# City and Hackney CCG and The City of London Corporation

# BCF Narrative Plan 2017-19

# 11 September 2017


NHS
City and Hackney
Clinical Commissioning Group

**Contents Page**


| | *Page* |
|---|---|
| Introduction | *3* |
| Local Vision and Approach for Health and Social Care Integration | *3* |
| Background and Context to the Plan | *11* |
| Progress to Date | *14* |
| Evidence Base and local Priorities to Support Plan for Integration | *16* |
| Plans to Address Performance | *18* |
| Significant Change and Developments | *19* |
| Equality Impacts | *21* |
| Better Care Fund Plan | *23* |
| National Conditions | *31* |
| Additional Conditions | *32* |
| Overview of Funding Contributions | *34* |
| BCF Milestones | *35* |
| Programme Governance | *35* |
| Risk | *37* |
| National Metrics | *41* |
| Approval and Sign Off | *42* |
| | |
| Diagram 1: Integrated Commissioning Arrangements | *5* |
| Diagram 2: Boroughs and Health Providers | *13* |
| | |
| Chart 1: Population Growth City of London 2012-2037 | *11* |
| Chart 2: Growth in City of London Population aged 85+ 2012-2037 | *12* |
| Chart 3: General and Acute Emergency Admissions | *17* |
| Chart 4: City and Hackney Emergency Bed Days by Provider | *18* |
| | |
| Table 1: Links with other plans | *7* |
| Table 2:Progress on Key BCF Metrics 2016/17 | *14* |
| Table 3: Adult A&E Activity | *16* |
| Table 4: City and Hackney Emergency Admissions by Provider | *17* |
| Table 5: Schemes for 2017 – 19 | *23* |
| Table 6: National Conditions 2017-19 | *31* |
| Table 7: National Conditions no Longer Required | *32* |
| Table 8: Funding Contributions | *34* |
| Table 9: iBCF Spend Profile | *34* |
| Table 10: BCF Milestones | *35* |
| Table 11: Risk Register | *38* |
| Table 12: National Metrics 2017-19 | *41* |
| | |
| Appendix 1: DTOC Plan including HICM action plan | *43* |

## Introduction

This document provides assurance information and details of plans for the Better Care Fund (BCF) and the Improved Better Care Fund (iBCF) for the City of London Corporation for 2017–19.

It builds on previous BCF plans developed since 2015/16 and includes additional information required to demonstrate how it meets the national guidelines and requirements as set out by the BCF Policy Framework for 2017 - 19. It also contains details of the plans for the additional iBCF money allocated.

This BCF plan continues with a number of successful schemes and the iBCF supports the provision of additional care packages, work around Continuing Healthcare and intermediate care.

The plan covers two financial years (2017 – 19) which aligns with NHS planning timetables, giving the opportunity to plan strategically and to have stability for some on-going schemes.

## Local Vision and Approach for Health and Social Care Integration

The City of London Corporation vision for health and social care is that:

- City of London residents live long and healthy lives, supported in their local community wherever possible by integrated health and social care services
- Health and social care services are person-centred, co-ordinated, high quality, responsive and fit around the needs and preferences of the individual, their carers' and family and that
- They deliver across the complexity and unique challenges of City of London boundaries, care pathways and partner interactions

As the Five Year Forward View stated, the traditional divide between primary care, community services and hospitals is increasingly a barrier to the personalised and co-ordinated health services patients need. The plan set a new shared vision for the future of the NHS, emphasising the need to move to place based systems of care where organisations collaborate and use their resources effectively to meet the needs of their local population in the most appropriate and effective way. It also explores the challenges to be addressed in the NHS around finance and efficiency, improving the health of the population and providing quality of care.

Local partners endorsed this approach but with the addition of social care as an integral part of the services needing to integrate around each patient and that we need ever closer working between the NHS and local government to achieve our aims for our communities.

In April 2017, the City of London Corporation entered into integrated commissioning arrangements with City and Hackney CCG to join up commissioning across health, social care and public health. The London Borough of Hackney has also entered into similar arrangements with City and Hackney CCG. See diagram on page 36 for further details of the governance structure.

The integrated commissioning arrangements aim to remove organisational barriers, develop more joined up plans and commission integrated services that benefit patients and service users. It supports an approach of moving to contracting for outcomes and commissioning providers to work across organisational boundaries.

The integrated commissioning arrangements are currently based on aligned budgets with some pooled budgets that are already in place such as the BCF. The longer term ambition is to have one larger pooled budget for integrated commissioning.

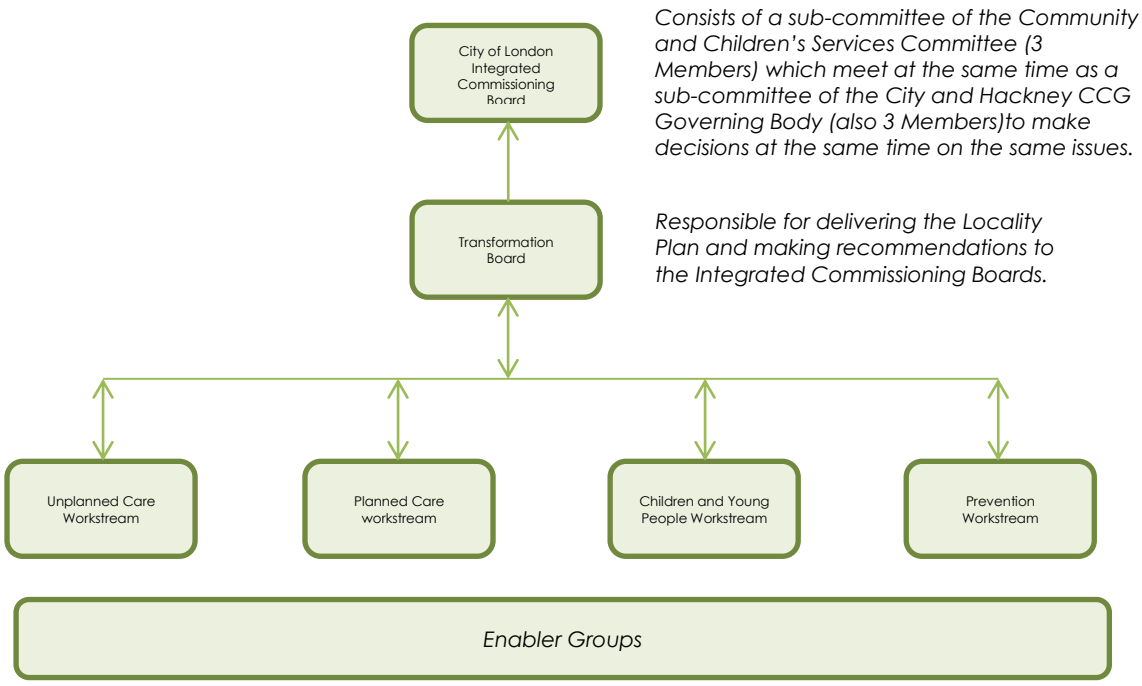
The aims of integrated commissioning include:

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

The City of London's BCF plan supports the wider vision for integrated commissioning.

The following sets out how integrated commissioning arrangements are structured

*Diagram 1: integrated commissioning arrangements*




*These groups work across the workstreams and include IT, back office and workforce*

*East London Health and Care Partnership (North East London Sustainability and Transformation Plan)*

The City of London is part of the North East London STP, known as the East London Health and Care Partnership (ELHCP). It also includes 7 other local authorities, 7 CCGs, 3 acute hospital providers and 2 mental health trusts. The focus of the STP includes promoting independence and enabling access to care closer to home with less dependency on the hospital system and beds. Key enablers include new models of care, workforce, technology and infrastructure.

Whilst each of the local areas has a different starting point, common challenges include a growing population, a rapid increase in demand for services, and scarce resources. Based on these NEL-wide challenges, ELHCP have identified six key priorities:

1. The right services in the right place: Matching demand with appropriate capacity in NEL
2. Encourage self-care, offer care close to home and make sure secondary care is high quality
3. Secure the future of our health and social care providers. Many face challenging financial circumstances

4. Improve specialised care by working together
5. Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies
6. Using our infrastructure better

The plan also articulates some potential opportunities, which the BCF plan helps to support. These include reducing avoidable hospital admissions through prevention and out of hospital schemes that support self-care management and patient activation; support for better patient flow and early discharge; and greater capability and capacity in the community to help people recover and return home.

Across NEL the ambition is to go further in integrating health and social care services in order to implement person centred care models. A key part of doing this will be developing Accountable Care Systems that bring together providers of health and social care services around a single service model and a set of outcomes. There is also commitment to the integration of commissioning functions to support new population based contracting models.

