our integrated care programme, identifying the key initiatives and projects having (or having potential for) systemic impact across services or care pathways for adults with long-term conditions and frail older people.
Homerton Hospital Review of Discharge Management	A review of discharge planning and management arrangements across both

	providers in relation to hospital inpatients to achieve better coordinated discharge planning arrangements across health and social care.
Local Annual Account 2012	The Local Annual Account sets out our vision and the changes we have made to our Adult Social Care Services in the previous year.
City Dementia Strategy	The strategy sets out the City's intentions to become a Dementia Friendly City, by engaging the community and delivering dementia awareness training. There are 10 key objectives within the Strategy.

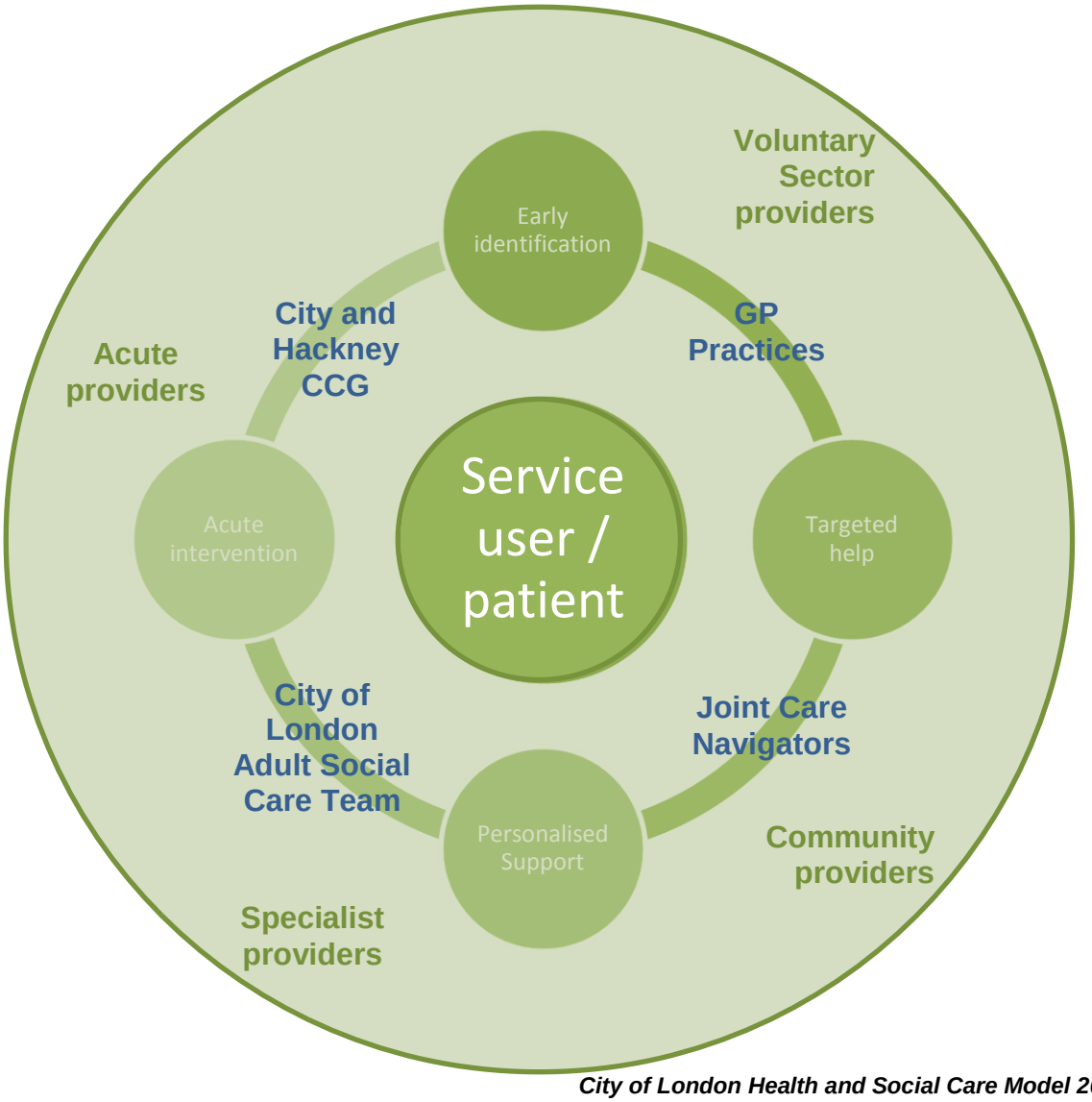
2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Vision

Our vision is:
To develop a bespoke locality model that meets the needs and wishes of City residents and to keep the experience of our service users/patients central to all the services we provide. Delivering the right services in the right place, at the right time.



City of London Health and Social Care Model 2014

Our Service Users are at the heart of our model to provide a seamless approach no matter where they are registered with a GP. There will be much more cross boundary co-operation between the CCGs and providers to enable this to happen.

The City and Hackney Commissioning Strategy fully reflects the intentions within our vision and that of Hackney in delivering integrated services responsive to the needs of patients.

Outcomes

Outcomes for service users / patients will include increasing the number of older people living healthier and longer lives in their own community. We have a low death rate in the City which means that we also have an ageing population. It is therefore important to us to manage the care needs of this older population and to respond to their needs.

Patient and service user experience will be enhanced by enhanced GP provision and the Joint Care Navigators who will 'hand-hold' service users through the health maze, meaning speedier access to services and only having to contact one key person who will act as a facilitator and which will be available 7 days a week.

Our population will feel less socially isolated and more supported by and engaged in their communities through the use of Social Prescribing which our GP practice is already applying and through enhanced volunteering opportunities, particularly through "befriending" activities.

Residential and nursing care admissions will be reduced still further through enhanced community services delivered locally.

Context of the City

The City of London is a unique area – it contains several populations in one space, with different needs and health issues. The City has a resident population of 7,400, found in densely populated pockets of the Square Mile. This resident population, found within 4,400 households, has grown slowly over last decade, but is projected to grow more rapidly to reach 9,190 by 2021. In addition to those who live permanently in the City, there are also 1,400 people who have a second home in the Square Mile. There are also 430,000 people who have jobs in the City (Nomis: Labour Market Profile 2011), as well as students, visitors and rough sleepers.

The City of London has the highest daytime population density of any local authority in the UK, with hundreds of thousands of workers, residents, students and visitors people packed into just over a square mile of urban and highly developed space.

The City of London Corporation is responsible for local government and policing within the Square Mile. It also has a role beyond the Square Mile, as a port health authority; a sponsor of schools; and the manager of many housing estates and green spaces across London.

When Public health responsibilities moved to local authorities in April 2013, the Health and Wellbeing Board of the City of London Corporation took over the statutory responsibility for undertaking the annual Joint Strategic Needs Assessment (JSNA) exploring local health needs and the Joint Health and Wellbeing Strategy

It is bordered by the London Boroughs of Hackney, Islington, Camden, Westminster, Southwark and Tower Hamlets. For health purposes, the City is formally linked to Hackney through the City and Hackney CCG. However its residents access care across three CCG areas of City & Hackney, Tower Hamlets and Islington. This creates complex care pathways.

Whilst the majority of our residents are registered with the sole GP practice in the City boundaries, it is estimated that up to 2,000 are registered with GP practices in Tower Hamlets, Islington or with private medical practices. This issue has been highlighted as particularly pertinent when trying to establish the actual care pathways and identifying which CCG is responsible for delivery of services to which patients. The current care pathway in itself has caused an inequality in the treatment of patients within the same surgeries across all three CCGs – an issue this plan will address through its delivery. Although our population is one of the smallest in the country, we recognise that the needs of our residents are as important as any other community. The City therefore acts on behalf of the residents to protect their interests – and is able to listen to and understand their needs in a way that would be prohibitive to most other authorities.

Our City Supplement of the JSNA predicts that:

- Life expectancy is expected to remain high amongst City residents.
- The number of older people in the City is small but is projected to increase rapidly in the next decade.
- Trends show that older people wish to remain living independently in their own homes for as long as possible.
- Incidences of age-related health problems such as reduced mobility, dementia and social isolation, as well as the need for additional support and care, are likely to increase.
- The City has been adapting to the increasing demands of the aging population through increased provision in telehealth, preventing social isolation and in creating a dementia-friendly City.

Source: City Supplement Health and Wellbeing Profile (JSNA), 2014

Demographics

Projected population age groups in the City to 2037, with percentage rise over previous five years (numbers rounded to nearest 100)

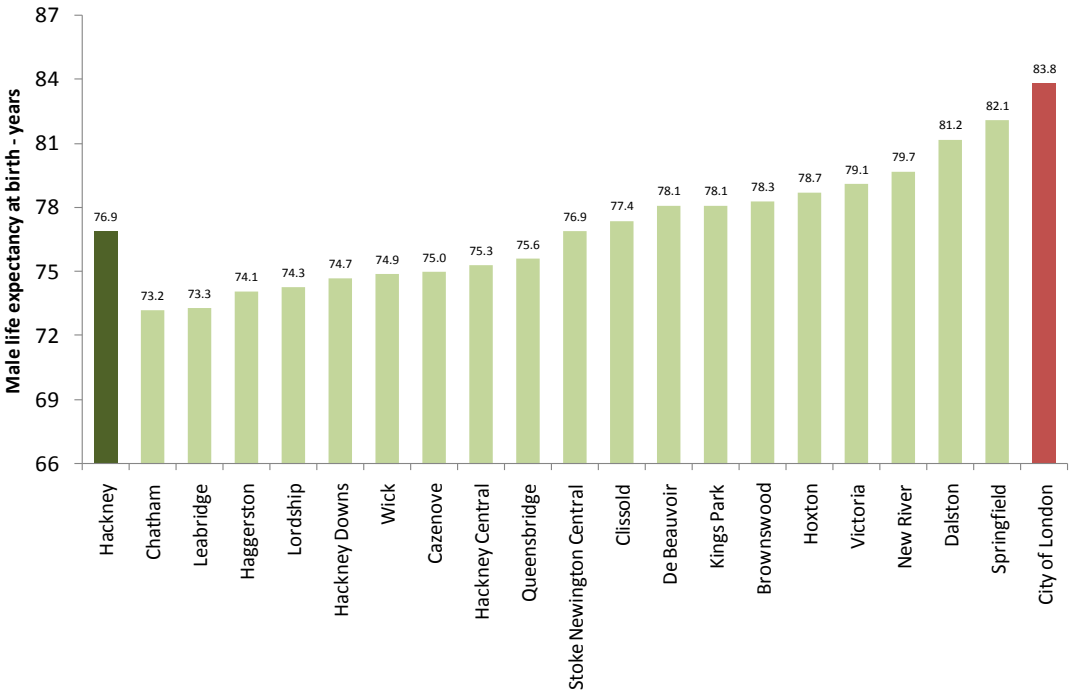
Year		The City				
		0–4	**5–19**	**20–65**	**>65**	**All**
2007	**N** **(% rise)**	300 (22.2)	600 (–0.7)	5,900 (3.6)	900 (4.4)	7,600 (3.9)
2012	**N** **(% rise)**	300 (–7.2)	600 (4.9)	5,700 (–2.1)	1,000 (10.9)	7,600 (–0.2)
2017	**N** **(% rise)**	300 (8.2)	600 (8.1)	6,000 (4.4)	1,200 (17.3)	8,100 (6.5)
2022	**N** **(% rise)**	300 (–0.8)	700 (7.7)	6,200 (2.7)	1,300 (11.3)	8,400 (4.3)
2027	**N** **(% rise)**	300 (–0.8)	700 (4.4)	6,300 (2.0)	1,500 (10.1)	8,700 (3.4)
2032	**N** **(% rise)**	300 (–0.4)	700 (0.3)	6,300 (1.0)	1,600 (13.2)	9,000 (2.9)
2037	**N**	300	700	6,400	1,800	9,200

	(% rise)	(0.4)	(–0.4)	(1.2)	(9.6)	(2.6)

