Integrated Care in the City of London

A One City model

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Version Control

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0.1	9 May	Tricordant	Initial draft for Project Sponsor review
0.2	14 May	Tricordant	Updated content for issue to Project Steering Group
0.3	16 May	Tricordant	Minor amend to Exec Summary text and insert system model diagram.
1.0	19 May	Tricordant	Final report released for publication to Health and Wellbeing Board

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Executive Summary

Introduction

- The brief for the Integrated Care project is to develop a City of London approach to Integrated Care – a One City model for City of London residents.
- The project scope is vulnerable adults and older people with long term conditions or frailty. This includes mental health, end of life care and public health, and also covers the support provided by the voluntary and community services sector.
- The key question posed by the review, in developing a One City model for Integrated Care is:
    - Can the Health and Social Care system in the City of London be organised to improve the equity of opportunity and experience for wellbeing across all residents?
- In answering the question, the proposed model will be rooted in the current reality, and will build on the foundations of the current and emergent patterns of service and relationships so that there is a clear and actionable route to implementation in the short and medium terms.

Current pattern of Services

- The City of London Health and Social Care system is both complex and complicated. While the complexity is shaped by the fact that lots of different organisations contribute to services in the City, the pattern of services is more complicated than necessary. The challenge in the project is to find a set of solutions that both help manage the complexity and also reduce the complications.

What service users say

- Despite the generally positive health status and outcome profiles for City of London residents as a whole, the experience of the service user remains fragmented and confounded by organisational complexity, suggesting there is more to be done to improve outcomes and experience.
- It is notable that the priorities for service users and professionals in the City of London consultation on the Better Care Fund reflect the desire of service users to **experience** joined up care.
- This focus on the service user experience, combined with Patient Choice in Health, drives the need to find some system and organisational solutions to best enable the experience of joined-up care.

Integrated Care service planning

- Integrated Care programmes are critical to the aim of delivering joined up health and social care and are a central component of the One City model.

- There are major Integrated Care programmes in City and Hackney, Tower Hamlets, in Islington and in Camden.
- All the major programmes for Integrated Care are based on virtually the same set of principles and evidence-base. In that respect the programmes in each of the CCG patches are mainly distinguishable by the pace of implementation and the stage of development they have reached.
- Each of these Integrated Care programmes contains service components such as risk profiling for vulnerable adults, rapid response services, discharge management, Multi-Disciplinary Teams wrapped around clusters of GP Practices in primary care, and Case Management for residents with long term conditions.
- All of these have an impact to a greater or lesser extent on City of London residents for whom the City of London Corporation provides Adult Social Care support.

Aims of the City of London Better Care Fund

- The success of the City of London Better Care Fund will be measured in part by the reduction of avoidable admissions to hospital and also of delayed transfers of Care from hospital.
- A key question therefore for this review is "into which hospitals are we trying to avoid admission, and out of which hospitals we are trying to expedite discharge?"

Alignment of Community Health Services (CHS) with acute hospital pathways

- The configuration of hospitals in London, together with patient choice, are just 2 factors that make it unrealistic to consider developing a model where all City residents will align to a single acute hospital and community health services provider for all services.
- While it will not be feasible to construct a model without boundaries and hand-offs/transitions between organisations, it is possible to reduce the number of provider organisations involved for City residents in healthcare, and therefore reduce the number of complications created by multiple hand-offs, pathways and relationships.
- City residents registered with Tower Hamlets GPs receive their CHS and Integrated Care support from Barts Health, and this appears to be the least complicated of the current arrangements in place.
- The least complicated CHS arrangement to serve the Neaman practice, with reduced organisational hand-offs (and therefore patient data transfer or information transparency between organisations) would be to align the Neaman practice with the CHS support to either the Royal London or UCL Hospitals.
- Pathways could arguably be simplified for City residents of the Neaman practice by aligning Primary care with the Rapid Response and Discharge management services around either the Royal London, UCLH or a combination of both.

- Options for optimum CHS support to the Neaman practice need closer analysis and it is recommended they be explored in the next stage of work in conjunction with the Practice, the City and Hackney CCG and the relevant CHS providers to examine the presenting options in conjunction with the opportunity of CHS re-commissioning by CCGs in 2015.
- The flows of patients to specialty centres for trauma, stroke and heart disease, in addition to the general acute flows, will be significant considerations in the appraisal of options.

Alignment of City of London ASC services with system partners

- To interface with the multiple health and CVS partners in the City of London, the Adult Social Care team needs to adjust its alignment with the partners in a systematic way to reflect the reality of patient choice and workflows. This will include:
- Development of the role of the ASC team to "hold the ring" for City residents and become the coordinator/navigator for joined-up health and care at the population level.
- Case management and Care Coordination are key component features of all the integrated care programmes, and will relate initially to the top 1-5% of Very High Intensity users of health care services. In addition to these most vulnerable adults, the remaining 95%, some of whom may otherwise become future high-intensity users, will benefit from Care Navigation support as part of the CoL ASC team and this role should be developed in partnership with GPs and NHS providers.
- With this extended role and scope of the team, the ASC team should establish an internal Residents' Care Coordination mechanism for exchange of regular and up-dated information on City residents who are active recipients of health and/or social care derived from the multiple relationships and information sources in the wider system, including support commissioned from the Community and Voluntary Sector.
- Participation of the City ASC team with the main Integrated Care Multi-Disciplinary Teams wrapped around the main GP practices serving City residents (both currently and in the potential future configurations).
- The CoL ASC team should align to the Rapid Response and Discharge management arrangements that are consistent with majority of acute hospital patient flows both into and out of the Royal London and UCL Hospitals.
- Public Health commissioning should be included in the Residents' Care Coordination team to ensure vulnerable residents have full opportunities to engage with preventive public health interventions and community support.

Summary and recommendations

A One City Model to deliver best quality of experience for every City resident will recognise the choices residents make about where to receive their care, and will focus on the organisation arrangements best suited in the short and longer terms to deliver the experience of integrated care.

The proposed model is rooted in the current reality, and will build on the foundations of the current and emergent patterns of service.

It will be important to satisfy competition rules and organisational legal powers in terms of any proposed changes to current arrangements and therefore much of the emphasis on next steps is around process to reach the right solutions.

The whole system model illustrated and outlined in section 7 of this report is feasible and deliverable through a work programme comprising 3 workstreams as follows:

1. To conduct an options appraisal with the Neaman practice and the City and Hackney CCG, working with providers, on the options for community health services and Integrated Care support to the Practice, in order to inform CHS commissioning for the Neaman practice in 2015/16.
2. In partnership with neighbouring CCGs in Tower Hamlets and Islington:
    a. To develop the commissioning case for realignment of Community and Adult/OPMH Mental Health Services in support of the Neaman practice.
    b. To address the "grey areas" of cross- LA boundary commissioning and clinical governance risk caused inadvertently by PCT legacy contracts for Community Health Services.
    c. To explore with the City and Hackney CCG the designation of a City of London Health commissioning resource to align specifically with arrangements for CoL residents.
3. To review and align arrangements in the CoL ASC team to:
    a. Explore and design the ASC team role to coordinate health and social care pathways on behalf of all City residents.
    b. Enable a whole-City view of residents through a Residents' Care Coordination team/mechanism ("air traffic control") for exchange of regular and up-dated information on City residents who are active recipients of health and/or social, including support commissioned from the Community and Voluntary Sector, and from local intelligence.
    c. To work with GP and provider partners to design and commission Care Navigation roles (x2) to provide 7 day support to the GP practices covering City of London residents.
    d. To ensure active ASC team engagement and participation in the Multi- Disciplinary Teams forming around relevant GP Practice clusters – preferably through named relationships.
    e. To ensure there are clear referral mechanisms in place for Royal London and UCL Hospitals Rapid Response and Discharge Management teams to enable admission avoidance and discharges from hospitals.