The latest version of the plan can be found here - http://eastlondonhcp.nhs.uk/wp-content/uploads/2017/06/NEL-STP-draft-policy-in-development-21-October-2016.pdf

The City and Hackney integrated commissioning arrangements have been acknowledged as a new model of care within the ELHCP and with the move towards Accountable Care Systems (ACS), the partners within the integrated commissioning arrangements are considering how this could develop into a more formal ACS.

*Table 1: Links with other plans*

| Government policy and local strategic context | Overview |
|---|---|
| **Care Act 2014** | Sets the legal framework for the adult social care system and is designed to focus on people's strengths and capabilities, supporting them to live independently for as long as possible. |
| **Carers Strategy (2015-18)**<br><br>http://www.cityoflondon.gov.uk/services/adult-social-care/Pages/carers.aspx | Sets out the City Corporation's priorities for supporting adult carers in the Square Mile. The strategy has been developed based on analysis of evidence and consultation with carers and stakeholders, and in the context of recent legislative change.<br><br>A key aim of the strategy is to identify and support more carers across the City, at an earlier stage, with a focus on improving their health and wellbeing. Delivery against the strategy will be monitored by the Adult Wellbeing Partnership.<br><br>The Strategy identifies six priorities:<br><br>**Priority 1:** carers are identified at the earliest opportunity and offered support to prevent , reduce or delay their needs and the needs of their cared for<br><br>**Priority 2:** carers are provided with personalised, integrated support that is tailored to their assessed needs and aspirations, gives them choice and control and allows them to take a break<br><br>**Priority 3:** carers are involved and consulted in the care and support provided to their loved ones, treated with respect and dignity, and have their skills and knowledge recognised<br><br>**Priority 4:** carers are supported to improve and maintain good physical and mental health and wellbeing<br><br>**Priority 5:** carers are supported to improve their individual social economic wellbeing, reduce isolation and fulfil their potential in life<br><br>**Priority 6:** carers are supported to cope with changes and emergencies and to plan for the future, including when the caring role is coming to an end and to have a life after caring. |

| | |
|---|---|
| **Community and Children's Services, Business Plan 2017 - 22** | The Community and Children's Services Business Plan has 5 priorities:<br><br>• Safe - People of all ages live in safe communities, our homes are safe and well maintained and our estates are protected from harm<br>• Potential - People of all ages can achieve their ambitions through education, training and lifelong-learning<br>• Independence, involvement and choice - People of all ages can live independently, be active in their communities and exercise choice over their services<br>• Health and wellbeing - People of all ages enjoy good health and wellbeing<br>• Community - People of all ages feel part of, engaged with and able to shape their community. |
| **Health and Wellbeing Strategy**<br><br>https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/joint-health-and-wellbeing-strategy.pdf | The Health and Wellbeing Strategy has 5 priorities:<br><br>• Good mental health for all<br>• A healthy urban environment<br>• Effective health and social care integration<br>• All children have best start in life<br>• Promoting healthy behaviours |
| **City of London Health Profile**<br><br>https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/city-of-london-health-profile.pdf | Summary of some of the key health issues facing the City of London |
| **Joint Strategic Needs Assessment (JSNA)**<br><br>https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/JSNA-City- | Assessment of the physical and mental health and wellbeing needs of individuals and communities in the City and Hackney. A City supplement has been produced to focus on the specific needs of the City. |

| | |
|---|---|
| Supplement.pdf | |
| **The Adult Wellbeing Plan 2014-17**<br>  | Set's out the City's vision for the right services at the right time, at the right place has determined the five key priorities of this Adult Wellbeing Plan.<br>• **Early Intervention and prevention** - we are committed to a long term shift in service provision away from crisis intervention towards services that prevent or delay needs and reduce dependency.<br>• **Stronger safeguarding** – we will lead locally in protecting peoples' health and wellbeing, and enabling them to live free from harm, abuse and neglect.<br>• **Personalisation** – we will recognise people as individuals who have strengths and preferences. We will put them at the centre of their own care and support and provide good quality information, advice and advocacy so that people can make informed decisions. Support will be tailored to people's needs.<br>• **Services working together** – we will work closely with other services and promote greater integration of health and social care to ensure that residents receive seamless, efficient and effective services to meet their needs.<br>• **Co-production –** we are committed to finding innovative, collaborative ways of working to involve and support people to design, deliver and evaluate services. |
| **Integration and Better Care Fund Policy Framework 2017-19**<br><br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf | Published in March 2017, the framework has guided the development of the BCF plans and this document. |
| **Housing Strategy**<br><br>http://www.cityoflondon.gov.uk/services/housing-and-council-tax/council- | The Housing Strategy sets out the City of London Corporation's ambitions to deliver homes and housing services fit for the future in the Square Mile and central London including improving joint working with health and social care to support vulnerable and older people. |

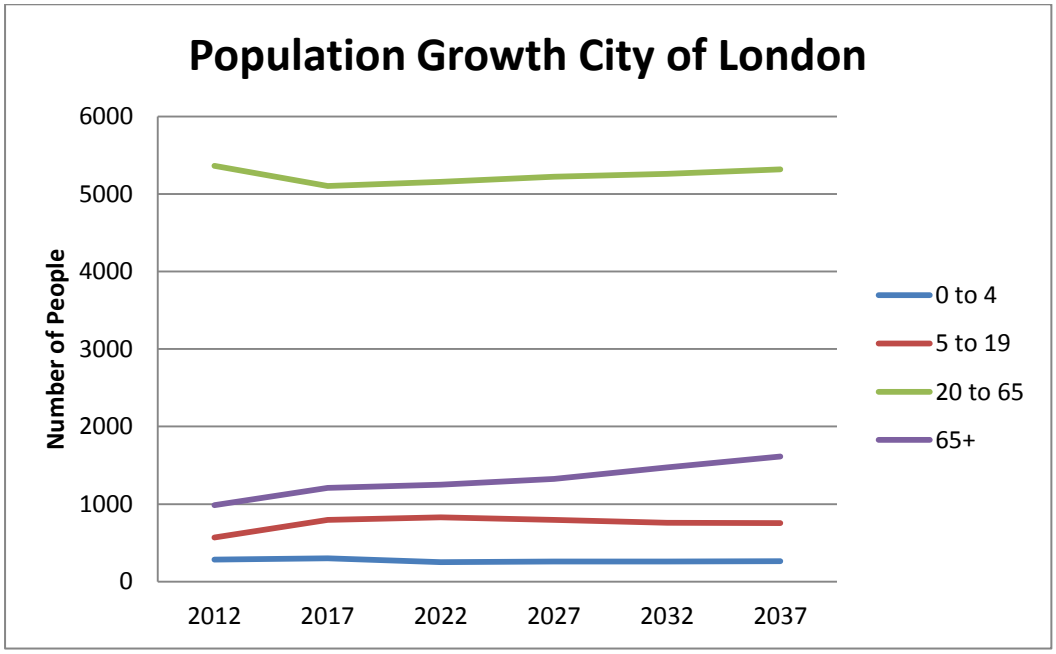
| | |
|---|---|
| housing/Documents/housing-strategy-draft-march-2014.pdf | |
| **Mental Health Strategy**<br><br>https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/city-of-london-mental-health-strategy.pdf | The overarching aims of the strategy are to improve the mental health of people in the City and keep people well and to provide effective support for people with mental health problems.<br><br>The priorities of the mental health strategy are:<br><br>• Prevention<br>• Personalisation<br>• Recovery<br>• Delivery |
| **Corporate Plan 2015-19**<br><br>https://www.cityoflondon.gov.uk/about-the-city/how-we-make-decisions/Pages/corporate-plans.aspx?page=all | The Corporate Plan's vision and strategic aims include providing and maintaining modern, efficient, accessible, responsive and high quality services to local residents within the Square Mile. These are supported by six key policy priorities including improving the value for money of services and maximising the opportunities and benefits afforded by the role of supporting London's communities. |
| **City and Hackney CCG five year plan**<br><br>http://www.cityandhackneyccg.nhs.uk/Downloads/About%20Us/Equality%20and%20diversity/5%20YEAR%20PLAN%20UPDATE%20final.pdf | Plan sets out the CCG's intentions until 2019. It sets out the intention to use the BCF to ensure services and providers are working in unison to deliver patients' care plans and system wide metrics. |

**Background and context to the plan**

The latest population estimates from the Office for National Statistics (ONS) places the City of London resident population at 9,400 which is projected to increase in coming years. Those aged 65 and over are projected to contribute the most to this growth, with their numbers increasing rapidly in the next decade. Life expectancy in the City of London is also better than the rest of London and England at 86.1 for males and 89 years for females. These two factors create potential for increased demand for health and social care services in the future.