Source: GLA

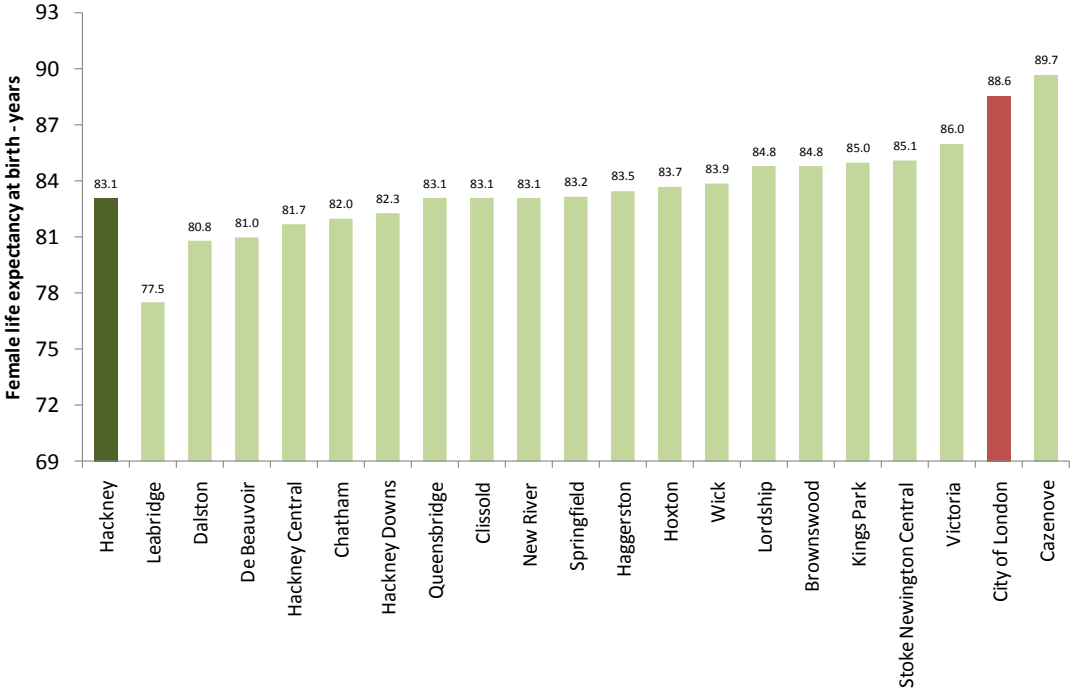
In the City, both the male (83.8 years) and female (88.6 years) life expectancies are higher than the figures for England (78.6 years for males and 82.1 years for females) and the surrounding boroughs.

Life expectancy for males, Hackney and the City 2006–10 (LHO)



Source: London Health Observatory 2010 (now Public Health England)

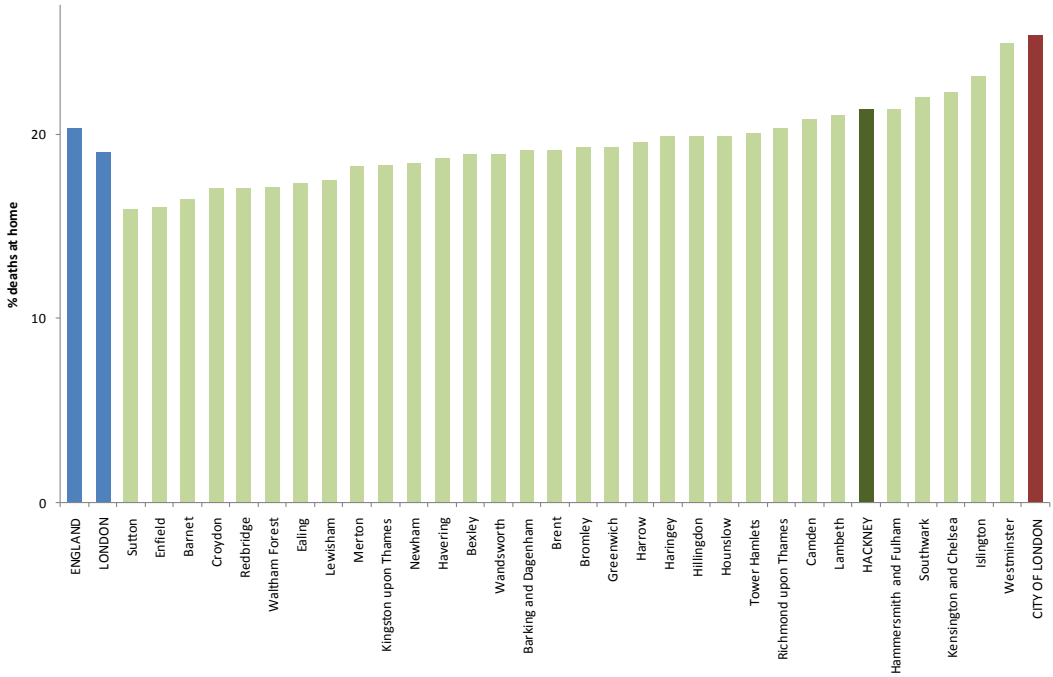
Life expectancy for females, Hackney and the City, 2006–10 (LHO)



Source: London Health Observatory 2010 (now Public Health England)

In 2010/11, over a quarter of the deaths amongst residents from the City took place at home – this was the highest average across all London boroughs and higher than that for London and England. Generally, more men die at home than women.

Percentage of deaths taking place at home, 2008–10 (HSCIC)



Source: London Health Observatory 2010 (now Public Health England)

Despite being such a small geographical area, the City of London has the fifth highest number of rough sleepers in London. Most rough sleepers are white, older males, with problems relating to alcohol and mental health.

Key Findings (JSNA)

- There is a potential to expand services in pharmacy to meet local health needs. Many residents use community pharmacists which are located outside the City; however, pharmacies can also be used to deliver services to City workers
- The City has a vibrant voluntary and community sector, as well as a time credits scheme, which help to strengthen and build communities

Residents

- 20% of City residents are registered with GPs outside the City – this has implications for how cross-border health services are provided.
- Deaths from all cancers and from premature cancer are well below the average for London, and premature deaths have fallen markedly over the last 6 years.
- Other disease prevalence estimates for residents are currently limited to those registered at the Neaman Practice.
- Adult social care in the City has been modernised, and most users of adult social care are happy with the service they receive
- Introduction of the Better Care Fund will enable better joined up working

between healthcare and social care services.

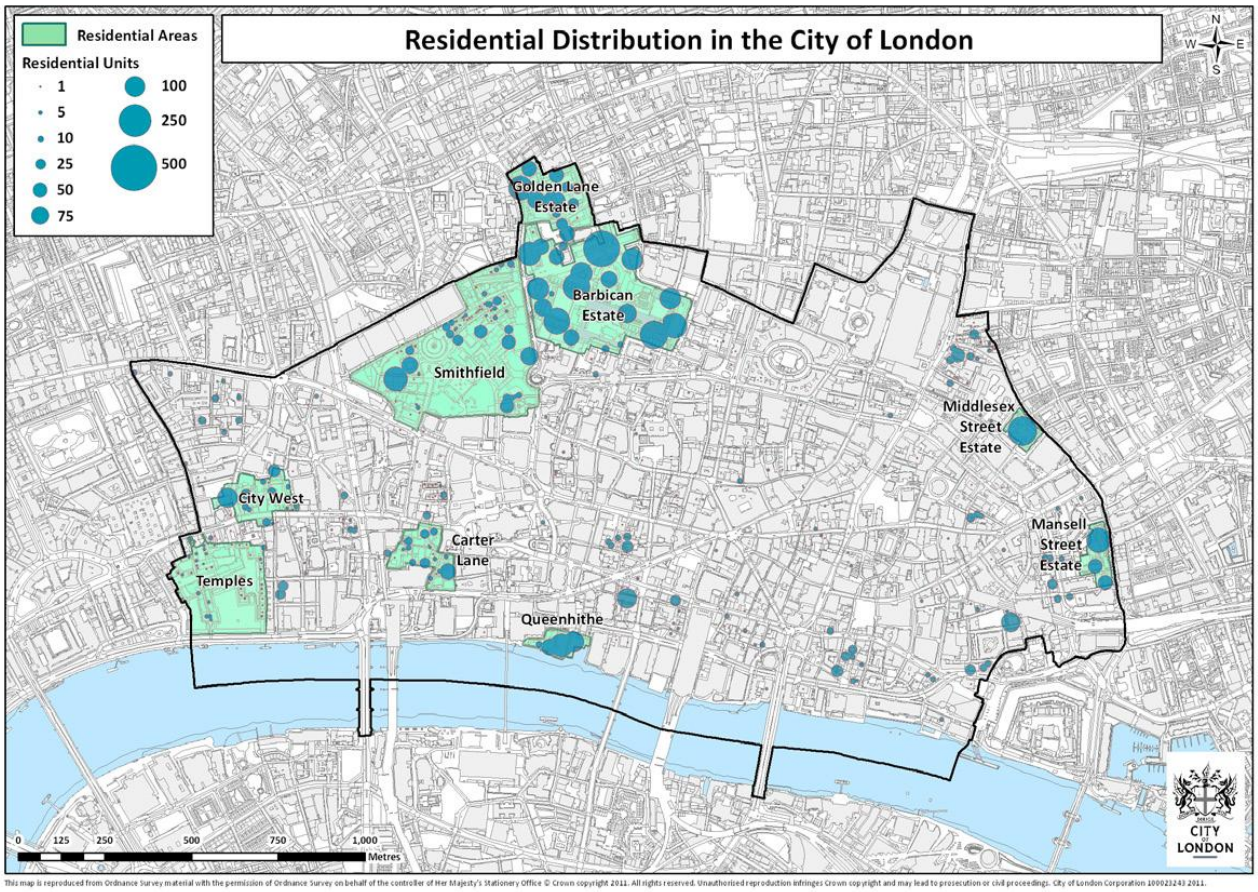
City workers

- Many City workers, particularly those in lower-paid sectors and roles, find it hard to access primary care services, as doing so requires taking time off work for appointments.
- One-third of City workers would choose to register with a GP near to work rather than near to home, if they were allowed.
- Musculoskeletal, respiratory and mental health problems are the major health conditions identified by City workers.

Rough sleepers

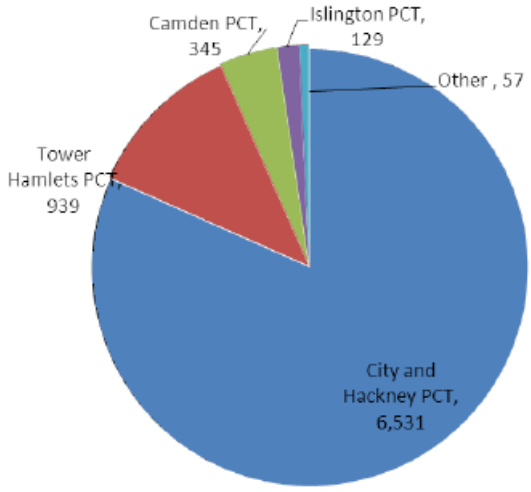
- Rough sleepers tend to have co-morbidities, and are likely to use A&E much more than the general population.
- Rough sleepers are particularly vulnerable to infectious diseases, for example, tuberculosis.

Source: City Supplement Health and Wellbeing Profile (JSNA), 2014



The resident population of the City is concentrated near its boundaries. This means that there is a natural preference of residents to register with GPs in neighbouring areas.

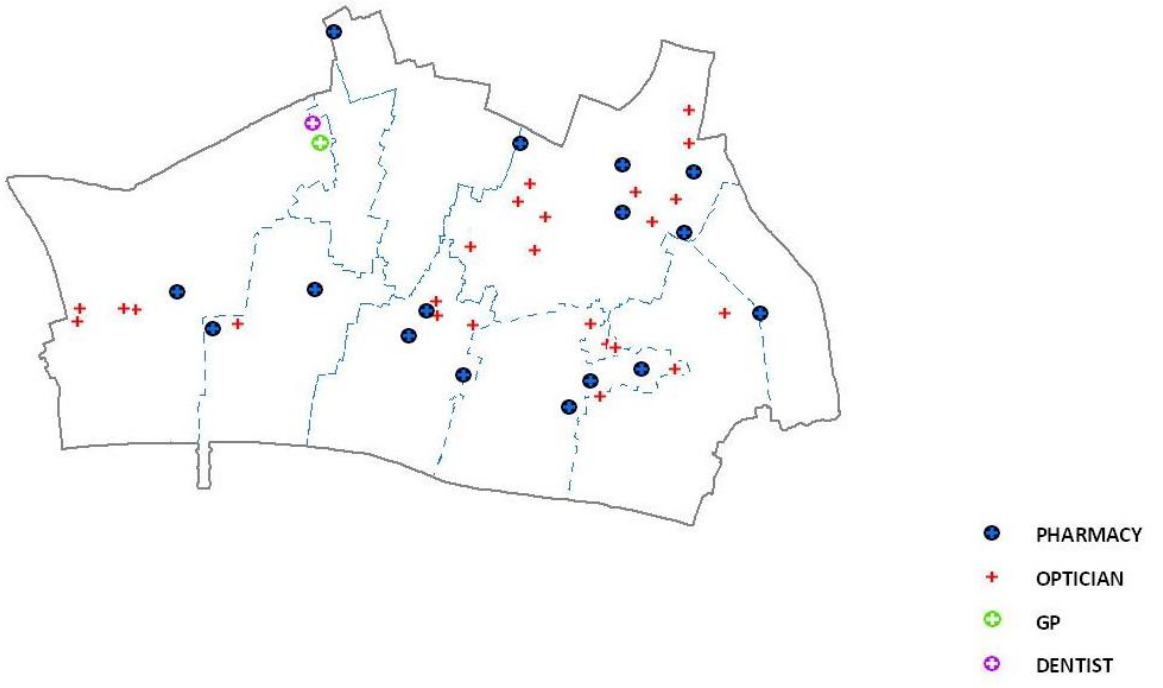
GP Registration by PCT



Practices with largest number of City Residents

Practice	Count of City Residents
THE NEAMAN PRACTICE	6512
THE SPITALFIELDS PRACTICE	597
ST PHILIPS MEDICAL CENTRE	206
CITY WELLBEING PRACTICE	156
WHITECHAPEL HEALTH PRACTICE	88
CLERKENWELL MEDICAL PRACTICE	80
GRAY'S INN ROAD MEDICAL CENTRE	66
ST. KATHERINE'S DOCK PRACTICE	45
Other	251
Total	8001

Primary care services in the City



GP registrations

The majority of City residents are registered with the Neaman practice in the City of London (81%), with the second largest registration being at the Spitalfields practice in Tower Hamlets (9%). Overall, 18% of residents are registered outside City and Hackney CCG; the majority of these are registered with GPs in Tower Hamlets (12%). While the practice with the third largest registration of City residents is in Camden, only 4% of City residents are registered with a GP in Camden CCG.