A proposed programme of work to take the recommendations forward to the implementation stage will now be developed for agreement among the partners.

1. Introduction

The City of London Corporation commissioned Tricordant to conduct a review of current health and social care provision for older residents within the City and to make recommendations on how this could become a more integrated service.

On the face of it the geography and population size of the City presents a significant opportunity to implement effective and efficient coordination of person-centred health and social care. It is recognised by all parties that care and support services are currently fragmented and that they should be organised around the service user regardless of organisational or professional boundaries.

The Corporation is required to work with a complex and wide range of commissioners and providers, for all of whom the City of London is a small proportion of their total business. The challenge of aligning these various partners to deliver integrated person-centred care is therefore equivalent to many large English Councils in terms of complexity if not of scale.

There is, however, agreement across partner organisations, in line with the pan-London work, that Integrated Care is the intended way of future working for partners within the City of London health and social care economy.

1.1. Project brief and aims

The project brief is to develop a City of London approach to Integrated Care.

The scope of the project is integrated care for vulnerable adults and older people with long term conditions or frailty. This would include mental health, end of life care and public health, and would also cover the support provided by the voluntary and community services sector. Learning disabilities are not included in the scope.

The scope does not include implementation of the final proposals, although it does include developing plans for partnership agreement at Chief Officer level to the final proposals.

Also included within the scope is to make recommendations on the job descriptions of the “in-reach” roles funded through the S256 monies.

The work of the project was carried out over 2 stages, as follows:

1. Stocktake to understand the current position.
2. Development of the “One City” model.

1.1.1 Stock take

The purpose of the stock-take was to inform development by identifying the current activity, patterns and pathways of care, gaps in service and the key initiatives and projects having (or having potential for) systemic impact across services or care pathways for adults with long-term conditions and frailty.

The stocktake takes account of work in the neighbouring Borough Councils and CCGs, particularly in relation to their Integrated Care Pioneer programmes, as well as the pre-existing stock take work done by Tricordant with City of London, the City and Hackney CCG and the Hackney partners.

1.1.2 Developing the One City model of Integrated Care

Following the stock take, the project has developed a bottom-up approach to delivery of Integrated Care for City of London residents, building on the existing infrastructure of the Corporation, Social Care and NHS Primary Care.

The continuing engagement of all key agencies will be critical in co-designing the finalised new model.

1.2. Project methodology

Stage 1 of the project was set up to obtain input from organisational stakeholders through both structured individual interviews and in system-wide workshops or focus groups. In the actual working out of the project, however, it proved difficult to achieve the necessary attendance at workshops, and therefore the majority of the diagnostic work was done through structured interviews. Focus groups were held with the Neaman Practice and the Adult Social Care team.

Stage 2 was initially designed to use a system-wide workshop to co-design the new model. This was not possible for the reasons outlined in the previous paragraph and therefore the majority of work has been done through the Tricordant team working in consultation with the project sponsor and Steering Group members.

1.3. Thank you

Tricordant recognise the support and contribution from the stakeholder organisations and their representatives involved in the project and on the project steering group. In particular we thank

Chris Pelham and Marion Willicome-Lang from the City of London who have acted as Project Sponsor and Project Manager on behalf of the Corporation

2. Context

2.1. About the City of London

The authors recognise much of the material in this report will be known to some readers through other key documents such as the Better Care Fund plan and Public Health profile reports, but the material is included here for completeness of understanding for those readers less familiar with the context and demography of the City of London.

The City of London Corporation has both the largest working and transient population and the smallest resident population in England and Wales which combine to create unique challenges and opportunities. As a local authority it has exactly the same statutory obligations as any other authority in England and Wales, most of which it does through its own organisation and some in partnership with near neighbours. The resident population is dwarfed by the estimated 360,000 workers and tourists who arrive and leave in the City on a daily basis.

An overview of the key facts of the City and its resident population is shown below with a more detailed review attached at Appendix 8.1.

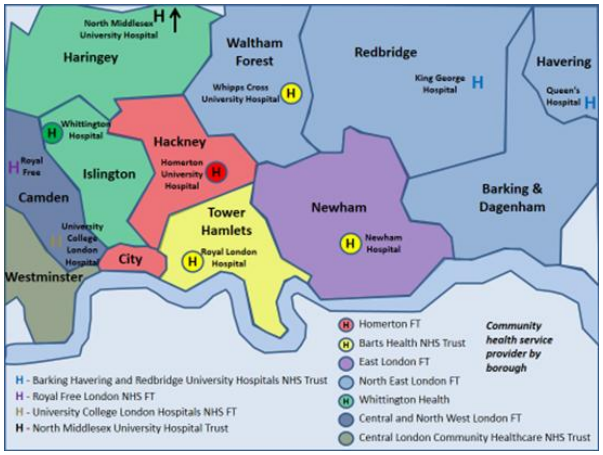
- The City has a resident population of 7,380 people living in 4390 households giving an average household occupancy of 1.7 (Greater London is 2.5 with England/Wales at 2.4).
- Of the total population 1500 people (20%) are over the age of 60.
- The "White" population is 78.6% compared to GL at 59.8% and E/W and 86%.
- Private rented housing accounts for 36% of housing in the City.
- 56% of City residents claim to live in very good health with only 2% saying bad and 1% claiming to be very bad.
- In the Index of Multiple Deprivation the City of London is ranged 259 out of 326 local authorities making it in the 40% less deprived category (similar to the likes of Kingston, Bath, Warwick and Tonbridge) and is the second least deprived in London just behind Richmond.
- There are two distinct population areas to the City; the first being Barbican/Golden Lane and the second the Portsoken Ward around Mansell St/Middlesex St; both areas having their own distinctive situations and differing deprivation and health levels.
- The population of the City is expected to grow to around 10,000 by the year 2026 with the majority, numerically, of that growth being in the 20-64 age group.

- Significant, however, is the growth in the 65+ age group which will see an over 40% growth in that segment from 1500 to 2170.

The data can be summarised as showing:

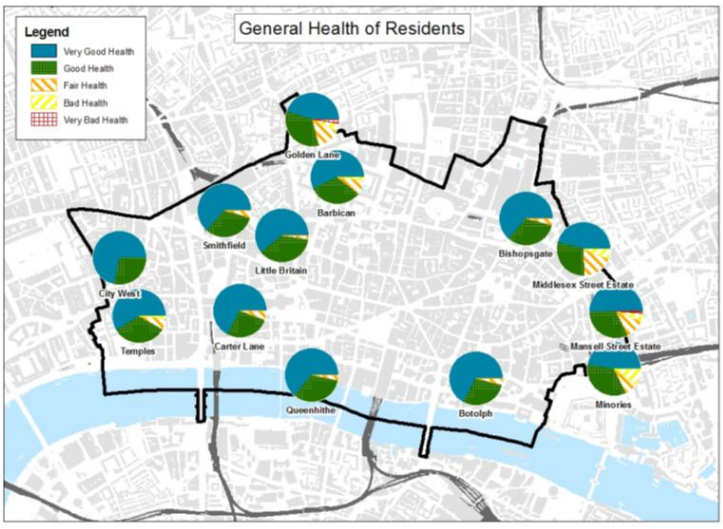
- Compared to the residents of neighbouring authorities, and nationally, those living in the City of London are less deprived, generally in better health and live longer.
- There are pockets of greater deprivation within the City, however this is relatively small and less severe than neighbours; nonetheless significant for those affected.
- Whilst the overall numbers are low, the elderly population of the City are a large proportion and a group that will grow significantly over the next decade.