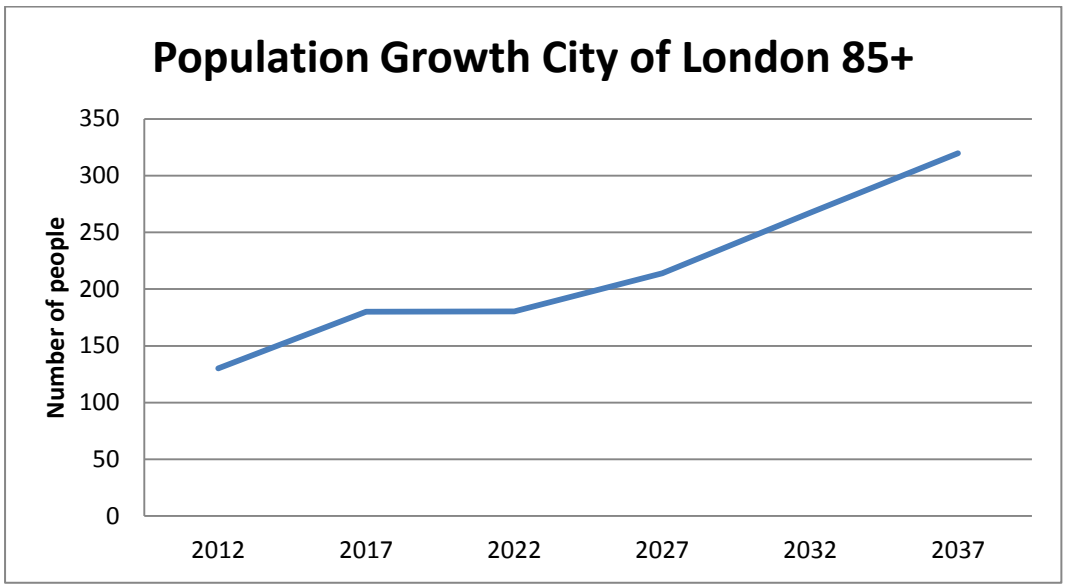
The charts below demonstrate the population growth in the City of London in the coming years. These are based on a different data source to the ONS.

*Chart 1: Population Growth City of London 2012 – 2037*




*Source: GLA Population Projections July 2017*

*Chart 2: Growth in City of London population aged 85+ 2012 – 2037*



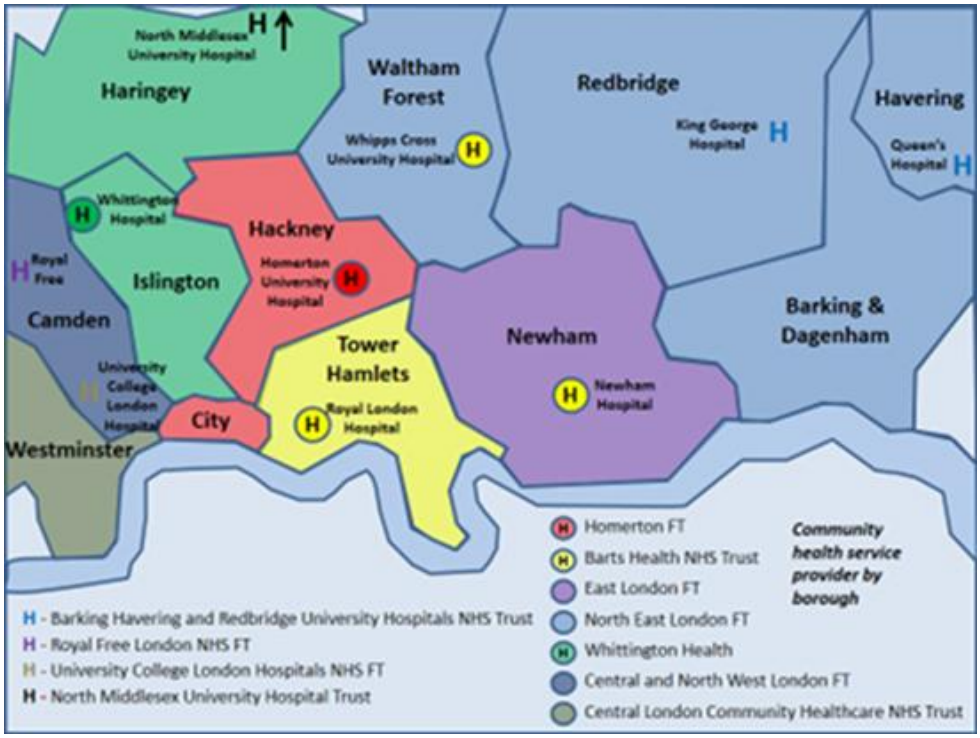

*Source: GLA Population Projections July 2017*

There has been improvement in the City's deprivation ranking in recent years but significant gaps remain between the areas of Portsoken in the east of the City (40% most deprived nationally) and Barbican (10% least deprived nationally).

The City of London has the highest daytime population of any UK local authority in the UK, with nearly half a million workers working in the Square Mile each day.

The City of London borders seven London boroughs and residents often have to access services that are delivered outside the square mile. As detailed in previous BCF plans, the City of London has complex care pathways. 75 per cent of City of London residents are registered with the one GP practice in the City, which is part of City and Hackney CCG. 16 per cent of residents, on the east side of the City of London, are registered with GPs which are part of Tower Hamlets CCG.

*Diagram 2: Boroughs and Health Providers*




For acute admissions, most City of London residents are taken to the Royal London Hospital (RLH) or University College Hospital (UCH). The main commissioned acute hospital for City and Hackney CCG is Homerton University Hospital Foundation Trust (HUHFT). Community Health Services are also provided by HUHFT and available to all City of London residents regardless of GP registration.

There is no residential care or supported living provision within the City boundaries and given the levels of demand for these services, they are spot purchased rather than block purchased. There is a single home care provider commissioned by the City of London Corporation in 2017. A number of service users use their direct payments to purchase other home care providers of their choice.

The City of London also commissions a number of preventative and support services from the voluntary sector. These include a Memory café, a carers' network, a wellbeing service and a universal advice service.

Given its size and location, the City of London does not have a huge range of providers within its boundaries but engages with a wider market through a number of market engagement events and tools. The integrated commissioning arrangements provide opportunities to look at existing contracts and identify if they can be provided in different, more efficient

ways. This also provides the City of London Corporation to potentially have access to a wider range of providers. One example is the planned Care workstream of the integrated commissioning arrangements which is developing a working group to address issues related to continuing care and social care placements. System partners will develop a proposal for integration of the continuing healthcare pathway with the wider social care and residential care provision. These proposals will also consider arrangements for brokerage and market management with the local authorities taking the lead.

**Progress to Date**

As noted above, the move to an integrated system has progressed significantly since the last BCF plan with the development of integrated commissioning arrangements. The BCF and iBCF are integral parts of this.

*Table 2: Progress on the key BCF metrics 2016/17*

| Metric | Baseline | Target | Final Outturn | RAG | Comments |
|---|---|---|---|---|---|
| Non-elective admissions | 549 | 549 | 600 | | Across City & Hackney, there has been an increase of 3.3% in admissions in all age groups which is greater than the increase in previous years. There was a 2.4% increase in admissions 2015/16 to 2016/17 in 60-74 year olds and a 7.8% increase in 75+ |
| Permanent admissions to residential care | 13 | 11 | 3 | | The City of London Corporation has continued to focus on supporting people maintain their independence at home as far as possible |
| Effectiveness of reablement and rehabilitation – still at home 91 days after discharge | 88% | 85% | 89% | | This target was met and those cases that were not at home 91 days after discharge were due to deaths rather than readmissions. The small cohort that this relates to means that any deaths or |

| | | | | | |
|---|---|---|---|---|---|
| from hospital | | | | | readmissions have a significant impact on the final percentage.<br><br>The actual figures for 2016/17 were 16 out of 18 who were still at home 91 days after discharge. The other two individuals passed away. |
| Delayed Transfers of Care | 216 | 200 | 795 | | These are actual days rather than rate. The bulk of these days were recorded as NHS attributable delays and were due to awaiting public funding or friend and family choice. There were a small number of longer term delays where people were awaiting discharge from non-acute care to further health services. Going forward, DTOCs will be seen as a system wide issue rather than the responsibility of one organisation and HICM will be a key mechanism for managing this. |
| Carer Reported Quality of Life | 8.8 | 8.8 | 8.8 | | This survey is only carried out every two years and therefore the existing figure of 8.8 stands. A new survey has been completed and results will be published nationally shortly. |
| Service user experience | 63% | 63% | 63% | | This survey is only carried out every two years and therefore the existing figure of 63% still stands. A new survey has been completed and results will be published nationally shortly. |

**Evidence Base and Local Priorities to Support Plan for Integration**

There is no acute hospital within the City boundaries, and as mentioned above, most patients attend the RLH or UCLH. The following information illustrates our emergency activity and flow through our acute hospitals which relate to the BCF metric for non-elective admissions and indicates some areas for system improvement.