The Portsoken ward contains two social housing estates at Mansell Street and Middlesex Street. Some of this residential accommodation was originally in Tower Hamlets, but was transferred to the City under The City and London Borough Boundaries Order 1993. The ward's relatively recent addition to the City means that the Portsoken area's links to Tower Hamlets are still strong, and not all of the services in the area are provided by the City. The catchment area of the City's only GP practice does not cover the Mansell Street and Middlesex Street Estates, meaning that residents of these two estates must register with GPs from Tower Hamlets. A Tower Hamlets GP practice currently provides services to Portsoken residents at the Green Box Community Centre, located on the Mansell Street Estate.

City Workers

City workers who are entitled to register with a GP must do so in their home locality. This means that many City workers, particularly those in lower-paid sectors and roles, find it hard to access primary care services, as doing so would require taking time off work to make the appointment.

Research conducted with City workers showed that one-third of City workers would choose to register with a GP near to work rather than near to home, if they were allowed, and 82% would choose dual registration if this were to become possible. Allowing City workers to register close to work has the potential to make services more accessible, support longer-term health needs, provide more opportunities for screening and prevention, and require less time off work to access services.

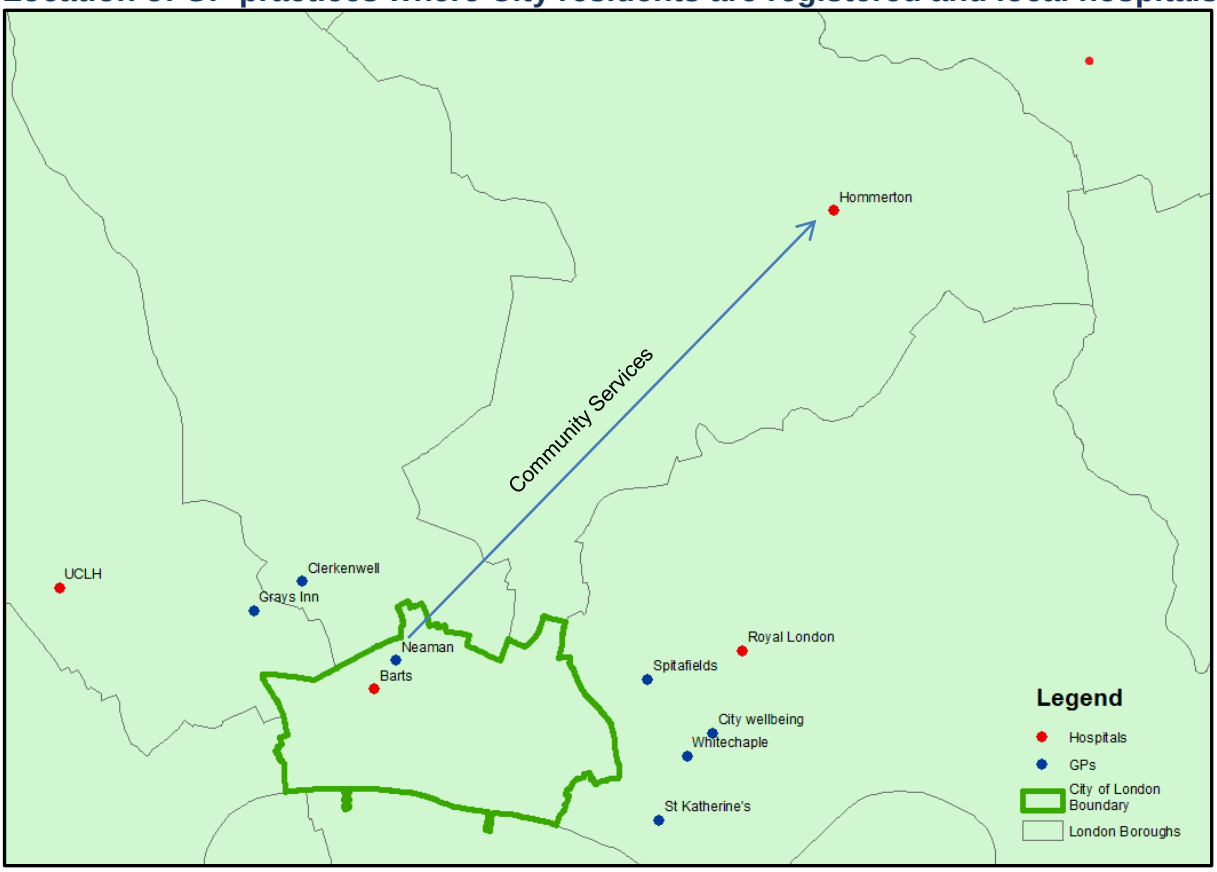
Research shows that City workers wish to access health services and clinics during early mornings, lunchtimes and evenings. The short waiting times for services at private sector clinics are seen as a distinct advantage; however, private services are only available for those who can afford them.

NHS walk-in centres around the country have higher throughputs and longer waiting times than private clinics but they are also open to all and free of charge; however the only NHS walk-in clinic in the City was closed in 2010.

Rough Sleepers

Rough sleepers can register at the Neaman Practice in the City, but most choose to register at Health E1, a specialist GP surgery for homeless people, which is just outside the City. The City's homelessness strategy has made improving the health and wellbeing of homeless people, including rough sleepers, a priority.

Location of GP practices where City residents are registered and local hospitals



Source: Hospitals and GP surgeries attended by City residents 2014.

Whilst Barts, the Royal London and UCLH are the closest hospitals for our residents both for acute and community services, they are frequently unable to access community services locally or even some acute services because of the fact that they live in the City. Planning is underway with the CCGs in Tower Hamlets and Islington as well as City and Hackney to improve accessibility of services for our residents and to map out coherent care pathways.

The Homerton Hospital in Hackney is the key acute provider for our CCG. However, many of our residents will attend or be admitted to University College London Hospital, the Royal London or the Whittington and we are therefore working closely with these providers in our considerations of integrated care. The Community Services commissioned by the CCG are provided through the Homerton.

Currently, we have arrangements where we spot-purchase many services that would be commissioned by other authorities. This gives us flexibility and the ability to provide responsive bespoke packages of care, tailored to the needs of individuals within our community within a timely manner, where other authorities might be restricted by the numbers using a particular service.

Over the last 2 years, the City has invested in an in-house Reablement and Occupational Therapy service combined with assistive technology. This has increased the number of people able to live independently at home and reduced reliance on Adult Social Care. It remains our vision, to facilitate and enable our service users to live in their own homes as

long as they are able and while it is their preferred option.

When the Better Care Fund was announced, we wanted the opportunity to be able to build on our existing bespoke models of care and support. Reliance on services commissioned by others, or partnerships in which the City is the minor party, have not served our residents well in the past nor met their needs appropriately. We are keen to explore some of the pilots being implemented by our neighbours and tailor them to meet the needs of our users.

Our Public Health work is very strong within the City and whilst we work with our 7,400 resident population, we also undertake preventative work with over 300,000 City workers who benefit from a number of projects within the City. This includes funded smoking cessation services and a late night levy to licensed premises to minimise the effects of alcohol intoxication.

We have created various 'apps' to improve health including the CityAir App which helps users to reduce exposure to areas of poor air quality and encourages people to take simple action to help improve local air quality, and preventing unnecessary ambulance call-outs for breathing related difficulties as well as longer term impacts on health relating to air quality.

The Drinksmeter and Drugsmeter apps provide feedback to individuals in relation to their own, personally-reported use of alcohol or drugs. The apps provide advice on reducing the risks associated with the use of alcohol or drugs and links to treatment and other services.

This highly effective Public Health offer within the City has wider implications for preventative health services across the country in encouraging workers in the City to live healthier lifestyles. Evidence from the Census 2011 identified a high number of young male workers. This predicts particular health issues in relation to alcohol usage and sexual health and where people may not want to attend their own local GP to discuss these issues, they are more inclined to retain their anonymity by attending services within the City.

The City also commissions NHS health checks for low paid routine, manual and retail service industry staff in the City, as many of them are unable to access primary care services during working hours in their home boroughs. The City also works in partnership with City businesses to encourage healthier working practices, as well as commissioning information and advice services for City workers.

Whilst these services are relatively new, we are monitoring their use and the impact of their use through the number of Ambulance Service call outs (and admissions) for alcohol or drug related issues within the City.

Links to other plans

There are a number of other plans that are referenced throughout the development of this BCF plan. The key plans identified as the JSNA and the city and Hackney CCG 5 year Strategic Plan form a baseline for all agreed developments. The priorities and visions within these documents enshrine the principles adopted within the BCF.

Joint Health and Wellbeing Strategy

Our City of London Joint Health and Wellbeing Strategy identified key priorities for

residents, for rough sleepers and for City Workers:

Key Health & Wellbeing Challenges

1. Residents

- Ensuring that all City residents are able to live healthily, and improving access to health services.

2. Rough Sleepers

- Working with health and outreach services to ensure rough sleepers are given the range of support they need.

3. City workers

- We want the City to continue to be the world leader in international finance and business services, and a healthy workforce is key to this.
- We want workers in the City to thrive here, and for The City of London to lead the way as an exemplar for workplace health. We want to meet the needs of all of our workers, especially those in lower-paid and non-professional positions. All kinds of people work in the City, and so we need to think about different ways to engage with them, and ensure we can keep them healthy.
- We want to work with City employers and City workers to prevent ill health, reduce sick days and improve the productivity of City businesses. It is acknowledged that many of the challenges that apply to residents also apply to workers.

These priorities are translated into action within the Joint Health and Wellbeing Strategy, the spirit of which underpins the BCF Plan.

City and Hackney CCG 5 year Strategic Plan

The City and Hackney 5 year Strategic Plan outlines the vision and key actions for the residents of City and Hackney over the next 5 years. This includes commitment to the BCF plan and to delivering a range of services that will enhance the patient experience.

Our vision for the City and Hackney health economy is:

- Patients in control of their health and wellbeing;
- A joined-up system which is safe, affordable, of high quality, easy to access, eliminates patient waste and improves patient experience;
- A collaborative approach to reducing health inequalities and premature mortality and improving patient outcomes;
- Getting the best outcomes for every £ we invest through an equitable balance between good preventative services, strong primary and community services and effective hospital and mental health services which are wrapped around patient needs;
- Services working efficiently and effectively together to deliver patient and clinical outcomes and providers in financial balance.

City & Hackney CCG 5 year Strategic Plan

Many of the schemes developed in Hackney form part of the BCF plan, however will be modified to meet the needs of residents in the City. This includes the commitment from neighbouring CCGs in Tower Hamlets and Islington to work with us in removing barriers to effective cross border working.

Preparation for the Care Bill

Much of the emphasis of this plan is developing our arrangements for the implementation

of the Care Bill. By enhancing the choice of our residents and giving them more of a voice locally, particularly in relation to how they are cared for and in developing our systems in relation to personalised budgets and deferred payments we will be in a strong position once the Bill becomes enacted.