2.2. Geography, health profile etc.



The City is bounded by the River Thames, the London Boroughs of Camden, Islington, Hackney and Tower Hamlets plus the City of Westminster; all of whom are significantly larger geographically and in terms of resident population and local authority financial budget. The City is however, home to the major financial institutions of the UK and is a world financial and trade centre. It has an incredible historical heritage, is a major tourist area and home of many national treasures. Nationally and internationally, the City of London has major importance.

The map below highlights the main areas of population within the City and shows the general state of health within each of these. Further detail is contained in the data report attached at Appendix 8.1.



Whilst the general picture of the City is one where the health, general wellbeing and life expectancy are much better than neighbouring authorities and, in most instances, the national picture there are small pockets of some concern. These areas around Golden Lane, Mansell St and Middlesex St are well known to the Corporation. However, the latter two

are served by GPs registered in Tower Hamlets CCG and there is some ambiguity contractually in terms of responsibility for CHS provision because of the PCT legacy contracts in place. This is a key area for resolution.

2.3. The Better Care Fund (BCF) and national drive for Integrated Care

The development and delivery of integrated health and social care is central to government plans and the requirements of the BCF have injected genuine financial incentives to move the debate beyond "good intentions". The levers for integration have been strengthened by the introduction of the BCF as a pooled budget overseen by the Health and Wellbeing Board to help drive integration. The pooled budget for the City of London is £819k for the year 2015/16; which compares to the budget of £20m for neighbours Hackney.

2.4. Complex system with lots of partners

The City of London is the only local authority in London who do not have a dedicated and co-terminous Clinical Commissioning Group (CCG) for healthcare services. Across the spectrum of healthcare services the City is dwarfed organisationally by large providers serving significantly larger residential populations, which makes relationship management difficult.

More positively the City team has very good working relationships with various agencies established to work in partnership with social services. There is also excellent and close working with a range of voluntary services both specific to the City and cross-boundary.

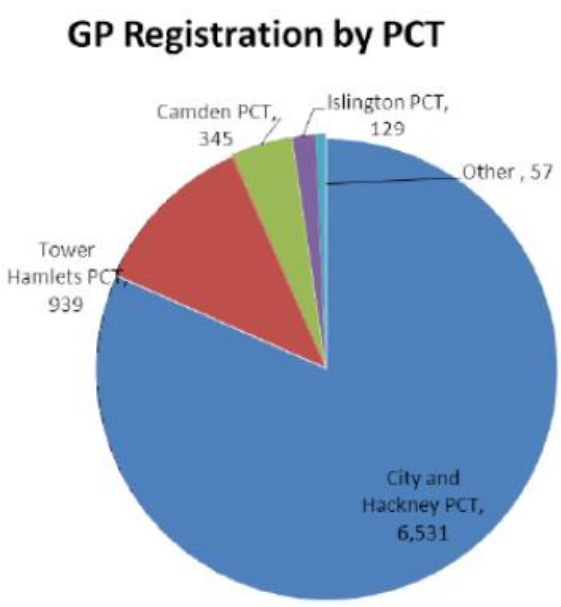
2.5. The partners providing services

Within the stocktake 22 major stakeholder partner organisations were identified and these are listed in Appendix 8.2 along with details of those people who were interviewed from each organisation. The Royal London in Whitechapel and UCLH in Euston are the two principal acute hospitals used by City residents, the former being commissioned by Tower Hamlets CCG and the latter by Camden CCG. The acute hospital commissioned by City and Hackney CCG is the Homerton which is quite some distance from most City residents and therefore rarely used by them.

2.6. GP practice distribution

The Neaman Practice, situated by the Barbican, is the only NHS GP practice based within the boundaries of the City of London and which is a member of City and Hackney CCG. There is one other

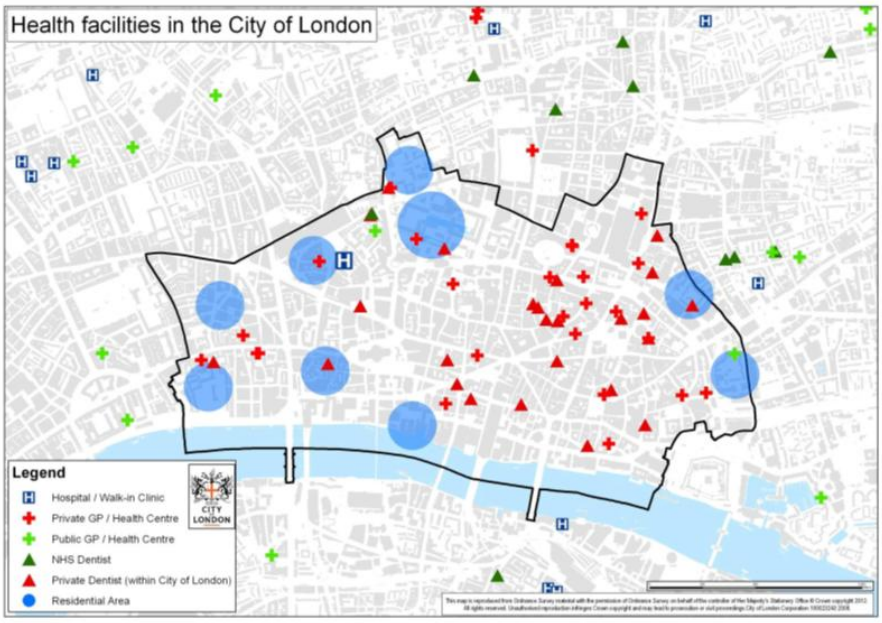
satellite surgery, named the "Green Box" due to being based in a green portable building. This surgery is a satellite of the City Wellbeing practice which is a member of Tower Hamlets CCG.



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

The table above shows the GP practices with the largest number of City Residents and the split by PCT (forerunner of the current CCGs). From this it can be seen that the Neaman Practice cares for the significant majority of City residents with 3 others having a reasonable minority with the remainder spread across a high number of practices across a range of neighbouring CCGs.



Within the City there are also 12 private GPs and this map shows the location of a range of health services across the City. Currently there is little or no relationship with private GPs or hospitals and this is a potential area of development within the new management model.

3. Diagnostic review

3.1. Data headlines

Appendix 8.1 contains a data report which highlights key data with regard to the population, housing, health, health and social care activity plus some data is used throughout the body of this report and in particular section 2. Some key headlines with regard to health and social care activity, however are:

- The number of emergency admissions to hospital is extremely low, estimated at 370 per annum (all ages) which is equivalent to 5% of total population. Hackney, by comparison has some 20,000 per annum equivalent to 8% of their population.
- The number of admissions classed as potentially avoidable is 39 per annum and the target is to reduce this to 10.
- Placements into residential care are down to 4 per annum with a target to further reduce to 3.
- Reablement is proving relatively successful with 86% of those discharged from hospital still at home after 91 days.
- There are approximately 80 open social care cases.

3.2. Data availability

We have been unable to obtain City of London activity data from provider stakeholders during the course of the project. This is not necessarily a sign of unwillingness but more of the "needle in a haystack" element where the level of activity for City residents is inversely proportionate to the effort for large providers to extract it. UCLH found some data that suggested they may have had 10 emergency admissions in one month which has to be taken against their 2,500 emergency admissions on average per month.

The numbers are such that it is a major task for the providers to find the data; however with planning and management agreement this could be managed in future through forward planning rather than retrospectively.

While it will be necessary to obtain accurate data to satisfy the BCF requirements in the future, the authors believe there are low-tech mechanisms that can have an early impact on the reality and experience of residents, such as care navigation and a live "air traffic control" operations board in the CoL ASC team to coordinate and pool local intelligence and knowledge about residents actively in the health and care system at any one time.