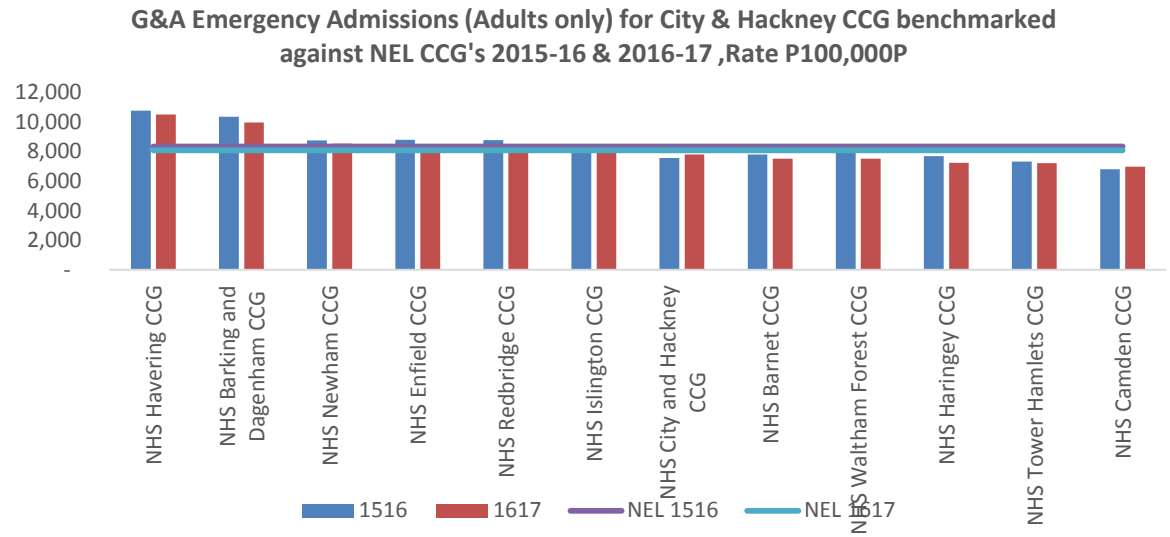
*Table 3: Adult A&E Activity*

| Provider by City and Hackney Patients | 14/15 - 15/16 % Change | 15/16 - 16/17 % Change | A&E 16/17 Activity |
|---|---|---|---|
| All Providers | 4.80% | 0.70% | 95189 |
| Homerton (ED & PUCC) | 5.00% | 0.00% | 61376 |
| Barts | -1.40% | 7.90% | 9622 |
| UCLH | 10.20% | -0.40% | 4399 |

- Despite the rate per 100,000 reducing by 2%, because of a growth in registered population there has been a small increase in C&H A&E attendances across all providers.
- Barts has the greatest percentage increase in attendances, which is far higher than other providers. UCLH has seen a reduction.
- The slight growth in A&E attendances is being driven by older adults. There has actually been a reduction in attendances from the 19-59 age group
- A greater percentage of patients arriving at the HUHFT A&E are being seen in the Emergency Department rather than the Primary Urgent Care Centre resulting in an increase in ED attendance of 3.5%
- There has been a rise in lower acuity activity seen in the Emergency Department
- The City and Hackney conversion rate from Emergency Department to admission has risen slightly from 2015/16 to 2016/7
- A rise in Emergency Department attendances potentially impacts on the ability to meet the 4 hour performance target

*Admission Activity*

*Chart 3: General and Acute Emergency Admissions*



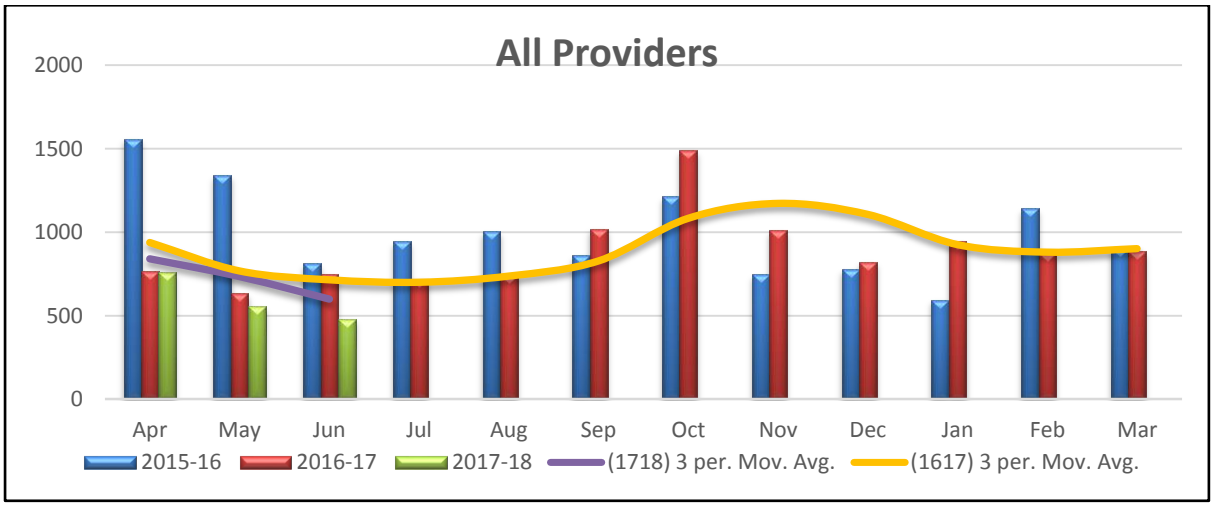

- City and Hackney admission rates have increased by 3.3% per 100,000 population from 2015/16 to 2016/17.
- City and Hackney remains just below the North East London average however, have seen the largest percentage increase in admission rate across North East London CCGs.
- There has been an increase in rate of same day and short stay admissions
- Short stay admissions are driving the increased admissions (short stay contribute 77% of the total increase in North East London admissions)

*Table 4: City and Hackney Emergency Admissions by Provider – adults only*

| Provider by City and Hackney Patients | Admissions 14/15 - 15/16 % Change | Admissions 15/16 – 1617 % Change | Actual Increase in admissions 1516 -1617 | 2016/17 Admissions |
|---|---|---|---|---|
| All Providers | 4.0% | 6.1% | 1047 | 18137 |
| Homerton | 0.6% | 6.8% | 766 | 11998 |
| Barts | 10.7% | 9.3% | 282 | 3304 |
| UCLH | 41.4% | 9.3% | 76 | 889 |

- The rise at HUHFT for C&H patients is slightly above the 6% rise in admissions which the trust has seen across all patients
- Barts Trust has seen a reduction of 6% in admissions overall; however, admissions for C&H patients has risen by 9.3%
- UCLH has seen only a 3% rise in admissions overall; however, C&H patients have seen a 9.3% increase.

*Chart 4: City and Hackney Excess Bed Days by all Providers*




- City and Hackney had an overall reduction of -26.4% in excess bed days from 2015/16 to 2016/17 across all providers with the downward trend continuing for this year. This may be seen as a proxy measure for better flow through the hospital and may link to reductions in delayed transfers of care.
- Overall reduction of 3.4% in emergency bed days 2015/16 to 2016/17 across all providers.

**Plans to address performance**

Work is currently being undertaken to review the HUHFT Primary Urgent Care Centre, including how patients are streamed between PUCC and the emergency department, and what the expected diversion rate should be. The specification will also be reviewed ensuring value for money, and it is our intention for 2018 to develop a plan for PUCC to become a Urgent Treatment Centre, meeting the national UTC Standards. Our commissioning intentions for 2018/19 also include local implementation of the pan-London Redirection and Streaming Guidance, which will maximise the use of primary care and PUCC to reduce any unnecessary ED attendances. This will involve working with the RLH and UCLH to ensure that City and Hackney patients can be redirected back to local community services.