The City has operated deferred payments for those who are admitted to residential and nursing care for a number of years. This means that we are well-positioned for the implementation of this aspect of the Care Bill

In terms of the finances around the BCF, we have modelled this on the individuals using particular services to enable us to be cost effective, and to be able to follow the service user with payments rather than paying for services that are not used by the City residents. This will help us to deliver services around the users spot purchasing relevant and timely interventions.

What changes will have been delivered in the pattern and configuration of services over the next five years?

Locality working model

By 2016/17 we will have developed, and be operating a locality working model where people are able to access resources locally and in their homes where appropriate. We want to see the City as a locality in its own right rather than it being seen as an 'add-on'.

Our Adult Social Care Team already successfully integrates Reablement, OT and Mental Health with Social Care. This gives us flexibility to be responsive to the needs of our service users and already allows us to share information between disciplines. We will use this model to integrate further with Health and with Community Nursing to ensure that service users are able to access relevant services in a responsive and timely manner by knowing who needs which services and use flexible commissioning arrangements to source services in Hackney and in Tower Hamlets and Islington or commissioning jointly with the CCGs.

This will require much closer scrutiny of the care pathways used by our residents. We are already working with our partners and stakeholders to identify and review these pathways in order to deliver a model that fits for residents whether they are registered in the City or in one of our neighbouring CCGs. This will also benefit those from our partner CCGs in understanding the care pathways of their residents registered with our GP practice. Initial findings suggested that there were system issues in relation to where residents may be referred for particular services depending on where they were registered with GPs. These are being addressed and simplified and the implementation of recommendations from this review will commence in 2014/15.

The City will be a hub for the delivery of community based services that are commensurate with the needs of our population. These services are likely to be delivered from our GP surgery.

Reducing unnecessary admissions

We will ensure that acute admissions are minimised through our preventative support, through reablement and through our services within the community. The City of London will therefore be a healthier and happier place where people are able to access preventative services locally that meet their needs and are able to retain their

independence longer and to exercise their choice of staying at home.

Joint Care Navigators will work with GPs to identify the health needs of vulnerable service users and will give advice and support to service users and to signpost them to community services where relevant to prevent the need for admissions. By having Joint Care Navigators in place we will have a much clearer indication of how we can improve our preventative work to reduce unnecessary admissions still further.

Using the Risk Stratification Tool, our GPs will identify those patients at most risk of hospitalisation and prioritise these for the development of integrated Care Plans to be discussed within the multi-disciplinary teams. This way of working will assist us to deliver packages of care and support that will prevent unnecessary admissions

Our admissions avoidance service will contribute to the reduction in the number of emergency admissions through intensive intervention and 24hour support at home for up to 72 hours over an acute period.

We have estimated a reduction in unnecessary admissions of 50% which would deliver £62k savings in the first year and £80,850 ongoing.

Recognising the importance of carers

The involvement of carers will be pivotal to our plans and their involvement in the care plans for our residents will be essential. We will demonstrate our commitment to carers through our locally devised performance measures, ensuring that they have timely health assessments themselves and that they feel that they have been listened to and involved in the development of any care plans for the person they are caring for.

We already have carer assessment processes in place and have a cohort of carers managing their own individual budgets. Carers are involved in user groups and in our Adult Advisory Group and are therefore able to directly impact service design and delivery. However, we know that historically our carers have not reported a good quality of life and are therefore committed to improving their access to services and support. We also know that key to this is the improvement of local services for the person they care for.

Our local metric of Carer-reported quality of life will be reviewed annually by our Adult Wellbeing Partnership, however underpinning this indicator will be a review of the percentage of carers receiving their own health assessments and who felt involved in discussions about the person that they care for. This will help identify whether carers need additional support in meeting the needs of the person that they care for.

The Carer's Grant has not previously been allocated directly to the City as the CCG funded a joint contract with Hackney for the delivery of Carer support. It is evident however that our carers were not accessing this service and the BCF process has allowed us the opportunity to address this issue.

Integrated data sharing

Building on the City and Hackney model, residents will be confident that they are able to 'tell their story' just once for that information to be shared and understood across health and social care. Care plans will be developed that clearly state a single named person who will guide the person through the health and social care system and who will navigate any discharges from hospital, minimising any delays and reducing the number of people having to be readmitted.

We are mid-way through a joint project between Health and Social care to review our data and information sharing arrangements and to recommend the next steps in securely managing shared data.

The outcomes of this joint review of information sharing arrangements will be presented to partners and will conclude in June 2014 with an agreement to the 'One City' information model. Our Caldicott 2 compliant Information Sharing agreement will be signed off by October 2014.

Running in parallel with this is an exercise to include the NHS identifier on all social care records to enable us to communicate using this number. This exercise will be completed by July 2014. Communication between health and the local authority using this number will commence by September 2014.

Robust data collection

Patient data is to be disaggregated from each of the CCGs to be able to form a clear picture of the residents within the City of London to enable better planning based on actual needs rather than synthetically estimated projections. This will mean that services are fit for purpose and will be effective in meeting the needs of our residents at a time and place they want or need them. We are working across the 3 CCGs to gather data relevant to the City population in order that we can analyse trends and better match provision with needs.

This work sits alongside the improvements we are already making through the creation of a separate JSNA supplement specific to the City which will enable Health and Social Care to make robust decisions on the projected needs of residents. We will be able to identify further key savings to be made in the system, by delivering services that are needed rather than contributing towards services that our residents do not ever use.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims and objectives

The key aim within the City of London will be to deliver integrated preventative services to support residents to remain within their homes and to provide support to prevent emergency admissions to hospital and to support frail older people with health problems including those with long-term conditions to promote independence. This will take a whole-system approach that is engineered at a micro-service level in order to improve pathways for individuals and therefore improving the service user experience.

We will achieve this through pulling together all of our key strategies that span health, social care and housing that affect the physical and mental wellbeing of our population and using our unique assets to respond quickly and innovatively to the needs of our population. Many of these strategies identify actions that will ultimately improve the health and wellbeing of our residents and when implemented will drive many of the changes required by the Integration agenda.

By creating the Adult Wellbeing Partnership we have a body of accountable senior officers who will ensure that our plans are delivered and who will be accountable to the Health and Wellbeing Board for the timely delivery of integration across health and social care.

We are developing a more specific Adult Service User Feedback survey to capture satisfaction with integrated services and jointly delivered services to enable us to monitor closely the difference our services are making for our residents.

Specific objectives

1. ***Joint working*:** The City has an ethos of co-production with our residents and service providers and we want to ensure that our Better Care Plans are (centrally) co-produced and monitored by our service users.
2. ***Promoting independence*:** We currently provide our own reablement and OT services which have helped residents who prefer to stay in their own home rather than going into residential or nursing care. We want to widen the scope of our service to provide greater independence and support.
3. ***Meeting expectations*:** Our Adult Advisory Group is a key driver for many of the changes in the City and for service improvement and development. Together with the GP User Group, we will ensure that our plans meet their expectations and that service users, carers and patients report better experiences of their care.

Outcome measures

Health gains for local residents

The principal health gain will be the number of people from all adult social care client groups who have fulfilling lives within their own community.

We will ensure that independence is promoted using the following assessments:

- Frequency of permanent admissions to residential and nursing homes
- Proportion of people still at home 91 days after hospital discharge into rehabilitation services
- Frequency of delayed transfers from hospital including mental health admissions
- Number of avoidable emergency admissions

We will ensure that expectations are met through:

- The Adult Service User Feedback Survey
- The Carers' Surveys
- Feedback from our Adult Advisory Group
- Regular feedback sessions facilitated by Healthwatch as part of our Annual Local Account

We will ensure that Joint working is effective using the following assessments:

- Establishment of joint governance arrangements
- Member attendance and engagement at all meetings within the governance structure
- Collation of feedback from our Adult Advisory Group and GP User Group

Additional benefits will include:

- Fewer unplanned admissions and more proactive case management
- Reduced numbers of elderly people and people with physical or mental health problems needing admission to residential or nursing care and more people using personal budgets to manage their own care
- More people having access to preventative services delivered locally within the City.

Gains for the wider system

In developing the model in the City, we want to demonstrate a system that can work for the individual as well as for the wider Health and Social Care community. Our system has reciprocal benefits for the CCGs working with us, in that we have Reablement and OT services that work particularly well. Having an enhanced service that includes Joint Care Navigators, we will be demonstrating on a small scale a personalised approach that service users across the country should expect from care integration and modelling the behaviours that are at the heart of the BCF policy.

Making changes for each individual and seeing them as a 'whole person' rather than as a list of individual medical interventions will have a bigger cumulative impact on patient experience than wide-scale policy changes.

Areas that other CCGs and areas will be able to learn from will include:

- Recognising the individual as a person rather than as a statistic
- Recognising their needs as important to them
- Delivering a real ‘customer-service’ model
- Understanding their holistic needs rather than their needs in isolation of each other
- Having a named person who can follow the service user through from before they are admitted to hospital right the way through the pathway past discharge and back to post-discharge pathway.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

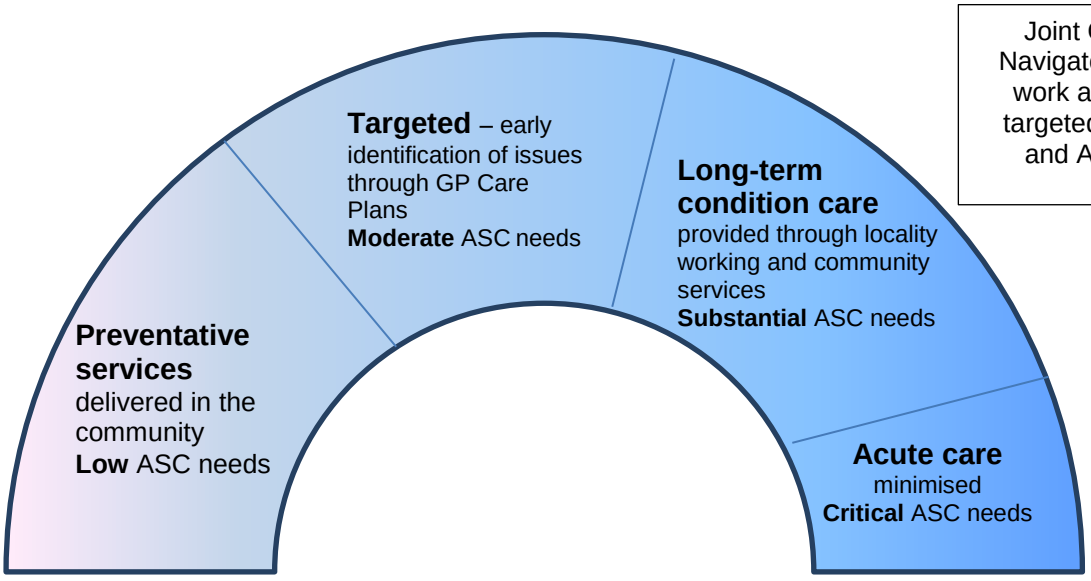
Introduction

Within the City our aim is to further develop our preventative and targeted services to reduce the numbers of people ever reaching the acute level. We currently deliver universal and preventative services through a number of activities and voluntary groups within the City which is enhanced by a Public Health offer that addresses the wellbeing of the whole resident population and that of some 300,000 City workers. This has been the focus of the City for the last 2-3 years and

Targeted services to those who may be at risk of requiring further intervention are delivered through understanding the needs of our community. Wellbeing checks for over 75s are undertaken by our GP. Early diagnosis of dementia is a key example of targeted work where we have established support groups to enable patients to maintain their independence and to regain their confidence following diagnosis.

Those with long term conditions are supported to manage their condition at home and this is supported with the use of Telecare to help prevent acute admissions. Where admission is necessary, our Reablement and OT Service and our community services manage the rehabilitation processes and offer support, minimising the chances of readmission.

Preventative services will be met within the existing budgets, however additional BCF funding has been allocated to assistive technologies, information sharing and robust data collection. This will help use to ensure that people do not formally enter the social care system and are assisted to manage their own care at home.



Preventative Services

Preventative services will be offered to all residents in order to maintain their general health and wellbeing. Many of the preventative services have been developed through our Public Health offer and are not specifically listed here. These services will enable us to identify any early need and offer support alongside our voluntary sector.

The City works very closely with our neighbour authority in Hackney, and so whilst some of the schemes within our plan link to the pilot schemes that are in development there, we are taking the opportunity to tailor these to fit the specific needs of the City in this pre-implementation year. We are also able to link to the schemes in Tower Hamlets and Islington in order to ensure smooth transition between acute and community services for our residents registered with GPs outside our CCG footprint.