3.3. Quality of partnership engagement.

Amongst stakeholder organisations there is an understanding of the "dilemma" faced by the City; however the practical realities of busy large organisations and the day-to-day pressures of the senior managers within them has made quality engagement, with some honourable exceptions, difficult for this project. The difficult reality is that the City has not been seriously understood by the major provider organisations and has not been on their "strategic radar" for integrated health and social care prior to this project.

3.4. City of London team, agencies and voluntary services

The engagement issues generally faced with the large organisations (with the honourable exceptions) were diametrically opposite to the engagement with the Corporations own team and with those from commissioned agencies and the voluntary sector. These stakeholders were very willing to engage and very positive about working with the City both as an organisation and the individuals within where good relationship appear to have been developed.

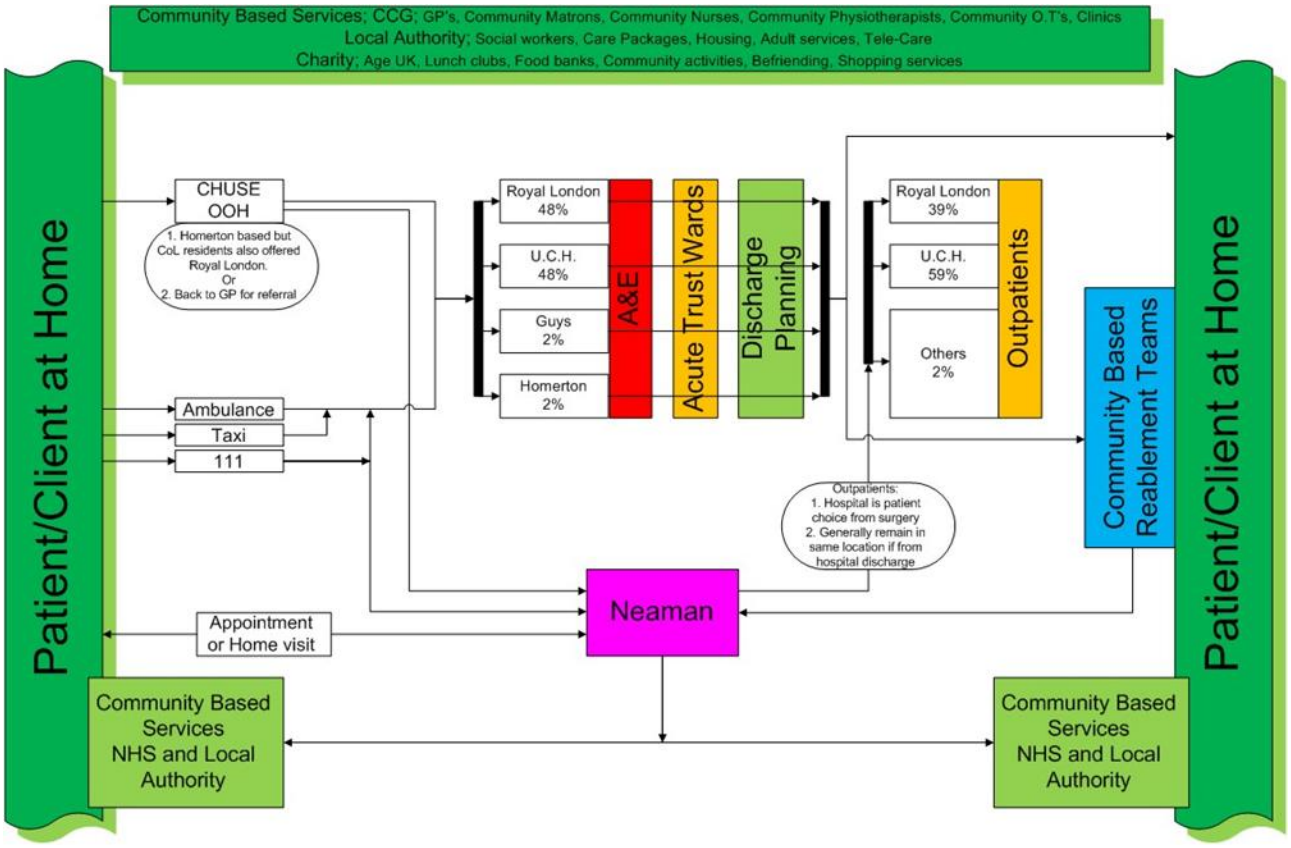
3.5. Complexity of pathways

The project team have been unable to meet with Tower Hamlets GPs despite requests, and therefore it was only possible to review patient pathways from a primary care perspective for those patients who are registered with the Neaman practice.

Technically we understand that HUHFT is commissioned to provide CHS to the whole of the City resident population through its legacy PCT contract. In practice we understand the community health services for residents registered with a Tower Hamlets GP are provided through the Tower Hamlets CCG commissioned contract provided by Barts Health.

The pathway map, below, highlights the key elements of the Neaman practice pathway and the organisations involved. Key factors to note are that UCH and Royal London are the two main acute hospitals for emergency admissions, both with roughly the same level of activity from the practice. The Homerton which is the acute hospital directly relating to and commissioned by City and Hackney CCG treat a very small proportion of patients; which will be single figures (around 5) per annum.

The new City and Hackney out of hours service (CHUSHE) is based from the Homerton hospital, however it is possible to have appointments booked through CHUSHE at the Royal London hospital.



The matrix diagram below captures the complicated nature of the current arrangements for typical patients with long term conditions as we understand them. The matrix illustrates both:

- The numbers of organisational hand-off points (which are the points where continuity of care and transfer of information are at highest risk).
- The uncertainty about responsibility for CHS provision particularly for Islington residents of the Neaman practice.

Provider Pathways: initial stocktake view for City of London

Profile – OVER 65	Residence	GP practice	ASC	CCG	CHS provider	Specialist community provider	Community geriatrician	Acute provider	MH provider
COPD	City	Neaman	City	City and Hackney	HUHFT	HUHFT	HUHFT	Barts or UCLH	ELFT
	Islington	Neaman	Islington	City and Hackney	HUHFT or North Central London FT?	HUHFT or North Central London FT?	HUHFT? HUHFT or North Central London FT?	Barts or UCLH	Camden and Islington MH FT
	City	Spitalfields	City	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts or UCLH	ELFT
	Tower Hamlets	Spitalfields	Tower Hamlets	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts Health	ELFT
Dementia	City	Neaman	City	City & Hackney	HUHFT	HUHFT	HUHFT	Barts or UCLH	ELFT
	Islington	Neaman	Islington	City and Hackney	HUHFT or North Central London FT?	HUHFT or North Central London FT?	HUHFT or North Central London FT?	Barts or UCLH	Camden and Islington MH FT
	City	Spitalfields	City	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts Health	ELFT
	Tower Hamlets	Spitalfields	Tower Hamlets	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts Health	ELFT
LTC regular admission	City	Neaman	City	City and Hackney	HUHFT	HUHFT	HUHFT	Barts or UCLH	ELFT
	Islington	Neaman	Islington	City and Hackney	HUHFT or North Central London FT?	HUHFT or North Central London FT?	HUHFT or North Central London FT?	Barts or UCLH	Camden and Islington FT
	City	Spitalfields	City	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts or UCLH	ELFT
	Tower Hamlets	Spitalfields	Tower Hamlets	Tower Hamlets	Barts Health CHS	Barts Health	Barts Health	Barts or UCLH	ELFT

3.6. What does and doesn't work well for the Neaman Practice

The Neaman practice focus group highlighted areas that worked well and some that didn't which are relevant to this project, the summary being:

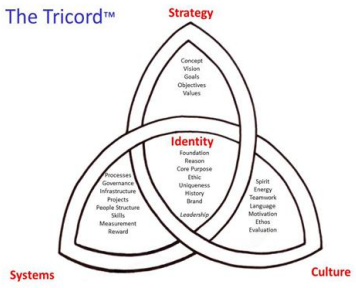
Works well:

- District nurse referrals to the practice and acknowledgements
- Very good relationships with St. Josephs hospice and palliative care team

Not so good:

- IT links to Royal London and UCH
- Communications from hospital to practice including discharge reports
- Patchy communications on A&E attendance and admissions
- Access and provision of Mental Health services to Islington residents
- Only see reports from community reablement teams at end of intervention period – different teams in different locations adds to the void of information
- Poor relationships with social services, no sense of team

3.7. Tricord analysis



Within the Tricordant methodology is the principle of viewing organisations or a work system/service in the context of a "Whole System" and to do this we take a TRICORD view based on the diagram opposite. The Tricord describes all aspects of an organisation that need to be aligned for the whole to be healthy. It is the alignment of the three outer domains of the Tricord acting in balance around the central core that is the source of organisational wholeness.