We are also currently engaged in a procurement for the North East London Integrated Urgent Care service (111 + Clinical Assessment Service) which will be implemented in 2018 as will a new local model for 24/7 access to urgent primary care.

A retrospective case review of emergency admissions was done by the HUHFT in July 2017 to understand the drivers behind the increases in admissions. The review aimed to develop a greater understanding of why emergency admissions occur and to understand what interventions and/or

service developments could reduce emergency admissions in the future. The final report is pending. A similar audit is being proposed to the RLH and UCLH as they have seen an increase in City & Hackney NEA compared to a decrease in all other patients registered to other local CCGs. The audit results will be reviewed by the Unplanned Care Board and recommendations for system change made. Further work will also occur with the RLH in the coming year to support discharge.

**Significant change and developments**

One Hackney and City was an integrated care and support model funded through the BCF which ran for 2 years until the end of March 2017. It was a model built around care co-ordination and multi-disciplinary working.

Although the City of London Corporation did not need to use the whole model, it did use the Voluntary Sector Framework which provided access to a wider range of voluntary sector services than would normally be available to City residents.

The model was evaluated from a number of perspectives including the service user perspective, the experience of the voluntary sector and, the main evaluation, which looked at whether the model had met its objectives. The outcome of the main evaluation was that it was too early to conclude about meeting objectives when the service had only been delivered for 12 months.

These evaluations provided some valuable information and lessons to be learned going forward but also to unpick some of the areas for improvement, in particular, to develop a new model (the Neighbourhood Model) more clearly aligned to the objectives of the BCF and integrated commissioning.

In order to progress implementation of the Neighbourhood model, agreement of business cases will be via the Unplanned and Planned Care workstreams and then presented to the Transformation Board. There is the potential that we may consider other business cases if the Neighbourhood model does not look like it will spend the full £1.2m this year. Any uncommitted monies may also be used to address any cost pressures from non-elective admissions.

*The Neighbourhood Care Model*

Locally, there have been a number of pressures on the health and social care system including increases in emergency admissions, increased costs and an increasingly challenging financial environment which mean that there is a move towards transforming the way these services are delivered. This is coupled with a continuing focus on delivering the best quality care possible and delivering improved patient outcomes. These are underlying principles of the integrated commissioning arrangements.

There are significant opportunities to improve the way that primary care works and communicates with other providers (health, social care and the voluntary sector) and vice versa to improve quality and reduce costs. Co-production is an underlying principle of the integrated commissioning arrangements and patients and service users will be involved in shaping the neighbourhood model.

The proposed new model will mirror the principles of the Primary Care Home model in Hackney and City, creating small neighbourhood areas that will become provider networks for integrated care. All community / out of hospital services will be asked to arrange care within these neighbourhoods working closely with the practices within the neighbourhood. Community Health Services are provided by Homerton Hospital for all City of London residents.

Detailed mapping of populations and population would need to confirm the make-up of the neighbourhoods but it is expected that they will be:

- Mostly contained with existing quadrant boundaries
- No smaller than 30,000 patients and no larger than 50,000 patients
- Geographically co-located
- As far as possible not dividing existing community groups

Underpinning improvement work

In addition to the work required to develop neighbourhoods and organise services to create strong integrated working in these neighbourhoods, there are a number of underpinning improvement work streams which are currently underway. These include:

- Co-ordination/case management model for complex/high risk individuals

As part of this work, a project lead will work with teams to develop a proposal for the neighbourhoods for the coordination/support of complex/high risk individuals. This will also set out some guidelines for the type of patients who will benefit from this additional support and therefore attempt to clarify likely demand (and therefore resources required).

- Clinical pathway work

Once the detailed data analysis has been completed and shared with clinicians, the need for specific clinical pathway improvement work will be agreed. This will be based on a shared agreement that there is scope within a clinical pathway to improve the care provided to patients, the outcomes for patients and therefore an assumption that there will be efficiency savings.

It is expected that any clinical pathway improvement work will build on the principles of the redesign process carried out in New Zealand. Any clinical pathway work will also link into existing work within the CCG and system to avoid duplication of existing work.

- Formal (Paid) Carers

It was agreed in the initial scoping of this work stream that a project would be included on formal (paid) carers. This would look at:

- Could the formal carer role be enhanced to release time of other community teams
- This is based on an assumption that there are tasks which some community team members do which might be carried out by formal carers with appropriate training (and appropriate remuneration)
- Could the role of formal carers be developed to enhance their ability to more proactively identify deteriorating health/mental health needs based on time with their client to the appropriate person
- Could the role of formal carers be enhanced to improve signposting in times of crisis to the appropriate service
- Could formal carers be organised into neighbourhoods and develop stronger relationships with GPs/GP practices?

There are on-going discussions about how the neighbourhood model can be made to work in the most effective way for the context of the City of London.

**Equality impacts**

A Test of Relevance was carried out on City of London commissioned schemes in the 2016/17 BCF plan which did not identify any negative impacts on any of the protected characteristics set out in the Equality Act 2010 and therefore a full Equality Impact Assessment was not required.

As the schemes in the BCF 2017 – 19 remain the same and there have been no significant changes in the profile of the population since last year, the Test of Relevance remains valid.

Going forward, as new schemes come on stream such as the Neighbourhood Care Model or existing schemes are changed within the integrated commissioning arrangements, specific Equality Impact Assessments will be carried out as necessary.

CHCCG adopted the following equality objectives for 2016/17 to help deliver the CCG's commitment to deliver local priorities and to continuous improvement:

• Reduce mental health inequalities amongst communities in east London;
• Reduce mortality from cardiovascular disease and respiratory disease;

- Ensure equitable access to services for residents in the City of London;
- Implement the Equality Delivery System 2 (EDS2) toolkit that helps NHS organisations improve services and consider health inequalities.

In August 2016 a CCG wide working group was established to review progress against these objectives, to ensure that Equality and Diversity are embedded in all our plans and decisions and to formalise the processes around this. The work of this group is continuing across 2017/18 and includes focus on some areas within the BCF.

**Better Care Fund Plan**

*Table 5: Schemes for 2017-19 City of London BCF*

*Metrics*

| | |
|---|---|
| Metric 1 | Non-elective admissions (General and Acute) |
| Metric 2 | Admissions to residential and care homes |
| Metric 3 | Effectiveness of reablement |
| Metric 4 | Delayed transfers of care |

The table below shows the level of impact (none, low, medium or High) each project will have on each of the 4 Metrics.

| Scheme | Lead commissioner | £,000 16/17 | £,000 17/18 | £,000 18/19 | Brief Description of the scheme | Planned impact on Metric |
|---|---|---|---|---|---|---|
| Care Navigator | City of London Corporation | 60 | 60 | 60 | Supporting safe hospital discharge for City of London residents to minimise DTOCs, prevent readmission and maintain independence | Metric: Impact<br>1: High (readmissions)<br>2: High<br>3: High<br>4: High |
| Reablement Plus | City of London Corporation | 30 | 65 | 65 | Provision of up to 72 hours of 24 hour care to prevent hospital admission and to facilitate safe hospital discharge at weekends and bank holidays. City of London Discharge to Assess model | Metric: Impact<br>1: High<br>2: N/A<br>3: N/A<br>4: High |

<table>
<tr>
<td>Mental Health Reablement and Floating Support</td>
<td>City of London Corporation</td>
<td>60</td>
<td>120</td>
<td>80</td>
<td>ELFT working with people with chronic mental health conditions living in supported living to support reaching of full potential with move to more independent living where appropriate. Ongoing floating support to ensure links are made with local health and community services and independence sustained.<br><br>Can also receive direct referrals to assist in the discharge process</td>
<td>
<table>
<tr><th>Metric</th><th>Impact</th></tr>
<tr><td>1</td><td>Medium</td></tr>
<tr><td>2</td><td>Medium</td></tr>
<tr><td>3</td><td>N/A</td></tr>
<tr><td>4</td><td>N/A</td></tr>
</table>
</td>
</tr>
<tr>
<td>Carers' support</td>
<td></td>
<td>10</td>
<td>10</td>
<td>50</td>
<td>To provide specialist independent support, information and advice to informal adult carers to support them in their caring role and promote their health and wellbeing</td>
<td>
<table>
<tr><th>Metric</th><th>Impact</th></tr>
<tr><td>1</td><td>High</td></tr>
<tr><td>2</td><td>High</td></tr>
<tr><td>3</td><td>High</td></tr>
<tr><td>4</td><td>High</td></tr>
</table>
</td>
</tr>
</table>