The key challenge for the City is in ensuring that all of our residents are able to easily access services, regardless of where they are registered with a GP. We have started to review each of these schemes in order to assess how GPs in Tower Hamlets and Islington can access appropriate services in a timely and effective way for our residents who are registered with them. We are developing links through local network meetings to ensure that barriers to provision are minimised thereby improving patient experience.

Early identification

We have undertaken to identify residents who are at risk of vulnerability. We will use the risk stratification tool alongside our GP practice and those where our residents are registered in Tower Hamlets and Islington, to identify not only those residents who are at high risk and who are housebound, but those who are vulnerable to ensure that we can meet their needs at an early stage, reviewing potential housing needs to identify whether aids and adaptations, assistive technology or Telecare / Telemed may be required to support the resident to maintain their independence.

Information Sharing

Tricordant have been commissioned to undertake a review of the information sharing arrangements and system requirements of integrating our data through the use of improved technology. The Social Care database has recently been replaced with Framework-i which has the capability of recording the NHS identifier and already facilitates the communication between our GPs and Adult Social Care. By developing the technology and the agreements for information sharing during 2014/15, we will be in a good position for implementing step changes to the way in which we share information between the health and social care systems.

Building robust data collection

One of the workstreams will address the data issue by providing a baseline as to where City residents are registered with GPs and then to produce robust data concerning our residents so that we are able to monitor improvements. This will assist us in updating our City specific JSNA supplement and delivering a map of health and social care interactions to ensure that integration is delivered for all City residents, no matter where they are registered. It will also help us to identify gaps and forecast likely future needs.

Social Prescribing

In addition to providers within the City, we have a wealth of volunteering opportunities that has been extended by the use of a “Time Credit” scheme which has been implemented in the City.

Alongside colleagues in Hackney, we have developed a Social Prescribing scheme in the City, where residents may also be 'prescribed' to participate in social activities within the City to reduce social isolation and promote health and wellbeing. Social prescribing is targeted towards patients who repeatedly attend GP surgeries due to loneliness. Our GP surgery is primed to identify a range of support services, including welfare advice, befrienders, walking clubs, arts clubs and exercise groups. This process is sometimes called 'community referral', as activities and services are on offer locally and are mostly provided by the Voluntary and Community Services.

These activities fit within our ethos of preventing acute admissions where possible by promoting healthy lifestyles within the City and reducing the impact of social isolation. There is a worker at our GP practice and this is working well, especially in relation to dementia.

Time Credits have been trading in the City since June 2012, and since then over 1,700 hours have been contributed by 180 people through 21 connected providers and community groups. The focus of the programme has been on developing Time Credits in the Portsoken ward, one of the most deprived areas of the City. Spice has been liaising with the commissioning team to involve users in commissioning, designing and delivering services – and in training providers to adopt the Time Credits system – and is currently working with City Gateway, CSV, Recycling, Fusion, Toynbee Hall, Artizan Street Library and Community Centre and Healthwatch. Local residents are also growing in confidence and are starting to set up more community-led groups, including gardening clubs, good neighbours' schemes, activity groups such as Zumba and sewing, and social groups for women and young people.

By encouraging more people to get involved in services, local community groups and third sector organisations, Time Credits create opportunities for individuals to learn new skills, gain confidence and raise their aspirations. By spending Time Credits, individuals can try new activities and improve their health and wellbeing. Many participants have commented that, through the Time Credits Network, they have been able to try activities they could not previously afford. As a result of their increased participation, individuals have better access to peer and community support networks, and a more positive perception of their ability to contribute to the local community.

Initial findings from our evaluation survey, carried out a year after rollout, show that 31% of people involved with Time Credits have never previously volunteered within their community. 62% feel that the scheme is helping to improve their quality of life.

Medicines Management

Effective team working between patients, doctors, nurses and pharmacists will be developed to limit the risks of polypharmacy and optimise prescribing. The CCG is commissioning practice based pharmacists to work alongside each practice to support this initiative. This will particularly benefit frail elderly who are often at risk of adverse reactions and decreased adherence to treatment through prescription of multiple drug therapies.

Targeted Services

Targeted services will use the risk stratification tool to identify those residents who are at higher risk of poor health and vulnerability. These services link very closely with preventative services although they will have an element of delivering support for needs

that are greater than those of the general population. Following on from early identification, these residents are likely to have additional assistive technology requirements.

We have identified these services on the finance spreadsheet under the heading of Case Management for the Frail Elderly and Practice Based Co-ordinated Care. Joint Care Navigator work is included within Admissions Avoidance.

Case Management for the Frail Elderly

We will adopt a targeted, general practice-based proactive approach of care for vulnerable, elderly patients. General practitioners will lead the development of care plans for most of their frail and vulnerable elderly patients within the City. They will be identified using the risk stratification tool. Our goal is for each vulnerable patient to have: (a) an individualised care plan; (b) regular scheduled home visits, which typically will occur quarterly; (c) one responsible named doctor to ensure continuity of care is maintained.

General Practitioners will have overall responsibility for undertaking these care plans and will provide input into addressing the medical issues identified in the plan. They will be supported by community nurses, who will be trained to initiate the patient-centred plan and develop goals with these patients. Patients will be asked their consent for their care plan to be shared and the health information exchange system will be developed as an option for sharing care plans across organisations. It will be of particular importance to develop and share crisis plans across organisations, so that the patient, carers and responsible health and social care professionals are aware of what should happen in the case of a crisis. Care plans will be introduced in 2014-15 and we will enter into contracts with our practice to deliver this. Care planning will be supported through setting up practice based co-ordinated care as outlined below.

The City approach will see this scheme developing further throughout 2014/15 by piloting a single joint assessment undertaken by Adult Social Care and the GPs, with the GP retaining responsibility for the healthcare element of the assessment and resulting plan and the joint care navigator providing the coordination between that and the Adult Social Care responsibilities to ensure that the patient can be guided through the pathway simply.

Practice Based Coordinated Care

Our GP practice will establish practice-based coordinated care as a cornerstone of joint working, based around frail elderly patients linking with other practices in City and Hackney CCG area. It will optimise the care and clinical outcomes of individual patients by developing a care plan designed and agreed with the patient, proactively reviewing their care plans and using joint expertise available within health and social care services to develop actions based around the care plan. Multi-disciplinary case management will be crucial to the care of these vulnerable, elderly patients and agreed with the patient, carers and across team members. GPs will have central roles organising and co-ordinating care, providing the medical input to care plans. They will be supported by a multidisciplinary team of community and specialist nurses, social care staff, community mental health workers, therapists, community matrons and acute clinicians including a Care of Elderly Consultant. For City residents, the Joint Care Navigators will attend these multi-disciplinary teams to ensure that the care pathways for our residents are clearly identified within the care plans.

We follow a holistic focus that supports service users to manage their own conditions at home and become more independent and resilient rather than having a purely clinical focus on treating medical conditions. There will also be the opportunity to develop

support services for families of these most vulnerable patients, to ensure that patients and carers concerns are addressed – particularly where there is anxiety and depression and other challenging issues.

The CCG is currently aligning its contractual arrangements across the different services and providers to ensure that they are working together to achieve the same outcomes.

Developing enhanced multi-disciplinary working will enhance the creation of informal and formal professional networks. These networks will facilitate developments in clinical practice and referrals to a range of health and social care services to maintain people within their communities and will help further improve their care.

This will be supported during 2014/15 by a local incentive scheme for City and Hackney practices, which will ensure that practices are contracted to undertake care planning, proactive home visits and continuity of care for the most vulnerable frail elderly patients. This will be further underpinned by imminent changes in 2014/15 to the GMS contract, which will ensure similar proactive case management for a wider cohort of vulnerable patients (top 2% of most vulnerable) although this may be extended for City residents to include a wider cohort. Processes will be introduced to audit the quality of care plans across all practices in the City and Hackney.

We have also commissioned the Tavistock and Portman NHS Foundation Trust to support the multi-disciplinary team members to develop the skills to negotiate and implement user led care plans across the various team members and in conjunction with the patient and their families and carers.

Integrated clinical services

Homerton Hospital already provides a highly effective Chronic Obstructive Pulmonary Disease (COPD) team which provides proactive support to patients with COPD and asthma, linking closely with local practices. The team aims to avoid emergency admissions by intensive community based support, by working alongside the A&E Department and by providing proactive management to support early hospital discharge and community follow-up – this is complemented by a service commissioned from local GPs to identify patients with COPD and manage exacerbations.

This service will be integrated with our planned development of practice based coordinated care, as will other specialist community teams such as the Community Heart Failure Nursing Team and Epilepsy Team.

We are aware that similar services are in place in Tower Hamlets and have been exploring how our residents could access these services if they are registered with Tower Hamlets' GPs.

Joint Care 'Navigator' posts

We have secured funding for 18 months for the creation of 2 posts which will have responsibility for co-ordinating services for our residents as they are discharged from acute care, this will include the facilitation of services within the hospital setting so that discharge can be a smooth transition to home and community based services or to other care as required. We intend that these two posts will be pivotal in supporting the multi-disciplinary teams and in supporting Care Planning meetings led by the GPs. They will also have responsibility for facilitating discharge for our residents from hospitals outside our CCG area and have therefore included Tower Hamlets and UCLH in our discussions about the development of these posts as they agreed in the necessity of having them.

These posts will be recruited to in 2014/15 in order to effect a smooth transition to integrated service delivery in 2015/16.

We have identified from research undertaken by Age UK in Kensington and Chelsea that there are potential savings of up to £859 per referral in using these posts. We are reviewing this model to determine how it may be applied successfully within our context.

Long Term Condition and Discharge Services

Reablement Services

The City of London hosts its own bespoke Reablement Service and has been very successful in delivery of services to support effective reablement of our residents as supported by recent inspections of Reablement and have never had any fines relating to delayed discharges. We are able to deliver care services proactively due to our size and with the support of the two 'navigator' posts we expect that this will be improved still further through early identification of needs through joint care plans with the GPs. If intermediate care is required we have effective spot purchasing arrangements in place which ensures timely intervention to support rehabilitation and ensure that there are no delays in discharge.

We currently use aids and adaptations, assistive technologies and Telecare to ensure that people can stay safely in their home for longer where this is their preference and we have been able to effectively reduce the number of people being admitted to residential and nursing care following acute admissions.

Community based services

In relation to specific services, Community Nursing provision depends entirely on where the residents are registered with a GP and which CCG provides this. These are currently being reviewed alongside CCG colleagues to determine how our residents can access community based services seamlessly no matter where they are currently registered with a GP. We are exploring a resident-based commissioning model which will allow us to remove some of the current barriers in the systems and improve the integration of services provided across all three CCGs for the benefits of our residents.

Integrated Care Pathway

We are developing our integrated care pathway model that will be operational by 2015/16. This builds on the work undertaken with our neighbours in Hackney and will incorporate the GP practices in Tower Hamlets and Islington where some of our residents are registered to ensure that they are able to access services for our residents.

Mental Health

The City of London has two FTE AMHP (Approved Mental Health Professionals) social workers who cover the settled population of the City together with joint work with Broadway and the East London Foundation Trust (ELFT) CPN to support homeless people with no connection to another local authority. The AMHPs are located within the Adult Social Care Team which enhances the offer we give to our residents and serves to promote integrated working.

Dementia Care

In September 2013, the City published its Dementia Strategy which has established a City-specific approach to caring for our residents whilst tapping into the rich diversity of our community.

Synthetic estimates predicted that within the City there were up to 67 people living with

the symptoms of dementia, some of whom had been diagnosed but a large proportion of whom had no formal diagnosis. Whilst this may be a relatively small number, for those with the disease the support that they received is vital to their quality of life and their wellbeing, and the City is therefore committed to providing the best possible services to this particularly vulnerable group.

The aim of the strategy is to provide a responsive, high-quality, personalised dementia service meeting the needs of residents of the City of London. To achieve this, the strategy set out 10 objectives:

- Improve public and professional awareness of dementia and reduce stigma.
- Improve early diagnosis and treatment of dementia.
- Increase access to a range of flexible day, home-based and residential respite options.
- Develop services that support people to maximise their independence.
- Improve the skills and competencies of the workforce.
- Improve access to support and advice following diagnosis for people with dementia and their carers.
- Reduce avoidable hospital and care home admissions and decrease hospital length of stay.
- Improve the quality of dementia care in care homes and hospitals.
- Improve end-of-life care for people with dementia.
- Ensure that services meet the needs of people from vulnerable groups.

The strategy committed the City of London Corporation to creating a 'Dementia-Friendly City', where residents and local retail outlets and services would develop a keen understanding and awareness of the disease and offer support in a respectful and meaningful way. This built on the longstanding tradition within the City of caring for residents and delivering individualised packages of care and support. We already work in a quasi-integrated process by participating in multi-disciplinary meetings for those clients with Dementia.