A Tricord analysis relating to this project was carried out by the Tricordant team and the results of this are detailed in Appendix 8.3. A high level summary of the analysis would conclude that whilst the City, and the Corporation, has a strong identity and culture, the lack of dedicated providers causes both strategic and system issues. Indeed, the most significant areas of "weakness" are in the systems domain where there would appear to be a need for the Corporation to apply their own "identity stamp" through a revised management model.

3.8. High level messages

Some clear high level messages come out of the diagnostic and data review, summarised as follows:

- Multiple organisations, multiple pathways, significant complexity and complication for the population.
- The provision of Community Health Services don't match acute hospital flows for patients.
- City residents are only ever a minority consideration for other organisations.
- 4 CCGs commission services for City of London residents – but principally City and Hackney and Tower Hamlets CCGs.
- There are 3 major sub-systems for City residents in terms of community –based health services:
    - Mental Health – established and seems to be functioning well.
    - Tower Hamlets Integrated Care programme (WELC) – established
    - City and Hackney Integrated Care programme – developing
- Issues for the Corporation are not completely the same as for the Neaman practice – there is a significant complication for the Neaman practice of Islington residents and yet another sub-system – impacts such as MH Crisis Response and provision of Community Health Services.
- However, the sub-systems are all being built on similar principles for Integrated Care.
- There is no single "owner" or coordinator for current health and social care delivery, provision (or commissioning) for all City residents.

- Absence of comprehensive City-resident based information makes analysis difficult – but available data shows small numbers of social care cases, hospital admissions and delayed discharges.
- There is potential for ASC team integration into established and emerging GP practice/cluster MDT arrangements.
- Confusion around provision of Community Health Services for resident or registered populations (this is a legacy of NHS changes to commissioning arrangements and is a Clinical Governance risk).
- Some real assets in voluntary sector.
- Compared to the residents of neighbouring authorities, and nationally, those living in the City of London are less deprived, generally in better health and live longer.
- The projected growth of 65+ age group in next decade when taken with the number of older people living alone poses a significant challenge for the Corporation.
- Need to balance desire to have distinct City identity with established and emerging macro-systems from CCGs and NHS Providers.

4. What the service users and stakeholders say

During the development of the BCF submission the City undertook a consultation event with Healthwatch which produced some clear resident comments and desires in terms of improvements to health and social care. A copy of the report is attached at Appendix 8.4. In general feedback from the event was very positive, however requests for improvement were highlighted as:

- Seamless services without gaps in provision or in the knowledge of people's issues, or delays in providing support or equipment.
- A single named professional to help co-ordinate care at home or on discharge from hospital, and to help navigate through services.
- Information and records to be readily available to, and shared between, health and social care professionals.
- Better communication between services such as GPs and hospitals – especially when being discharged home.
- More individualised support, advice and information for carers - such as helplines, support groups, respite breaks and practical help.
- Services available around the clock.
- A "well-being MOT" to assess needs and the support needed to stay well.
- Support to avoid and tackle social isolation.

- Hospital discharge that is timely, has care in place whatever the day or time leaving hospital, and is not delayed by waits for medication or transport.

5. Current and planned services

This section describes in outline the current organisation and responsibilities for health and care services in the City of London. At Appendix 8.5 the provider matrix diagram was an early stocktake view of some of the system complexities. Whilst this is not, necessarily, totally accurate or up to date it does to a great extent reflect the realities and serves to act as an illustration.

5.1. GP practices

GP practices are now commissioned by NHS England and not by CCGs. The new Chief Executive of NHS England has recently invited CCGS to express an interest in co-commissioning primary care, and therefore there is scope for commissioning arrangements to change in the near future.

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, where residents 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. The out-posted service is commissioned by NHS England.

5.2. Emergency and elective hospital care

City residents are served primarily by the Royal London and University College Hospitals for their emergency and non-emergency hospital services. There are relatively few admissions to the Homerton Hospital for either emergency or elective are.

Hospital services are commissioned by lead CCGs within London. Barts Health by a consortium including Tower Hamlets, Newham and Waltham Forest, UCLH by Camden CCG and the Homerton by City and Hackney CCG.

The London Ambulance Service will despatch the closest ambulance to an incident rather than from a specific Ambulance station. Ambulances will take patients to the nearest available A&E, which could be either Royal London or UCLH.

The designation of Barts Health as a centre for trauma, stroke and heart conditions means that City residents with these conditions will increasingly flow to Barts Health and consolidate the acute hospital flow pattern.

5.3. Community services

Community Health Services (CHS) are commissioned by CCGs, technically for their resident populations, but provision in the City is currently complicated by the recent organisational changes in NHS Commissioning. The current contracts for providers with both HUHFT and Barts Health are legacy contracts from the Primary Care Trusts and are due for re-contracting with the CCGs in both City and Hackney and Tower Hamlets.

The HUHFT contract technically covers all City of London residents, but in reality covers the City residents of the Neaman practice and not the City residents registered with other GP practices outside the City boundaries. We understand the Barts Health CHS provider follows 2 specifications – one covering the Tower Hamlets Borough boundaries and the second covering the cross-boundary and historic "knock-for-knock" arrangements between the PCTs. Under the cross-boundary agreement the Trust provides CHS for the City residents registered with Tower Hamlets GPs.

A complication with CHS for City residents is that the in-reach admission avoidance and rapid response team from Barts Health will assess City residents in the Royal London A&E registered with Tower Hamlets GPs, but not City residents registered with GP practices in other CCGs.

In interviews representatives of Barts Health have confirmed that their Integrated Care programme, which commenced roll-out in October 2013, covers the GP registered population and therefore includes City residents with Tower Hamlets GP practices. The opportunity of CHS re-commissioning in 2015 alongside Integrated Care programme development potentially allows the re-alignment of CHS support to GP practices serving the City.

5.4. Adult and Older Peoples Mental Health

Adult and Older Peoples Mental Health Services are provided to City residents by the East London Foundation Trust and are commissioned by City and Hackney CCG. The arrangements are well established and are reported to work well from the standpoint of both the Corporation ASC team and

the Neaman practice. The ELFT footprint covering multiple CCGs helps avoid the complications created by the differing NHS and Local Authority commissioning responsibilities for registered and resident populations respectively.

The complication for the Neaman practice is that Mental Health Services for the adults and older people who live in Islington are provided by the Islington and Camden NHS Foundation Trust, which operates a different model of care to their counterparts in ELFT.

5.5. Adult Social Care

The City of London operate an in-house adult social care team to fulfil their statutory obligations. Comments via Healthwatch and commissioned agencies say that the service is generally high quality.