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Disabilities Facilities Grant | City of London Corporation | 26 | 28 | 30 | Mandatory scheme to support disabled people live more independently in their own home (private rented or owner occupied) | Metric | Impact |
| | | | | | | 1 | High |
| | | | | | | 2 | High |
| | | | | | | 3 | High |
| | | | | | | 4 | High |
| IBCF meeting adult social care need | City of London Corporation | - | 90 | 114 | To help sustain the adult social care system, by offsetting additional savings which would have been required, funding increased demand, and reducing pressures within services | Metric | Impact |
| | | | | | | 1 | Low |
| | | | | | | 2 | Medium |
| | | | | | | 3 | Medium |
| | | | | | | 4 | High |
| iBCF reducing pressures on the NHS | City of London Corporation | | 90 | 114 | To help support intermediate care and CHC processes to facilitate discharge. | Metric | Impact |
| | | | | | | 1 | Medium |
| | | | | | | 2 | Medium |
| | | | | | | 3 | High |
| | | | | | | 4 | High |

<table>
<tr><td>iBCF stabilising the care market</td><td>City of London Corporation</td><td></td><td>0</td><td>0</td><td>-</td><td><table><tr><th>Metric</th><th>Impact</th></tr><tr><td>1</td><td>-N/A</td></tr><tr><td>2</td><td>N/A</td></tr><tr><td>3</td><td>N/A</td></tr><tr><td>4</td><td>N/A</td></tr></table></td></tr>
<tr><td>One Hackney</td><td>CCG</td><td>54</td><td>-</td><td>-</td><td></td><td></td></tr>
<tr><td>One Hackney</td><td>CCG</td><td>38</td><td>-</td><td>-</td><td></td><td></td></tr>
<tr><td>Neighbourhood Care Model</td><td>CCG</td><td>-</td><td>40</td><td>40</td><td>Creation of smaller neighbourhood areas which will become the provider networks for integrated care. All community/out of hospital services will be asked to arrange care within these neighbourhoods working closely with the groups of practices within the neighbourhood.<br><br>A robust business case must be accepted by the workstreams</td><td><table><tr><th>Metric</th><th>Impact</th></tr><tr><td>1</td><td>TBC</td></tr><tr><td>2</td><td>TBC</td></tr><tr><td>3</td><td>TBC</td></tr><tr><td>4</td><td>TBC</td></tr></table>The impact on metrics will be considered as the model is further developed.</td></tr>
</table>

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | and TB in order to progress this model. | |
| Adult Cardio respiratory Enhanced + Responsive Service (ACERS) | CCG | 20 | 20 | 20 | To provide an early intervention service for those with COPD, with the objective of more people having their condition managed at home, reducing A&E and emergency admissions | <u>Metric</u> / <u>Impact</u><br>1 Medium<br>2 Low<br>3 Low<br>4 Medium |
| Bryning Day unit/Falls Prevention | CCG | 13 | 14 | 14 | The service manages patient at risk of falling, through interactive support and medicines management | <u>Metric</u> / <u>Impact</u><br>1 Medium<br>2 Low<br>3 Medium<br>4 Low |
| Asthma | CCG | 3 | 3 | 3 | Support and develop a robust integrated care pathway to include education and training for general practice in the management of patients with Asthma | <u>Metric</u> / <u>Impact</u><br>1 High<br>2 Low<br>3 Low |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | 4 | low |
| Palliative care - Out of hospital service | CCG | 20 | 20 | 21 | To provide high quality specialist palliative care to individuals wishing to remain in their own homes/the community at the end-of-life. | Metric | Impact |
| | | | | | | 1 | High |
| | | | | | | 2 | Med |
| | | | | | | 3 | n/a |
| | | | | | | 4 | High |
| Paradoc | CCG | 18 | 18 | 19 | The service provides an urgent GP and paramedic response service to patients in their own home/care home, reducing unnecessary conveyance to A&E via ambulance. | Metric | Impact |
| | | | | | | 1 | High |
| | | | | | | 2 | n/a |
| | | | | | | 3 | Med |
| | | | | | | 4 | n/a |
| Adult Community Rehab Team | CCG | 78 | 79 | 81 | To provide specialist inter-disciplinary and uni-disciplinary rehabilitation to those with a physical or neurological impairment. | Metric | Impact |
| | | | | | | 1 | n/a |
| | | | | | | 2 | High |
| | | | | | | 3 | High |
| | | | | | | 4 | High |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Adult Community Nursing | CCG | 147 | 161 | 164 | To provide an integrated, case management service to patients living within the community To improve patient pathway and health and social care outcomes | Metric | Impact |
| | | | | | | 1 | High |
| | | | | | | 2 | Medium |
| | | | | | | 3 | Medium |
| | | | | | | 4 | Medium |

**National Conditions**

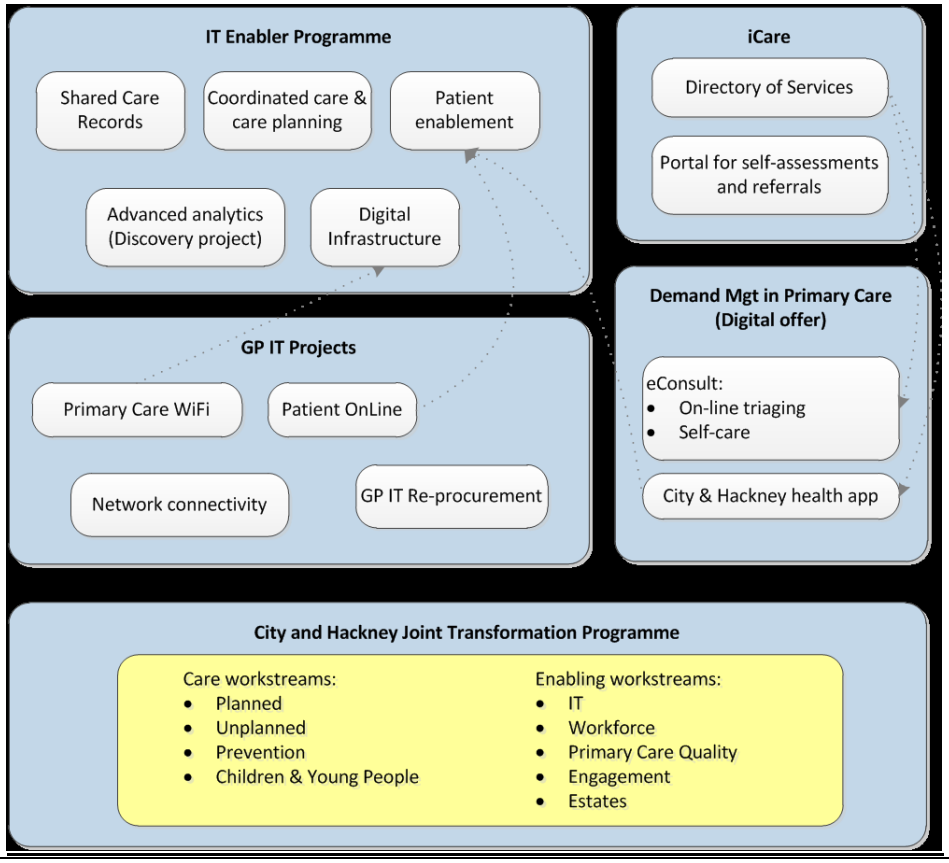
*Table 6: National Conditions 2017/18*

| Condition | Detail |
|---|---|
| Jointly agreed plan | This plan has been agreed through the integrated commissioning arrangements which include statutory organisations, providers and the voluntary sector.<br><br>Each of the schemes also sit within one of the four workstreams where their overall impact is monitored. |
| Social care maintenance | We confirm that the NHS contribution to adult social care is maintained in line with inflation and this is reflected in the BCF Planning Template. |
| NHS commissioned out of hospital services | Details on how the local area has agreed the use of BCF funding is evidenced in the BCF Planning Template.<br><br>Out of hospital services under the BCF include:<br>- ACERS<br>- Asthma<br>- Palliative care<br>- Paradoc<br>- ACRT<br>- Adult Community Nursing<br>- Neighbourhood Care Model |
| Managing transfers of care | The City of London has completed the High Impact Change Model (HICM) and the action plan is included in Appendix 1.<br><br>There has been good performance around DTOCs in the City of London in relation to social care but some complex cases causing higher levels of NHS delays. Moving forward, managing transfers of care will be seen as a system wide issue rather than the issue of one or the other organisation. This is reflected in the HICM action plan.<br><br>In 2016/17 there were 794 days of delayed days for City of London residents. The majority of these (718) were NHS attributable delays which were mainly due to friends and family choice, awaiting public funding and awaiting transfer top further secondary care.<br><br>The 76 days of social care delays are disputed as these do not match local data. There is work underway to strengthen the process for signing off provider information on DTOCs before being submitted for SITREPs. |