In creating a 'Dementia-Friendly City' the Dementia Adviser gives training to businesses and to the community so that they can recognize the symptoms and be able to support this vulnerable cohort and develop a keen understanding and awareness of the disease to offer support in a respectful and meaningful way. In addition to working across the Corporation with colleagues in Housing, Museums, Libraries and Art Galleries, we have been able to engage with retail outlets, the Police and our providers.

Skills for Care has worked in partnership with the City using this model and other good practice in order to develop a safe environment for those with dementia. This included a review of signage within the City to help those with Dementia to navigate easily to and from their homes.

A 'Memory Café' is being delivered in the City provided by Age UK Camden and is growing in success.

The strategy was agreed at the Health and Wellbeing Board on 5 September 2013, with the addition of a commitment to improving signage within the City, starting with the estates managed by the Corporation. The Housing Strategy which is due to go to Committee in April 2014 reinforces the fact that within the City we can work across disciplines to achieve the same aim.

Homerton Psychological Medicine (HPM) service

The Homerton Psychological Medicine service at HUHFT is a multi-disciplinary psychiatric liaison service provided by ELFT (East London Foundation Trust), but contracted through HUHFT. Its core model is derived from evidence accrued through a 2010/11 pilot project for liaison services in Birmingham where it was known as RAID (Rapid Assessment Interface and Discharge). The key objective of this service is to improve the quality of care for patients who are admitted to hospital, who also have a mental health diagnosis, through ensuring that they receive appropriate treatment for their mental health as well as their physical health condition. This new integrated approach should also lead to improved patient experience and cost-effectiveness of hospital resources. The Birmingham model highlighted that the likelihood of readmission was 70% lower for those patients treated by the core RAID team and the average length of stay was 0.9 days shorter. The Birmingham RAID cost analysis showed the RAID model delivered 160 avoided admissions in a full year and each of these resulted in a cost savings of £2,250. The total savings from this source was estimated at £360k per year. The NHS City & Hackney model expects to deliver a similar amount of savings in the performance outcomes and improve on the service efficiency across a range of services.

All people from the City who require Mental Health input under 65 would be referred to ELFT and HPM including RAID if required.

The City of London have 2 designated consultants psychiatrists who work closely with City patients and are located in south Locality. City patients are admitted to a designated ward which is managed by these consultants.

A social worker in the City Adult Social Care team co-ordinates discharge and care.

Enhanced Primary Care Services for mental health

The CCG will continue to work with its health and social care partners to develop its primary care mental health service and an improved primary/secondary care interface. The approach is intended to improve mental and physical health and social outcomes for people with mental health problems by developing a primary care mental health service with an emphasis on healthy lifestyles and social inclusion. This approach will support better integrated working across primary and secondary care and aspires to deliver true parity of esteem for mental health patients.

Acute Services

Services under this heading are included on the Finance Template under the heading of Managing Emergency Activity and Admissions avoidance service. We have identified that based on projected performance we would be able to save £62,520 in the first year across the NHS and Social Care and £88,850 thereafter.

Managing Emergency Activity

The City and Hackney CCG are commissioning an Urgent Telephone Advice Service from an A&E consultant at Homerton and a Rapid Access Community Geriatric Clinic – both of which are available to support GPs with advice to manage patients in the community including to the Neaman Practice in the City. The Care of the Elderly Consultant is also commissioned to undertake domiciliary visits with GPs and community matrons as well as providing clinical education and leadership across the clinical community.

The CCG also commissions an Observational Medical Unit at Homerton A&E – this is a consultant led service which manages patients in line with agreed integrated pathways

across primary and secondary care and seeks to discharge patients to the community rather than admit them to hospital, even for short stays. We are working with the unit to explore whether some pathways could be delivered entirely in the community without A&E attendance. In addition, the CCG commissions a consultant geriatrician in A&E to ensure that elderly patients receive the appropriate prompt specialist geriatric input in the event of an acute admission. Improvements in this aspect of acute geriatric care are being monitored through the City and Hackney urgent care board, which monitors the proportion of elderly (over 75) patients who are assessed in the OMU by a Consultant Geriatrician and the proportion of elderly (over 75) patients who are assessed by a consultant geriatrician within twelve hours of decision to admit. There is an incentive payment in place for Homerton hospital to meet these standards, set up through the commissioning for quality and innovation payment system.

We are aware that similar services are in place in Tower Hamlets and will be exploring how our residents could access these services if they are registered with Tower Hamlets' GPs.

Admission Avoidance Service ("One City Team" model for City of London)

The creation of a Single Point of Access through the Joint Care Co-ordinator posts will play a pivotal role in identifying pathways to ensure that patients are treated in the most appropriate location thereby avoiding unnecessary acute hospital admission. In doing so the Single Point of Access acts as an interface between health and social care providers. As well as realising savings through the delivery of an admissions avoidance service, we have a duty to make sure that wherever possible, patients are treated within their own homes or as near to them as practicable

The City of London or "One City Team" will be a rapid response integrated multi-disciplinary team that provides rapid assessment and clinical support to prevent admission to hospital for up to 72 hours. Patients accepted by the One City Team would be experiencing an acute episode and deterioration in their physical well-being which, without the input of the service, would result in an acute hospital admission.

The pilot team will include a Nurse, Physiotherapist, Occupational Therapist, Social Worker and 2 Reablement officers (we are looking to commission 2 of our Domiciliary Care agencies to be part of our One City 72 hour rapid response service). The service is designed to be for people aged eighteen and over who are resident in the City of London and will offer:

- 24hr support at home for up to 72 hours over acute period
- A full assessment of health and social care needs
- Once the referral has been accepted, patients would be visited within 1-3 hours depending on their clinical need.
- Following clinical and risk assessment, a support plan of care would be agreed with the patient and their carers where appropriate to enable the patient to remain at home.
- Based on the clinical needs of the patient, the team may visit up to four times a day to implement the care plans and facilitate patient safety.
- On discharge from the service team would ensure a safe handover to appropriate services for ongoing support via provision of on individual budget together with care and liaison with the patients GP.

This service will link in closely with the PARADOC service that is being commissioned by

City & Hackney CCG as identified within their 5 year Strategic Plan.

This links with The City and Hackney CCG's 5 year Strategic Plan which identifies investment in four practices across City and Hackney to open at the weekends and later in the evening to improve GP access for our patients.

- We are commissioning Homerton to help people who are using A&E and don't have a GP to register with a local GP and plan to extend this service to Hackney Service Centre so that more local people can register with our GPs;
- We have commissioned our GP out of hours provider to have community nurses working alongside them to provide more holistic care for our patients overnight and at weekends;
- We will be working with our Urgent Care Programme Board to think about how we could redesign the current PUCC service at Homerton to better meet the urgent care needs of our patients;
- We will be launching a big local campaign on how to access urgent care services, encouraging people to see their GP as their first port of call in and out of hours, and how to register with a GP.

Source: 5 year Strategic Plan: City & Hackney Clinical Commissioning Group 2014

d) Implications for the acute sector
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

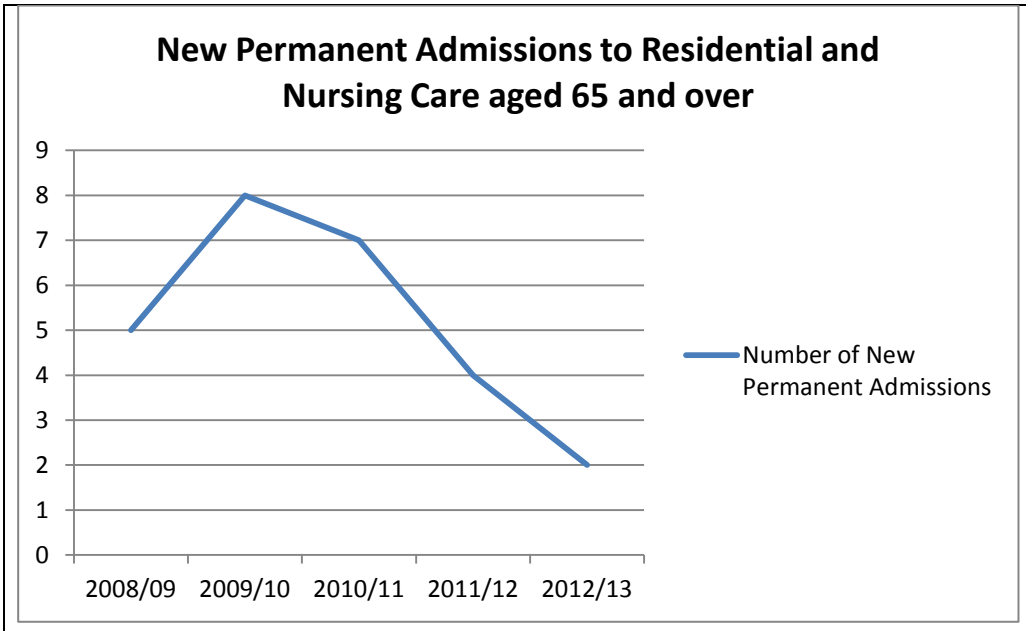
Permanent Admissions to residential and nursing care

In relation to admissions to residential and nursing care, we have already significantly decreased the number of people being admitted, increasing the domiciliary offer and helping people to maintain their independence longer. In the last year we had 4 admissions to residential care. Maintaining our trajectory of reductions, we anticipate a further 25% reduction down to 3. This has the effect of **£15k p/a** savings. (Note: these figures are not published within the ASCOF data so that individuals are not identifiable however within ASC we know the number of clients that have been admitted to residential and nursing care).

Had we not had the strategy to increase the number of people supported to live independently as long as they preferred to do so, we would have been accommodating between 7 and 10 people per year so this is an additional saving of 6 residential placements which would have cost **£219, 960** per year (based on an average cost of £705 p/w for residential / nursing care). As this was our intention long before the implementation of the Better Care Fund, we will continue to maintain a maximum of 3 permanent admissions per year (unless there are exceptions).

We have already implemented an approach within Adult Social Care that promotes the independence of our residents and through our support they are able to remain in their homes for longer and proportionally more of our residents than anywhere else in England are able to keep their wish of dying at home

Our plans will enable more people to be able to access services locally by preference, to remain in their homes longer and prevent admissions to residential and nursing care by having locally delivered bespoke services that meet their needs. Savings will be reinvested into extending domiciliary care provision and preventative services thereby protecting adult social care which will be delivering and commissioning these services.



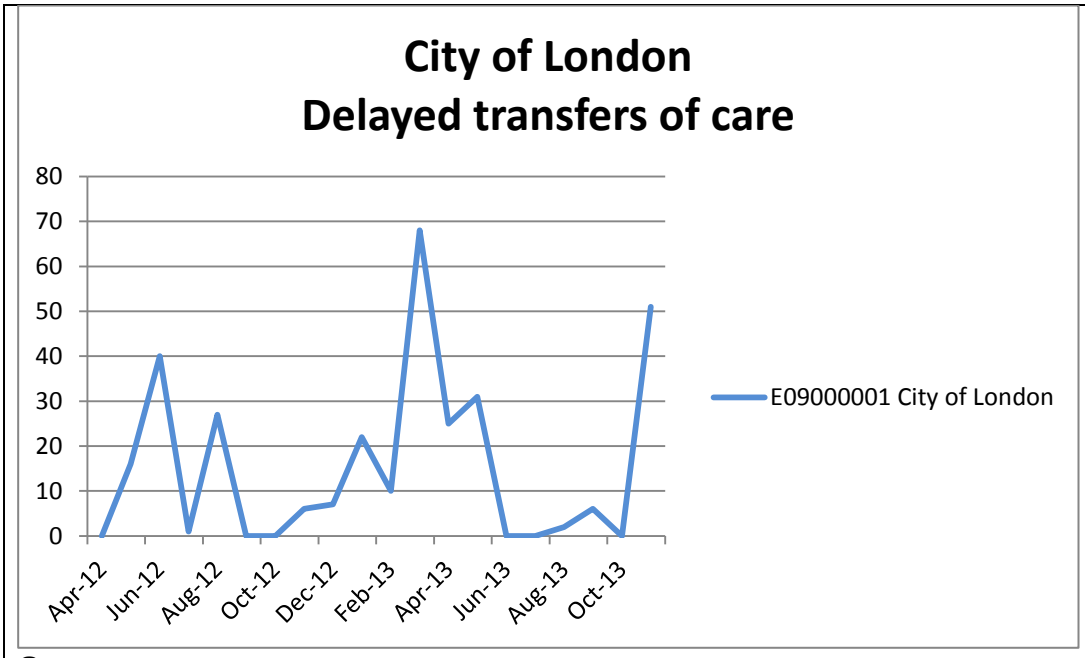
Reablement

In 2012/13 19 out of 22 residents were still at home after discharge from hospital into reablement / rehabilitation services giving us a metric value of 86.4%. One of the 3 residents died (and had returned home to fulfil their wish of dying at home), one was readmitted after having suffered a stroke and the third was readmitted following a fall. We have reviewed our service provision in relation to falls in order to mitigate against preventable readmissions and that is why we are confident in improving our performance to 90 – 100%. Our Reablement Service was inspected by the CQC in 2013 and received very positive feedback and with additional improvements in relation to aids and adaptations and the Joint Care Navigator, we anticipate being able to keep all of our residents at home, where readmission is preventable.