Reablement is a key feature of the ASC offering to residents and is used as a preventative measure as well as post hospital discharge. It is a small but effective, if expensive, service costing just under £200k including OT, for the City as a result of being delivered through a mix of in-house staff and commissioned agencies who handle "out of hours" care in evenings and weekends.

An understandable decision was made by the City not to use the City and Hackney intermediate care service, including reablement as part of the City and Hackney RICS review; however it is proposed that this be reviewed as the new model develops because reablement is a critical element of intermediate care and is increasingly integrating with rapid response services around the country.

Within the new model it may be more appropriate and resilient for the ASC team within the City to commission, manage and coordinate intermediate care rather than being the provider.

5.6. Voluntary services

The City work with a good range of voluntary services with whom they have extremely good relationships. Voluntary services are a key part of the overall social care system within the City, providing services to those with "moderate" needs. There is a significant foundation in place to further develop these services and there is a willingness within the sector to work on this with the City.

In addition to service provision, the voluntary sector also provide excellent communication pathways to advise residents of appropriate services and in particular the links in through residents group and local housing management teams. The work of the Penderel Trust in helping residents maximise personal budgets is another notable service provided by the City to their residents which provides a range of further development opportunities within a new model of care.

6. Key opportunities in developing the One City model

Here we describe the current and planned health and care services that will have a systemic impact on the development and delivery of Integrated Care in the City of London.

The purpose here is to identify the opportunities that help create the architecture of the One City model and align the key aims of the BCF submission with the emerging plans to help shape the next stage of planning and implementation of the model

CHS re-commissioning in 2015 in both C&H and TH presents a major opportunity to re-align CHS support to GP practices serving City residents.

6.1. Better Care Fund key aims

The ambition of the City of London BCF application is to create a locality working model for the City "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'"

The key components of the system are described as:

- Preventative support through reablement and through services within the community.
- Case management for the frail elderly
- Practice-based coordinated care.
- Joint Care Navigation.
- Risk stratification of vulnerable older people.
- Supporting Carers.
- Integrated data sharing.
- A "One City Team" to provide rapid response and assessment and clinical support to prevent admission to hospital for up to 72 hours.
- The rapid response team will link in closely with the PARADOC service that is being piloted by City & Hackney CCG and covers the City of London boundaries.

6.2. Community Health Services re-commissioning

In section 5.3 we described how the current configuration of community health services is shaped by the legacy contracts currently in place from the previous PCTs.

There are 2 relevant re-procurements due in 2015:

- City and Hackney CCG.
- Tower Hamlets CCG.

The CHS re-procurements offer 2 opportunities:

- To address the current clinical governance and quality risks in the legacy CHS contracts so that grey areas across local government boundaries are resolved. In terms of provider responsibilities.
- To consider the optimum alignment of CHS with the Neaman practice, taking account of acute hospital flows and the developing Integrated Care programmes.

6.3. Integrated Care Programmes

There are 2 major Integrated Care programmes impacting City of London residents, 2 of which are among the 14 national Pioneer programmes:

- City and Hackney. The programme is in development, with pilots being planned.
- Waltham Forest, East London and City (WELC), which includes Tower Hamlets. The programme is managed by Barts Health, it is one the national Pioneers and is in the second year of implementation.

Effectively these services are being set up by the larger neighbouring systems, of which different parts of the City are sub-systems, and therefore the challenge to the Corporation is how to join in these sub0systems most effectively.

6.3.1 What does good looks like in Integrated Care?

The 2 key Integrated Care programmes of interest to City residents, while different in timing and stages of development, fundamentally share the same characteristics and components to address the ambitions of the City Better Care Fund application. There is an increasingly strong evidence-base to support the interventions

These include:

- Self-care
- Risk profiling to identify the most vulnerable older people in the population.
- Care planning with GPs as nominated clinicians.
- GP Practice-based coordinated care.

- Case management and Single Points of Access for the vulnerable elderly
- Rapid response and discharge management teams.
- Reablement and Intermediate care aligned with rapid response services.
- Specialist support in the community (e.g. Community Geriatrics)
- Specific interventions such as the RAID model in Adult and Older People.

It is also notable that populations in the order of 30,000 to 50,000[1] appear to be the common size for a locality team in the new approach to Integrated Care, significantly larger than the City of London. To be economically viable therefore the One City approach will need to be part of a larger Integrated Care system.

One of the conclusions of this review is that, if the One City model is to be an effective sub-system of a larger Integrated Care model, serious consideration must be given to the options available to simplify pathways and organisational relationships for patients.

6.3.2 City and Hackney

A final draft specification for the Practice Based Integrated Care Pilot in City and Hackney has been sent to the provider community in City and Hackney to invite participation. The pilot has £2m funding from the CCG each year for 2 years 2014-6.

The CCG has committed to involving the City and Hackney Local Authority Commissioners to review the proposals and expect to make a decision no later than the end of May.

Practice based integrated care is a core element of City and Hackney's Better Care Fund Strategy to 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 to co-ordinate care for these patients. This non recurrent CCG funding is to pump prime services which may then be commissioned further as part of the Better Care Fund

The Integrated Care Pilot will focus on frail elderly patients, estimated to represent 20% of local people aged over 75 years.

This integrated care pilot spans three key elements:

- **Patient identification** - comprises risk stratification and enrolling patients
- **Patient management** - comprises creating care plans, running multi-disciplinary case conferences, care co-ordination and care plan implementation

[1] Nigel Edwards, Community Care and the Cost Conundrum, Health Service Journal, 2 May 2014.

- **Supportive measures** - comprise facilitation and training the multi-disciplinary team.

Within the cohort of patients, each patient will have

- An individualised care plan updated fully every year, and reviewed regularly, particularly after any Unscheduled contact with health or social care
- Regular scheduled home visits quarterly which are funded by the CCG contract for vulnerable patients and home visiting
- A responsible named doctor and named nurse who will ensure continuity of care is maintained.
- Via the Cquin Homerton is commissioned to ensure care plans are amended and reviewed as part of any hospital stay and changes communicated to the patient and the registered GP

The City and Hackney Integrated Care Pilot will use individual patient focussed case conferences and Quadrant-based case co-ordination; these are summarised below.

Practice-Based Case Conferences

- Practices will use these case conferences for in-depth case discussions and facilitating the care co-ordination and case management of patients in the scheme.
- They will occur monthly.
- The team will comprise: General Practitioners, Community Matrons and District Nurses, with attendance from other integrated care providers when necessary.
- Funding for GP time to participate in practice based case conferences is funded via the CCG Vulnerable Persons contract.
- GP Practices will be grouped into 4 separate geographical quadrants of c 10 practices per quadrant
- The providers to deliver a multi-agency integrated care team for each quadrant who will provide care to patients on the registered lists of the practices in each quadrant.
- The integrated care team should consist of General Practitioners, Community matron, District Nurse, Mental Health workers, Social Worker, Specialist Nurses, Intermediate Care Therapists, Geriatrician
- Under the model we expect there to be at least one quadrant coordination meeting per quarter
- The specification states that a specific response to meet the needs of the Neaman Practice/City of London is expected from providers in the pilot.

Crisis Response

A key component of this pilot will be to ensure that these patients receive an appropriate out of hospital clinical response at times of crisis rather than an automatic conveyance to A&E. It is essential that the RICS staff are members of the multi-disciplinary team and that the crisis plans developed in the practice meetings are conveyed and communicated to the rapid response team as well as other urgent care services (e.g. LAS and GP OOH).

See Appendix 8.8 for proposed pathway for frail elderly.

6.3.3 WELC programme (commissioned from Barts Health)

The IC Programme in 2 stages, the first of which went live in October 2013.