**Additional Conditions**

*Table 7: National Conditions No Longer Required 2017-19*

| Condition | Detail |
|---|---|
| Seven-day services | Provision of a 7 day service for City of London residents includes out of hours social care, out of hours GP services, provision of a weekend reablement service, and an integrated independence team. There will be continued focus in 2017/18 on how to co-ordinate the full suite of integrated and urgent care services across 7 days and will be reflected in the High Impact Change Model action plan. |
| Better data sharing | The City of London and London Borough of Hackney are both part of the Health and Social Care IT Enabler Programme. Data sharing is being addressed by a joint IG group in WELC (Waltham Forest, east London and the City). A specific data sharing agreement has been signed off by C&H health providers, and will be extended to include social care in 17/18 which is to be signed off by all partners.<br><br>The IT Enabler programme is now considered one of the enabler workstreams supporting the care workstreams within our integrated commissioning arrangements. The Local Digital Roadmap has an aim to achieve paperless working by 2020. Shared care records are largely being achieved through the east London Patient Record, or eLPR, previously known as Health Information Exchange. Homerton Acute, Community, City and Hackney GP practices and ELFT mental health are all linked to HIE at varying levels of maturity. St. Joseph's Hospice can also access health data using HIE. Homerton Acute can also view Barts Health data.<br><br>All suppliers are working towards delivering an "any-to-any" connection model across east London by end Mar 2018. Other projects include building links with community pharmacies; extending electronic orders for diagnostic tests for GPs and St. Joseph's Hospice; and safeguarding.<br><br>There are also opportunities to build on the work already underway for e-referrals, namely around "advice and guidance". This has the potential to change the way patients interact with health care services and reduce the number of physical attendances by the patient at hospital. Similarly the re-procurement of the 111 and out of hours service will require digital solutions to support the new models and streamlining the patient journey from the initial point of contact through to |

| | |
|---|---|
| | onward referrals to local services.<br><br>Going forward, IT Enabler programme members and workstream directors will attend each other's meetings/workshops with a view to working up proposals for digital initiatives for the balance remaining within the financial envelope of £2.5m (this is outside the BCF envelop).<br><br>Digital initiatives in City and Hackney are illustrated below:<br><br>  <br> |
| Joint approach to assessment | Coordinated care and care planning – City and Hackney remains a top performer in the adoption of Coordinate My Care. 93% of patients on the End of Life registers (5% declined) and 93% of patients on the frail home visiting registers (4% declined) now have a CMC plan.<br><br>Latest analysis shows that overall 65% of C&H CMC patients have died in their preferred place. Where C&H patients have a CMC record, 27% die in hospital; nationally, 47% died in hospital. Planning to improve CMC adoption across care settings and build IT links with provider IT systems to streamline workflow is continuing.<br><br>Further joint approach to integrated assessments are part of the Trusted Assessor section of the High Impact Change Model action plan. |

**Overview of Funding Contributions**

*Table 8: Funding Contributions*

| ***Running Balances*** | **2017/18** | **2018/19** |
|---|---|---|
| | | |
| Local Authority Contribution (Disabled Facilities Grant) | £28,304 | £30,294 |
| CCG Minimum Contribution balance | £611,588 | £623,208 |
| Additional CCG Contribution balance | £0 | £0 |
| iBCF | £178,726 | £228,418 |
| | | |
| **Total** | **£818,618** | **£881,920** |

The funding contributions for the BCF have been agreed including identification of funds for Care Act duties, reablement and carers' breaks from the CCG minimum. These are detailed in the excel planning template that accompanies this narrative plan.

The CCG and the City of London Corporation have agreed to apportion the iBCF funds as follows:

*Table 9: iBCF spend profile*

| **Scheme** | **Funding Source** | **£,000** | **%** | **£,000** | **%** |
|---|---|---|---|---|---|
| | | **17/18** | **17/18** | **18/19** | **18/19** |
| iBCF meeting adult social care need | CoL | 89,363 | 50% | 114,209 | 50% |
| iBCF reducing pressures on the NHS | CoL | 89,363 | 50% | 114,209 | 50% |
| iBCF stabilising the care market | CoL | 0 | 0 | 0 | 0 |
| **Total** | | **178,726** | **100%** | **228,418** | **100%** |

*Agreed approach to the use of the iBCF funding to increase capacity and stability in the market*

In light of significant financial pressures in Adult Social Care services nationally, the Government announced the improved BCF (iBCF) which provides non recurrent funding to assist with the financial pressures on adult social care. The iBCF was announced in the Spring Budget of April 2017 and

the allocation for the City of London is £179,000 for 2017/18 and £138,000 for 2018/19.

The iBCF grant is given direct to local authorities subject to the conditions set out in the grant determination which is made under Section 31 of the Local Government Act 2003. Local authorities are required to use the funding to meet adult social care need, reduce pressures on the NHS and stabilise the care market.

The plans for the funding are set out in the table of schemes above (table 6).

**BCF milestones**

*Table 10: BCF Milestones*

| Milestone | Date |
|---|---|
| BCF plan submitted | 11 September |
| BCF plan agreed | TBC |
| S75 signed | 30 November |

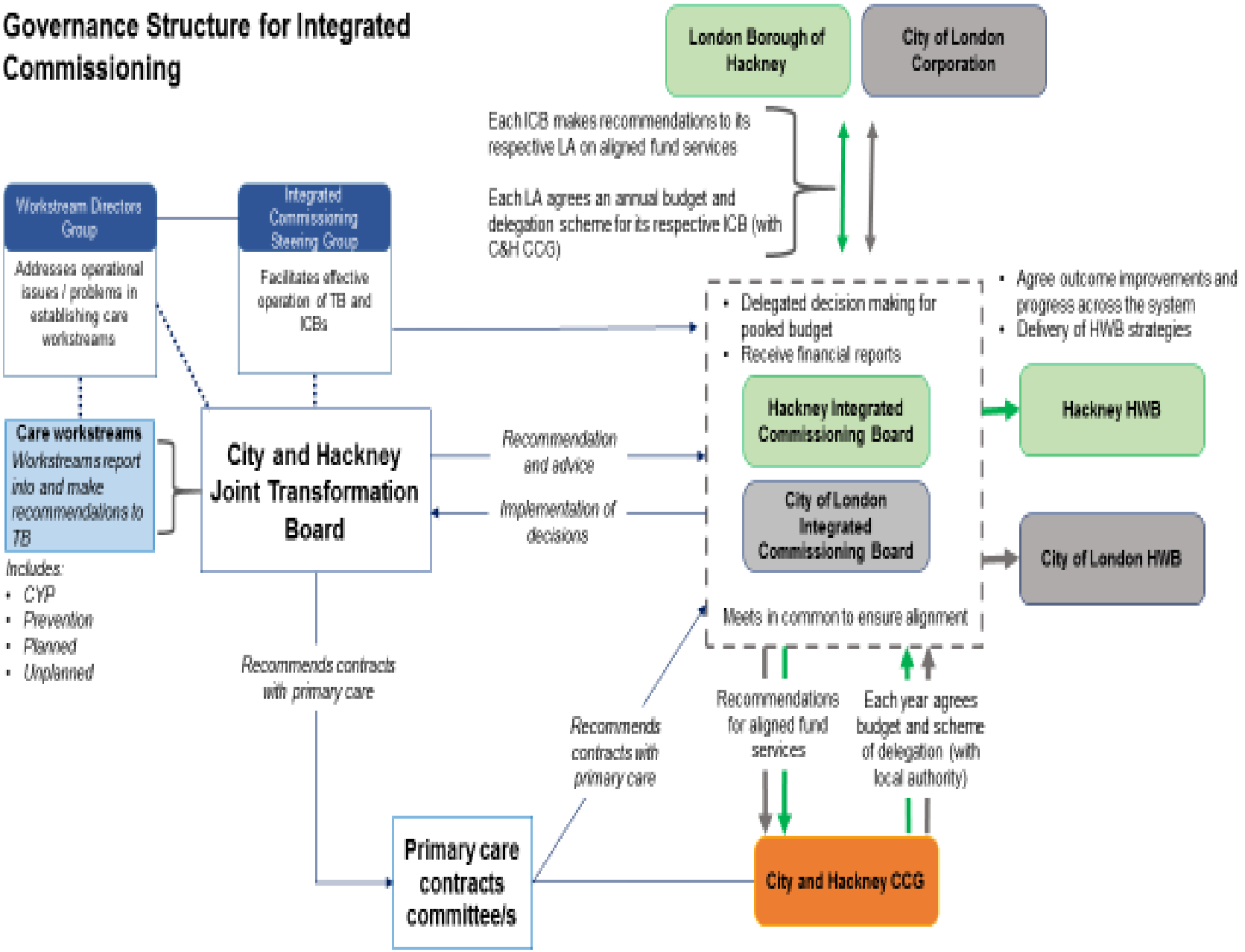
**Programme Governance**

As part of the new integrated commissioning arrangements, the local authorities will be the host parties for any pooled budgets, including BCF. For the City of London, the internal Integration Programme Board will oversee the City of London Corporation commissioned project. There will also be a core operation group responsible for the administration of the BCF which will consist of the CCG and both City of London Corporation and the London Borough of Hackney.