We have identified that we are technically able to achieve 100% against this target, but that due to our small numbers, one person can become an exception.

Delayed transfers of care

By managing the care of our residents at a 'micro'-level we will be able to minimise the frequency with which those with long-term conditions find themselves admitted to hospital and where they are admitted, reduce the length of stay by being prepared for discharge in advance of the admission itself. This will reduce pressure on the hospitals our residents use. In reducing delayed transfers of care from 19 days per month to 10 this would have the impact of **£11k** savings based on £250 per bed day. Estimates of savings are conservatively based solely on bed cost rather than therapy costs etc.

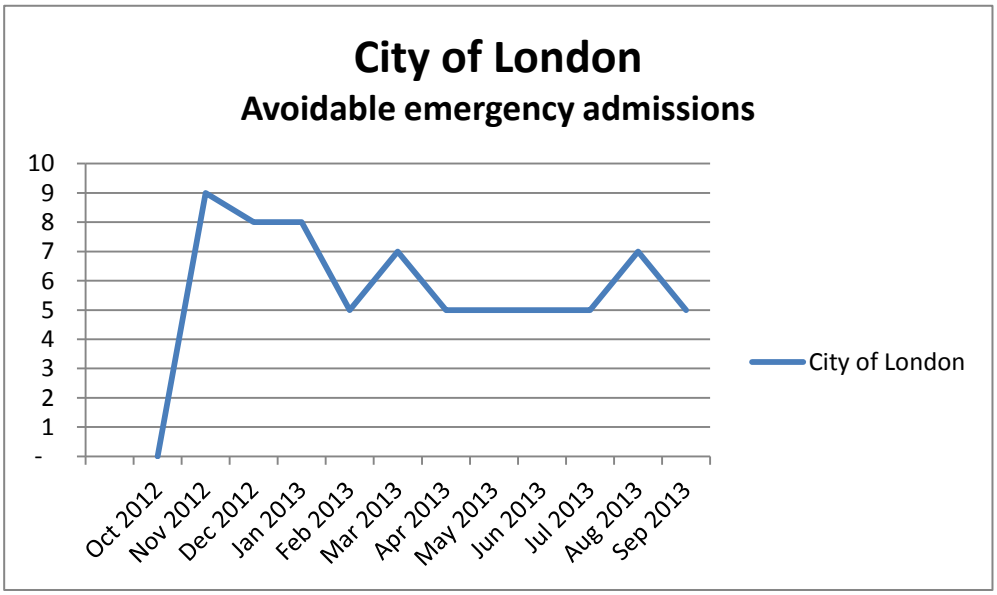


Source: Better Care Fund historic, baseline and denominator data, NHS England 2014

The Joint Care Navigator posts were agreed by colleagues in our provider hospitals in Hackney, Tower Hamlets and Islington and will improve the co-ordination and integration between health and social care, minimising the effect of bureaucracy on the discharge process and supporting the patient to successful rehabilitation at home.

Avoidable emergency admissions

Our admissions avoidance service will be the key service by which we will reduce the number of non-elective emergency admissions, furthermore we anticipate that alcohol related emergency admissions will be reduced through the preventative strategies we have put in place to support City workers. Through the development of the care navigator posts and the admissions avoidance service, we anticipate a 20% reduction in acute admissions from 39 per annum to 30. This would generate £62,520 savings in the first year followed by £80,850 recurrent savings.



Source: Better Care Fund historic, baseline and denominator data, NHS England 2014

e) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Health and Wellbeing Board will hold partners and the Adult Wellbeing Partnership to account for their part in the delivery of the plan.

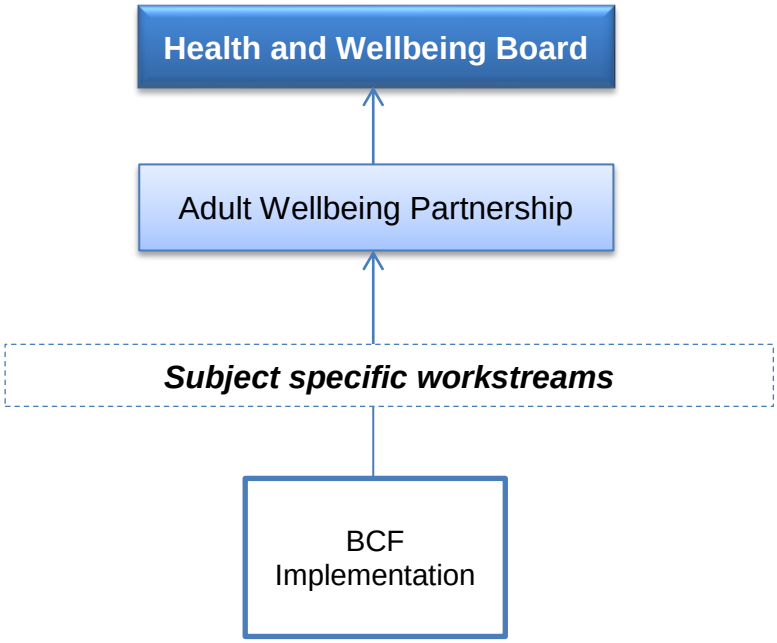
Healthwatch have assisted us in the coproduction of our plans and we ask them to consult with our residents on the impact of the changes and communicate this back to the Adult Wellbeing Partnership and the Health and Wellbeing Board.

The Adult Wellbeing Partnership monitors various aspects of the operational delivery of key strategies relating to Adult Wellbeing in the City as subject specific workstreams. The BCF plan is already being monitored through the Adult Wellbeing Partnership and progress on it is being reported through the BCF Implementation workstream.

The objectives of this group include:

- To provide strategic management oversight of the Adult Wellbeing Partnership,
- To monitor the various workstreams and performance of those workstreams through the delivery of the workplan and regular highlight reporting,
- To support the development and implementation of the action plans within the workstreams at an operational level,
- To ensure that the City of London works with partner agencies in the development of plans to integrate health and social care across the City,
- To advise the Health and Wellbeing Board on the progress of the various workstreams,
- To have oversight of key issues including resources, IT and partnership working.

In relation to pooled budget arrangements, the City will be holding the pooled budget. Further work has started in relation to defining the governance arrangements of the pooled budget which will also report through the Adult Wellbeing Partnership.



The above structure shows the reporting line between the subject specific workstream, the Adult Wellbeing Partnership and the Health and Wellbeing Board. Other subject specific workstreams include Dementia Strategy Implementation and Carer's Strategy. Our Service User Engagement Group comprises members of the Adult Advisory Group and is supported by Healthwatch. This group has been key in consulting on the BCF Plan.

The City's Health and Wellbeing Board draws its membership from the following partners:

- Elected members of the City of London Corporation*
- Officers of the City of London Corporation, including the Director of Community and Children's Services* and the Director of Environmental Health and Public Protection
- The Director of Public Health for City and Hackney*
- City and Hackney Clinical Commissioning Group*
- HealthWatch; contract awarded to Age UK*
- The City of London Police

The Health and Wellbeing Board became fully operational in April 2013, and the partners marked with an asterisk are the statutory members.

Assurance process for risk and performance

The sign-off process for this plan includes regular meetings and discussions with partners to finalise agreed processes, presentation to the City and Hackney CCG Board on the 28th March and final sign off by the Health and Wellbeing Board on the 1st April 2014.

The CCG will report performance to the Joint Commissioning Board in relation to contracts specific to the City in line with their Commissioning Strategy approach of measuring performance:

- User, clinical and process outcomes for each service, contributing to and delivering system outcomes;
- KPIs across aligned contracts and tracking system -wide changes in activity and spend;
- Financial balance maintained and all providers remain viable and without significant performance concerns.

These performance reports will be further discussed at the Adult Wellbeing Partnership which has a shared approach to performance and risk management.

Risks agreed in section 3 below will be discussed at the Adult Wellbeing Partnership meetings and form the partnership risk register which will be kept under review. Regular quarterly performance and risk monitoring reports will be considered by the Adult Wellbeing Partnership in order to manage and mitigate the operational risks prior to strategic risks being reported to the Health and Wellbeing Board.

Pooled budget governance

The BCF will be the first pooled budget arrangement between the CCG and the City. As such, governance arrangements will be agreed during the course of 2014 to be signed off at the Health and Wellbeing Board by September 2014. This allows for negotiation in

relation to performance management and monitoring. It is already agreed however that whoever holds the pool will report to a Joint Commissioning Board who are responsible for the contractual arrangements and performance reporting on these contracts to the Adult Wellbeing Partnership.

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Whilst the City of London agrees to maintain eligibility at Critical and Substantial, we will be evaluating this position with the development of new eligibility criteria in the Care Bill.

We will protect social care services by offering the right level of support according to a person's assessed needs. This will be supported by the development of the integrated Care plans led by the GPs and the multi-disciplinary teams which will include Adult Social Care.

The City already has a strong record of delivering individualised support and supporting people to exercise their choice to remain at home and retain their independence, empowering them to do as much as possible for themselves while they are able.

Enhancing health services to include admissions avoidance and enhanced preventative support will mean that there is potentially an increased number of service users for whom the City will be delivering care and support. Integrating with Health will assist us to deliver a range of options to those requiring support, including more personalised budgets including a health focus.

Please explain how local social care services will be protected within your plans

The City is fully committed to protecting its social care services and although it may appear vulnerable due to its size, the CCG is fully supportive of the BCF Plan and have been actively engaged in the development of it. Our colleagues in the CCGs in Tower Hamlets and Islington have committed to engage with the delivery of the plan and with joint working across areas in order to support our residents who are registered in their areas and for their residents registered in our area.

In the fact that the City has its own BCF plan and a distinct pooled budget, we will ensure that the fund is demonstrably spent for the benefit of our residents. This in itself will protect social care services in that we will be able to identify further preventative work that comes under the auspices of social care or of Housing working jointly with our social care staff.

By enhancing the preventative services we offer, we will be aligning our position with the Care Bill well in advance of it being enacted and therefore increasing the opportunity of making a difference to service users in a timely way. This takes on importance particularly for those residents who might benefit from schemes such as Telecare. As the major provider of accommodation within the City, our Housing services can enhance our use of aids and adaptations of the clients who are most in need, but also installing Telecare for those who might otherwise require a GP visit or even who might be admitted.

During 2014/15 we will be reviewing and monitoring usage of services and monitoring the budget closely so that we can realign and deliver further cost savings as many of our residents do not use particular services, or if they do use them, this will be in minute volume. This will enable us through our Joint Commissioning Group to align funding to

needs and to respond proactively to those needs.

Clear care pathways are being established which identify who the lead providers are for key interventions. Our eligibility criteria of substantial and critical need remains and all who meet the FACS criteria will continue to receive good care management and regular review of needs. This duty of care will continue to be met with the funding allocation of 2014/15 and thereafter.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

The Reablement and Occupational Therapy service sits within Adult Social Care and focuses primarily on offering a service to people who are coming home following a serious illness or injury, and need rehabilitation and confidence building to regain their skills and independence back in their own homes. The team offers daily support for up to 6 weeks. The service has recently been inspected by the Care Quality Commission, and was found to have met all key outcomes for a safe, efficient and professional skilled service.

Adult Social Care runs a responsive daily duty service from 9-5 which is linked to the Reablement service. The City's ability to offer support for people being discharged from hospital is exemplary, with no charges from hospital trusts for any delayed discharges. Adult Social Care have sought to develop sound links with key hospitals including the Royal London and University College Hospital, to ensure good communication leads to safe discharge back home for City residents.

There are very few admissions from the City to the acute sector, even fewer at a weekend. We will be working with Paradoc out of hours (a scheme whereby a GP will attend emergency calls with a paramedic to meet needs of people who might otherwise have been directed to A&E) as part of an admissions avoidance service, emulating a model being developed in Islington. Having our Joint Care Navigator posts will assist us in identifying patients from the City who would potentially be discharged on a weekend to ensure that services were in place to support them leaving hospital. We have a long-standing commissioned arrangement with Hackney Borough Council to provide our out of hours social care service.