In Tower Hamlets there are 8 GP Networks, each having a locality MDT, which are planned to be co-located over the next 3 months. The locality teams included specialist input, concluding Community Geriatrics.

City residents registered with Tower Hamlets GP practices are covered by these arrangements. The Spitalfields practice is in Zone 2 with City Wellbeing (which runs the Portsoken Greenbox) in Zone 3.

Stage 1 (year 1)

- Risk profiling (Q Admissions tool) is live and creates flags in the GP and CHS systems (both EMIS), the GP out of hours (Adastra) and ASC Framework I systems. There are plans to join connect in the Mental Health and acute hospital systems via the Orion portal.
- GPs are remunerated and incentivised by the Network Incentivisation Scheme (NIS). This includes mandatory NIS coverage of Palliative Care, Dementia and Heart Failure.
- Network Community Health Teams have
    - District Nurses
    - Community Matrons
    - Physios
    - OT
    - SLT
    - linked MH workers and Palliative care from St Josephs
    - Case coordinators Band 5 and Band 4 attached to each MDT (job descriptions in appendix 8.6)
- There is a Single Assessment Process in the Community Health Teams.

Stage 2 (year 2)

- Alignment with reablement, Mental Health and 3rd sector.
- Rolling out case finding through predictive risk profiling to the next tranche of population.

6.4. Care Navigation

Funding has been secured by the City of London for 18 months for the creation of 2 posts which will have responsibility for coordinating services for 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. The two posts will be pivotal in supporting the multidisciplinary teams and in supporting Care Planning meetings led by the GPs. They will also have responsibility for facilitating discharge for residents from hospitals outside the CCG area. The posts can be central to establishing the Residents Coordinated Care function within CoL. These posts will be recruited to in 2014/15 in order to effect a smooth transition to integrated service delivery in 2015/16.

Research undertaken by Age UK in Kensington and Chelsea demonstrates 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 this context.

While care coordination roles in the Integrated Care teams will focus on the 1-5% most vulnerable older people, Care Navigation roles have potential to cover all patients and take a much broader view. They are well established and evaluated roles in several parts of the country. Sample documentation, evaluation and sample job descriptions are attached at Appendix 8.7

A meeting with Age UK has been arranged to discuss the potential role, and it is recommended that the Integrated Care providers then be engaged to help refine the role in order that it can complement and best fit with the work of Care coordinators as they develop.

6.5. Care planning and named GP responsibility

Through the Vulnerable People's LES contract the City and Hackney CCG 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.

The goal is for each vulnerable patient to have: (a) an individual care plan; (b) regular scheduled home visits, which typically will occur quarterly and (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.

6.6. Paradoc in City and Hackney

This GP and Paramedic fast response service pilot started on 28 March and is based out of the Homerton Ambulance Station, operating 7 days a week from 12pm to midnight.

This service is available to all City of London residents.

6.7. Public Health

Public Health services play a vital role in the maintenance of good health and the prevention of disease. The full range of Public Health commissioned contracts are under review.

Potentially relevant contracts include

Most contracts joint with Hackney, but several are City only contracts:

- Smoking Cessation – level 2 service through 15 Boots pharmacies. There are 16 pharmacies in City in total. 180k pa
- Smoking cessation [level 3] Queen Mary Hospital. 52k pa.
- Exercise referral programme with Fusion Lifestyles – 37k. Accessed via Social Prescribing via GP.
    - Neaman practice over target on referrals.
    - Working with TH re access for TH GP registered City-resident patients.

- Community Health Engagement Coordinator in Portsoken Ward. Operates out of Portsoken Health and Community Centre. Employed by Toynbee Hall. Supports Bengali women accessing exercise and diet advice. Police run boxing classes for youth.
- NHS Health Checks.
    - Neaman practice contracted through Hackney.
    - City contracts with 2 Pharmacies – 1 Boots, 1 independent.
    - TLC target vulnerable and hard to reach adults. Trained in brief interventions for alcohol and obesity.

- Jointly commissioned with Hackney
    - Obesity management [Boots plus independent pharmacy]
    - Time Credit system, provided by Spice. Want to extend into Portsoken.

- Carers service – mainly respite care through Age UK Camden
- City 50+ - Toynbee Hall.
- Dementia programme- dementia friendly café
- Supported living – residential placements, with wide range of values.
- City Wellbeing Practice operates 2 half days out of Portsoken Health and Community Centre – TH GPs.
- Dentistry – Dental Health Promotion about to be reviewed and will include older people – has been mainly focussed on children to date.

6.8. Telecare, to include telehealth

Telecare and telehealth are proven interventions to support vulnerable people to live independently and we understand tenders are being invited by the Corporation for these services.

There is opportunity to develop a clear strategy for aligned telecare and telehealth with partners.

6.9. Adult and Older Peoples Mental Health

The City and Hackney CCG plans 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.

The City has a Dementia strategy with a City-specific approach to caring for residents and tapping into the strengths of the community.

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.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 use.

6.10. Livery companies

The livery companies are a unique feature of the City of London and support local charitable activities and they also provide alms housing. We are aware of Livery Company contributions to primary care developments in Tower Hamlets and note the opportunity for their continuing engagement in the development of the health and support system.

7. Developing the "One City" model

7.1. Whole System model map

In order to represent the complexity of the current system visually and illustrate how it can be made less complicated we have developed the model in figure 1.

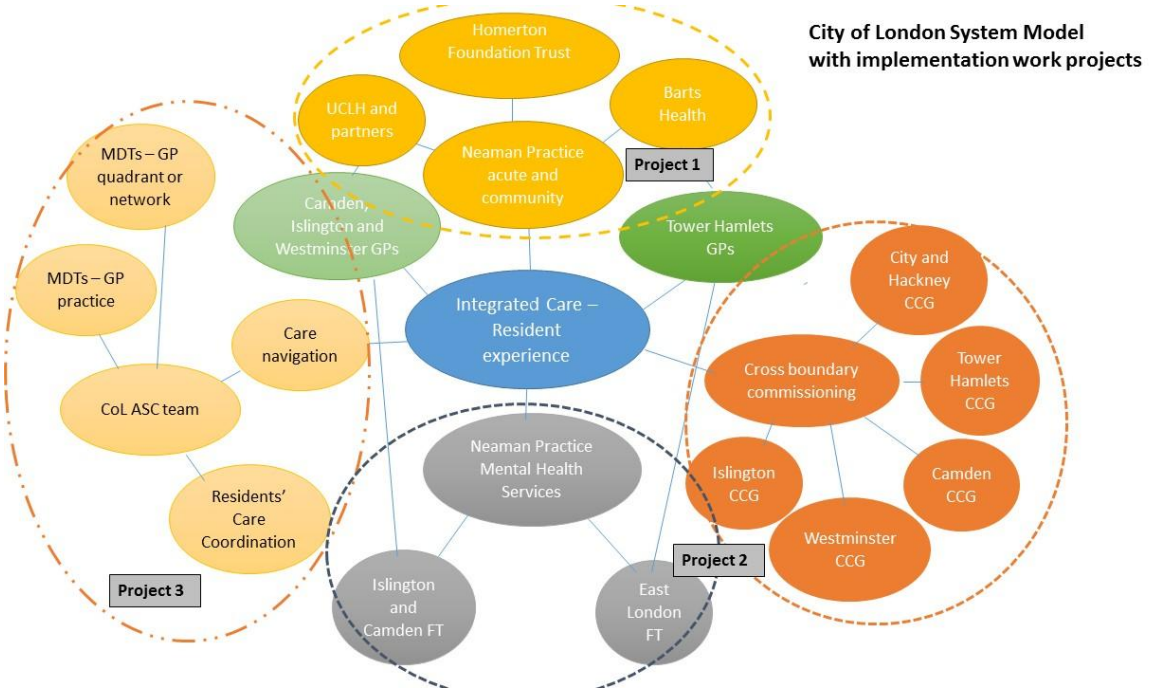


Figure 1

The model highlights four areas where component improvements in the system can combine to deliver improved experience in health and social care for the residents of the City of London. Depending on place of residence and registered GP practice certain components of the system will be delivered differently. The proposed model can operate as a managed system which:

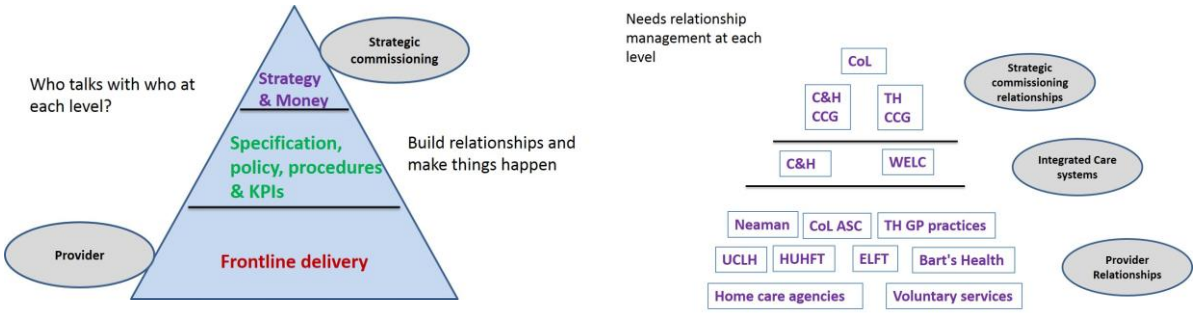
- Reduces the potential for organisational "fault lines", where the system risk is highest for patients and residents.
- Creates an explicit role for the City of London ASC team to coordinate the experience of residents through "air traffic control".

  Clarifies accountabilities across boundaries for the commissioning and delivery of health care.

7.2. Developing and managing relationships

A key to successful development of the "One City" model will be in the development and ongoing management of relationships with other organisations. These relationships will need to happen at levels of the organisations with the appropriate people held responsible for these key relationships. The management model of care depends on high quality personal relationships.

The two following diagrams illustrate the need to be clear on the named individuals who will work with their peers at each level and also the major organisations within each of the levels. The resourcing issue will need to be assessed through the proposed workstream 3 focussing on the role and shape of the ASC team.



In effect these diagrams illustrate how the "One City" model needs building on the foundation of relationships in commissioning, service specification and provision through clear multi-level peer to peer relationships. The knowledge of who is responsible for what and the holding to account for the delivery of the agreements is critical to making the model work.

7.3. The single point of knowledge

Within most integrated care systems there has been created a "Single Point of Access" or a "Single Point of Referral" which, depending on the specific model, is the one place all professionals can contact to seek guidance or effect a smooth patient handover to the next service.

Single Points of Access are being established in the wider Integrated Care systems which will impact on City of London residents. Therefore aiming to create a Single Point of Access in the City risks duplicating or not joining with the emerging systems.

There is however a clear gap in the system where currently no-one holds the ring or coordinates the "on the ground" intelligence and information about City residents who are actively engaged in the health and/or care system. The review has identified the gaps already in information availability between organisations, and these information transfer issues are clear fault lines in the system where handovers and speedy movement to the next stage of a pathway is essential for residents' experience of joined-up care.

We call this a "single point of knowledge" which is likened to air traffic control or ward rounds. It is a single point of coordination (or operation room) where the team will know, based on local intelligence gathered from multiple sources, who is in the system, where they are, what they are waiting for and what is planned for the next steps. It can operate as a low-tech system (such as a whiteboard in a confidential and secure area) where the next steps are not dependent on electronic data transfer between organisations.

Care Navigators are envisaged as the coordinators of the "air traffic control" and will ensure the smooth transitions and handovers with the appropriate teams in the sub-systems. Whilst this may benefit from integrated IT systems in the long run, it will need little more than good staff with pen and paper/white board to become very effective in the immediate term.

7.4. Delivering the points raised through Healthwatch

In section 4 we mention the issues raised at the Healthwatch event in December. We believe the recommendations and emerging services identified in this report will allow the City of London health and care system to respond to these points in the short and medium terms.

The key priorities were:

- Clear pathway and system, including hospital discharge, for each patient managed by a care navigator.
- Both C&H and TH CCG integrated care plans involve 7 day working, named professionals and 3 monthly home visits and MDT for all over 75s.
- Single point of knowledge combined with improved IT systems will allow better appropriate transfer of client data.
- Further development of voluntary services to deliver even better communication, resident/carer support and mechanisms to combat social isolation.
- Health MOTs starting to be delivered through Public Health commissioned Health Checks.

7.5. Summary and recommendations

A One City Model to deliver best quality of experience for every City resident will recognise the choices residents make about where to receive their care, and will focus on the organisation arrangements best suited in the short and longer terms to deliver the experience of integrated care.

The proposed model is rooted in the current reality, and will build on the foundations of the current and emergent patterns of service.

It will be important to satisfy competition rules and organisational legal powers in terms of any proposed changes to current arrangements and therefore much of the emphasis on next steps is around process to reach the right solutions.

The whole system model illustrated and outlined in section 7 of this report is feasible and deliverable through a work programme comprising 3 workstreams as follows:

1. To conduct an options appraisal with the Neaman practice and the City and Hackney CCG, working with providers, on the options for community health services and Integrated Care support to the Practice, in order to inform CHS commissioning for the Neaman practice in 2015/16.
2. In partnership with neighbouring CCGs in Tower Hamlets and Islington:
    a. To develop the commissioning case for realignment of Community and Adult/OPMH Mental Health Services in support of the Neaman practice.
    b. To address the "grey areas" of cross- LA boundary commissioning and clinical governance risk caused inadvertently by PCT legacy contracts for Community Health Services.
    c. To explore with the City and Hackney CCG the designation of a City of London Health commissioning resource to align specifically with arrangements for CoL residents.
3. To review and align arrangements in the CoL ASC team to:
    a. Explore and design the ASC team role to coordinate health and social care pathways on behalf of all City residents.
    b. Enable a whole-City view of residents through a Residents' Care Coordination team/mechanism ("air traffic control") for exchange of regular and up-dated information on City residents who are active recipients of health and/or social, including support commissioned from the Community and Voluntary Sector, and from local intelligence.
    c. To work with GP and provider partners to design and commission Care Navigation roles (x2) to provide 7 day support to the GP practices covering City of London residents.
    d. To ensure active ASC team engagement and participation in the Multi- Disciplinary Teams forming around relevant GP Practice clusters – preferably through named relationships.
    e. To ensure there are clear referral mechanisms in place for Royal London and UCL Hospitals Rapid Response and Discharge Management teams to enable admission avoidance and discharges from hospitals.

A proposed programme of work to take the recommendations forward to the implementation stage will now be developed for agreement among the partners.

8. Appendices

8.1. Data Report

CoL final report - data section v2.pdf

8.2. Stakeholder list and interviews

CoL Stakeholder and Interview List fo

8.3. Tricord analysis

CoL Tricord Summary for Report

8.4. Healthwatch consultation event

2013.12.12 BCF consultation event s

8.5. Provider matrix diagram

Matrix diagram for report.pptx

8.6. Care coordinators – Barts Health

Care Coordinator Band 4.docx

8.7. Care Navigators

K&C Primary Care Navigators 2012 201

care navigator - Age UK IoW.docx

Care-Navigator-Job -description-.doc

care_navigator Yorkshire and Humb

care navigator - job description pack.do

8.8. Proposed City and Hackney IC pathway