Agreement for these posts came through the City of London, the Royal London and UCLH and their CCGs, the City and Hackney CCG and the City of London Health and Wellbeing Board, and a copy of the bid is attached as one of the supporting documents to this plan.

Due to a very low volume of cases going into hospital, there are inevitably very few discharges that could not be managed within Monday to Friday working. However, where we are aware of service users who may be discharged over a weekend, the Joint Care Navigators will work flexibly to support these discharge arrangements and this form part of their contracts.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Currently we do not use the NHS as a primary identifier; however we are currently implementing a new social care IT system which has the capability to use the NHS number; we have therefore begun a process to commence implementing this.

We have commissioned a project to undertake a review of integrated care with the City and also of our IT systems and data sharing. We will use their recommendations to both refine our overall integrated care pathways and also our use of IT systems. Through this project work we will work closely with partner organisations to develop appropriate agreements and use of Open APIs to secure interoperability standards.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Adult Social Care is committed to using the NHS number as a primary identifier. We have undertaken to include the NHS identifier on all social care records to enable us to communicate using this number. This exercise will be completed by July 2014. Communication between health and the local authority using this number will commence by September 2014.

The CCG has commissioned and is sponsoring a project to conduct a detailed review of our IT systems and integrated care processes and procedures which will help us to establish how this may be most effectively achieved.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Through the IT project commissioned and sponsored by the CCG we are committed to working with partner organisations and the use of Open APIs to secure interoperability standards. This work is currently in progress.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We are committed to ensuring the appropriate IG Controls are in place. The Information project will explore and scrutinise information governance more widely. The findings and recommendations will serve as our baseline of best practice to influence cybersecurity, system access, data sharing and related controls. In addition we will use this information to establish future best practice procedures.

This project is sponsored by the CCG Health and will review systems in both health and Social Care, including information sharing arrangements and will recommend the next steps in securely managing shared data. It will review the whole area of information governance and will be used to establish the correct controls and appropriate procedures.

The outcomes of this joint review of information sharing arrangements will be presented

to partners and will conclude in June 2014 with an agreement to the 'One City' information model. Our Caldicott 2 compliant Information Sharing agreement will be signed off by October 2014.

We are committed to ensuring that appropriate IG Controls are in place for the governance and exchange of health related data.

We are committed to ensuring that all information is protected in accordance with its level of confidentiality and sensitivity, and associated risks. Areas of focus include:

a) Confidentiality: assuring that sensitive data is read only by authorised individuals, and is not disclosed to unauthorised individuals or the public.
b) Integrity: safeguarding the accuracy and completeness of information and software, and protecting it from improper modification.
c) Availability: ensuring that information, systems, networks and applications are available when required to departments, groups or users that have a valid reason and authority to access them.

We have commissioned an assessment of the current state of readiness across partners with regard to information sharing and integrated care. The assessment will clarify information governance issues relating to integrated care and risk stratification and inform our development path for 14/15.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

We currently work very closely with the GP practice in the City to ensure that health needs are included in the Social Care Plan, based on the Adult Social Care Assessment. The CCG are working with GPs (including the one practice in the City) using a risk stratification tool to develop care plans for the most vulnerable frail elderly and to develop multi-disciplinary teams. The GP would be the accountable professional for the care plan. Our Joint Care Navigators will be attending the MDT meetings in both Tower Hamlets and Islington surgeries in order to co-ordinate the interface between health and social care and to assist those residents through the system if they are admitted to the acute sector.

A risk stratification tool will be adopted within each general practice with a focus on frail and vulnerable elderly patients and service users within the borough.

Our Practice- based Coordinated Care project described in 2c will have GPs taking the lead in coordinating care as the agreed accountable lead professionals for people who are assessed as high risk of hospital admission. The project will adopt the criteria put forward by the City and Hackney CCG Local Enhanced Service for vulnerable and frail patients which is as follows:-

- Well known to GPs as vulnerable
- A recent fall or 2+ falls in 2 months
- Medically unstable

- Socially isolated
- A high intensity social services package or under RICS
- Death of spouse or close family member within last 6 months
- On 4 or more medicines which have been prescribed for 6 months or more
- Repeatedly fail to attend medication reviews when invited
- Are over 75 and have not visited the surgery in 3 years
- Who are on other disease registers and do not attend checks when invited
- Someone over 65 whose prescribing costs are >£100 per month
- Over 65 who has had more than 2 OPD visits in the last 12 months
- Patients where the hospital has telephoned practices to discuss

Those who meet the criteria will be included in the project and the results of the proactive intervention will be closely monitored over the life of the project to assess the impact. We estimate that there will be 1771 such patients in City and Hackney and GPs will be contracted to lead the care planning and multi-disciplinary case management processes for these patients. There are approximately 30-35 service users in the City who have been identified as potentially meeting the initial criteria for a joint care plan.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk associated with pooling budgets	**Low**	2014/15 will be used to prioritise the development of a robust section 75 agreement and governance structure to support the BCF in 2015/16. This area of work will be jointly pump primed to ensure that the section 75 has appropriate arrangements to manage financial and performance related risks. The CCG and Council will seek to align budgets and explore opportunities to increase the budgets that are pooled in the future. A full business case and joint risk assessment will be required to before recommendations to pool additional budgets into the BCF are agreed.
Benefits realisation	**Medium**	Due to our size and the very small numbers of people requiring acute health intervention, there are very few financial savings that could be realised from our plan. We are aware, however that there are improvement there can be made in the patient experience of services and in delivering the changes our residents wish to see. We will use data collection methods already in use through the Adult Service User Feedback Survey and the Carers Survey to demonstrate a change in service user experience of the care and support they have received. This is reflected in the locally defined indicator we have agreed with the CCGs.
BCF performance funding	**High**	BCF plans are “front loaded” to reduce the risk of performance related national conditions and performance indicators not being met. In addition, the BCF financial model will include some contingencies to manage the risk of performance related payments, and the rate at which benefits are realised for reinvestment into jointly agreed plans. We approached NHS England in January 2014 to highlight the issue that performance in the City is impacted on when 1 additional person requires residential care (as an example). Assurance was given by NHS

		England that: “Our general approach is that targets should be set locally, so we would hope that you, the CCG and your area team could agree an approach that works for your unique situation.” (NHS England email 21st Jan 2014) and “It is not NHS England’s intention to penalise small local authorities.” (NHS England email 28th January 2014) The CCG has agreed our metrics alongside the City and what the required improvements should be and how we will use the Joint Navigator posts to enhance the services we currently provide in order to stabilise our performance.
National Conditions and Performance Measures	**High**	The National Conditions and Performance measures will be kept under review by our Adult Wellbeing Partnership where partners will hold each other to account for the delivery of the outcomes identified in the plan. The Health and Wellbeing Board will hold the Adult Wellbeing Partnership to account for delivery of improvements identified in the plan. Baseline data identified by NHS England from GLA estimates of population are significantly out of alignment with our own estimates of the population of the City. This has a significant impact on the assurance process which uses the GLA baseline. We have agreed realistic and achievable targets alongside City and Hackney CCG, however this could impact on our performance related payment despite assurances from NHS England (see above)
CCG may prioritise the needs of Hackney residents over the needs of City residents	**Low**	A separate plan is being submitted for each local authority. The City will be holding the pooled budget which serves as further leverage with providers to ensure that services are delivered for the benefit of our residents and enables us to tailor bespoke services and packages of care.
Impact on providers	**Low**	There is a perceived risk that because we have spot purchasing arrangements with most of our providers, we would be unable to benefit from large scale commissioning arrangements, particularly with delivering services at short notice as providers may prioritise their bigger contracts.

		In order to mitigate this we are reviewing our contract arrangements with our providers to ensure that we are given the same priority as any other local authority and that there will be financial penalties in place for the providers who are unable to deliver.
Organisational capacity	**Low**	BCF is something that both the CCG and the City are firmly committed to in order to improve services for our residents. By working jointly together and creating the Joint Care Navigator posts, we will see administrative efficiencies that will result in a better experience of services for our residents who require acute health intervention. We are reviewing our contractual arrangements with our providers and are using the opportunities that the BCF gives us to develop our market position and enhance the services that we provide locally. Our Adult Wellbeing Partnership delivers a programme management function and provides a strategic overview to the operational delivery of the services which will allow senior management to respond promptly to any emerging needs across health and social care.
Statutory requirements	**Low**	The Care Bill will create additional burdens for Local Authorities from April 2015 onwards. To ensure that Adults Social Care is ready for legislative changes we anticipate additional resources being required during 2014/15 and 2015/16 to deliver the changes that the legislation will require. Within the City, we already have a system that enables us to manage deferred payments. We have pre-empted the Act in evaluating the impact of the cost-cap and have estimated the increase in numbers of people who are likely to be eligible for care and support in future. Both of these issues have been consulted on with our Adult Advisory Group and with Healthwatch. The services we provide in relation to advice and information on care issues are

		commissioned from Toynbee Hall and the contract expires next year. We are already considering what the tendering process should look like and this will include a bigger focus on the Care Bill and advice and support around this. Costs of implementation will need to be met from the BCF and other additional DH funding, for which we are awaiting full guidance. Central Government Guidance regarding funding for the on-going increase in the numbers of eligible customers anticipated to receive social care support as a result of the Bill has yet to be announced. We will ensure that, in line with the guidance, the BCF plans for the City reflect the requirement to support the implementation of Social Care Reform, and that sufficient funding is allocated from the BCF and transferred to the Local Authority. This is currently a risk, as no additional funding is allocated to the BCF over and above the additional NHS transfer and the Care Bill has not yet been enacted, which means that there are potentially additional risks in relation to
Complex care pathways	**Medium**	As a large proportion of our residents are registered with GPs outside of the City and we interact with three CCGs, the care pathways for our residents are often complex. We have commissioned Tricordant to review the care pathways and recommend alternatives that will provide clarity for our service users. The Joint Care Navigators will assist patients with navigating their way through the pathways, ensuring that routes through care are co-ordinated and that delays are minimised.
Lack of support from Central Government for a separate BCF	**High**	Our residents and service users matter to the City. Their small volume makes them particularly vulnerable when decisions are made on a national basis. Rather than decisions relating to them being taken by an entity which is remote and does not appreciate the impact of its decisions, which creates a disadvantage for them, we opt to develop our own bespoke City BCF Plan.

		Baseline data identified by NHS England from GLA estimates of population are significantly out of alignment with our own estimates of the population of the City. This has a significant impact on the assurance process which uses the GLA baseline. We have agreed realistic, achievable and deliverable targets alongside City and Hackney CCG. In preparing a City-specific BCF plan that will be agreed by our Health and Wellbeing Board and our partner CCGs, we will ensure that we follow the national models but apply them in a way that protects our residents and delivers a positive change in experience of health and social care services.
Structural disadvantage makes it challenging to assess the impact of individual interventions on the overall metrics when delivered as an overall package – impacts on our ability to make investment / disinvestment decisions	**High**	This relates predominantly to our size, but also to the fact that our service users interact with 3 different CCGs. NHS England has been unable to deliver meaningful data to assist in the preparation of this plan. Poor evidence base for the scale of savings anticipated nationally to be achieved by reducing emergency activity under BCF – particularly applying to such a small resident population as the City. However, the City and its partners are clear that we can mitigate this risk by enhancing our data analysis capacity locally to ensure that meaningful data can be extracted across the 3 CCGs and the City's Social Care data through its database, Frameworki. All 3 CCGs are committed to meet together regularly to review the care pathways and to ensure that data is shared regularly for performance reporting to the Adult Wellbeing Partnership and Health and Wellbeing Board. This performance data will be scrutinised locally within management team meetings, the Adult Wellbeing Partnership and the Health and Wellbeing Board will hold the Adult Wellbeing Partnership to account for the delivery of relevant data.

Negative impact on the level and quality of mental health services	**Low**	Current structures will remain for service users with mental health issues and will be reinforced by the addition of integrated systems and early identification of service users with issues. ELFT will remain as the key provider and service users will be able to access RAID and AMHP social workers. Joint care navigators will work closely with both health and social care teams to provide a clear liaison between the two. Early identification of patients with dementia will be assisted through the multi-disciplinary integrated care plans. The quality of these services will be monitored through the Adult social care survey and through the regular feedback undertaken with service users and residents.
Information governance	**Low**	There is a strong commitment across the partnership to deliver the project within timescales and to include the NHS identifier for all social care records. A project will be undertaken in 2014 for completion by July 2014 for including the NHS identifier. Any delays in this project will not adversely impact the commitment to using the NHS identifier by April 2015 and the absolute latest for including the identifiers will be by October 2014.