The BCF Operational Group will report on achievement of metrics and any scheme issues to the Unplanned and Planned Care workstreams. Overall performance and any recommendations will subsequently be made to the Transformation Board and Integrated Commissioning Boards.

The diagram below sets out the overarching governance for integrated commissioning.

# Governance Structure for Integrated Commissioning



## Risk

### Assessment of Risk and Risk Management

*Financial Risk*

Financial overspends on services will be the responsibility of the lead commissioner and will not be funded through the pooled fund.

Financial underspends on the pooled funds will be managed as follows:

- For the capital spends, underspends will be retained by the City of London Corporation and applied in accordance with scheme requirements
- For the revenue streams, if there are underspends within the pooled fund, the under spends will be retained by each lead commissioner on a scheme by scheme basis in accordance with the scheme requirements

*Delivery Risk*

Failure to deliver the inputs required to deliver KPIs will be borne by the Partner failing to deliver.

A detailed risk register can be found on page 38.

### Risk Management Framework & Governance Arrangements

A comprehensive risk register will be in place for the BCF pooled fund to manage or mitigate known and emerging risks associated with the development and implementation of the BCF Plan.

Each BCF scheme risk Register will be reviewed by the lead commissioner. The CCG will provide the City of London Corporation with a risk log for the services for which it is lead commissioner. This will coincide with performance data submissions as required in the integrated commissioning arrangements.

An overall risk register for the BCF will be presented to the Transformation Board. Significant risks around the BCF will be escalated to the Health and Well Being Board as appropriate.

The Risk Register will also be kept under review in both health and social care individual governance frameworks.

*Table 11: Risk Register*

| Risk | | Likelihood | Potential impact | Overall risk factor | Mitigating actions | Action owner |
|---|---|---|---|---|---|---|
| 1 | The extent of cultural and organisational change required to achieve effective integration will not be achieved | 2 | 4 | 8 | The BCF has been in place for a number of years and has established a good basis for working together which the new integrated commissioning arrangements build on.<br><br>Further cultural and organisational change is being addressed as part of the work within integrated commissioning arrangements | Worstream Directors and SROs |
| 2 | Staffing shortages within the system or single points of failure where key staff are relied on | 3 | 4 | 12 | Work with providers to ensure they have contingency plans in place to deal with key roles and key staff leaving | Commissioners |
| 3 | Severe weather or outbreak of particular condition in community – impacting on admissions, falls etc | 3 | 4 | 12 | Winter plans have been developed by partners | The Unplanned Care Board (our local A&E Delivery Board) |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4 | New neighbourhood model does not reflect City needs / requirements | 2 | 4 | 8 | City of London Corporation sit on the working group for the neighbourhood model | City of London Corporation |
| 5 | Lack of consensus for the new neighbourhood (care) model which delays the scheme and the associated outcomes | 2 | 4 | 8 | Resources are being allocated to the project to ensure robust business case is developed and project plan is in place to develop and implement model. Steering Group is also part of formal governance structure of the Unplanned Care Board | Enhanced Primary Care Working Group / Unplanned Care Board |
| 6 | Provider failure | 1 | 3 | 3 | City of London has a fairly stable market but the market is small and there are some potential single points of failure. This is managed through good contract management and relationships with providers | Commissioners |
| 7 | Failure to deliver High Impact Change Model actions | 2 | 3 | 6 | Detailed action plan is being prepared which will be monitored by the City of London's internal Integration Programme Board | Integrated Discharge Project Group / Unplanned Care Board |
| 8 | Information flow and data is not robust | 2 | 4 | 8 | Discussions underway to strengthen relationships with out of area hospital discharge teams to address issue | Commissioners |

| | | | | | | |
|---|---|---|---|---|---|---|
| 9 | Difficulties finding suitable residential and nursing placements | 1 | 4 | 4 | The numbers of residential placements purchased is relatively low but more effective demand modelling is being put in place to manage this more effectively. Residential and continuing care are being considered as part of the planned care workstream and any joint commissioning could give the City of London Corporation more security to access placements | Commissioners |
| 10 | Poor quality of data upon which the outturn of data is calculated | 2 | 4 | 8 | Bespoke data analysis commissioned to support unplanned care workstream and the establishment of the neighbourhood model. Regular monitoring | BCF Operational group and Information Working Group for Unplanned Care Board |

**National Metrics 2017 - 19**

*Table 12: National Metrics*

| Metric | Performance 2014/15 | Performance 2015/16 | Performance 2016/17 | Target 2017/18 | How target was set |
|---|---|---|---|---|---|
| Non-elective admissions (general and acute) | 572 | 443 | 600 | 713 | Using figures set out by NHSE (note there is a discrepancy between this figure and the excel template which was prepopulated prior to the CCG's resubmission of NEA figures within the operating plan |
| Permanent admission to residential care | 4 | 12 | 3 | 10 | Considering number of people who are being supported at home but who are becoming frailer |
| Still at home 91 days after discharge from hospital | 100% | 79% | 89% | 85% | Based on past performance around re-admissions but taking into account that some people will pass away |
| Total days of Delayed Transfers of Care (actual not rate) | 188 | 228 | 794 | 237 | Set as part of the national modelling |

**Approval and Sign Off**

The proposed schemes for the City of London BCF and iBCF were considered by the City of London Integrated Commissioning Board on 2 August 2017 and recommended to the City of London Health and Wellbeing Board tfor approval.

The City of London Health and Wellbeing Board approved delegated authority to the Chair of the Board, in conjunction with the Director of Community and Children's Services to sign off the BCF plans if deadlines were such that sign off fell outside of the normal cycle of Health and Wellbeing Board meetings.

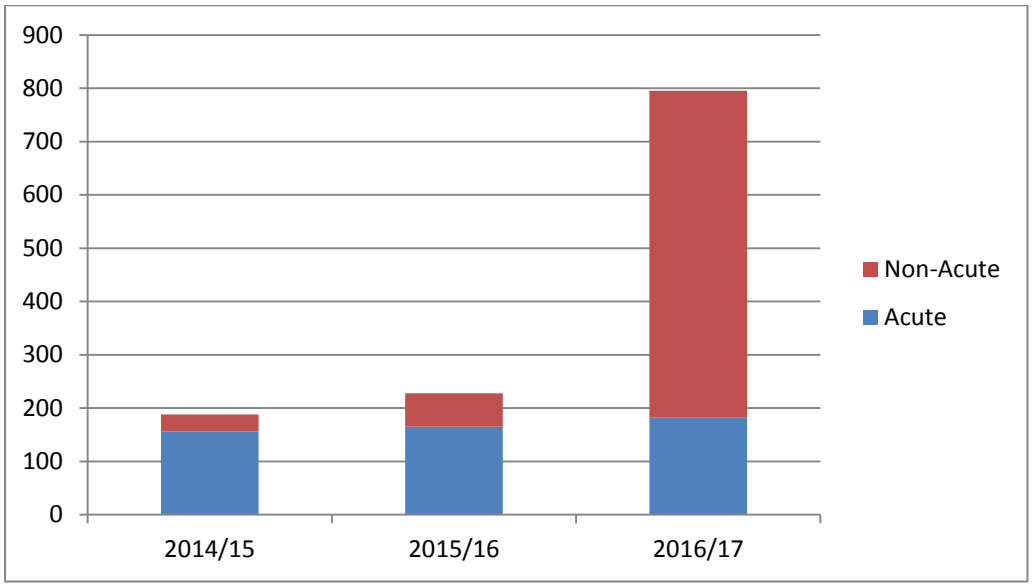
The Chair of the Health and Wellbeing Board, in conjunction with the Director of Community and Children's Services approved this submission on 8 September 2017 and a full copy of the document was circulated to the Board for their information at the meeting of 22 September 2017.

Appendix 1

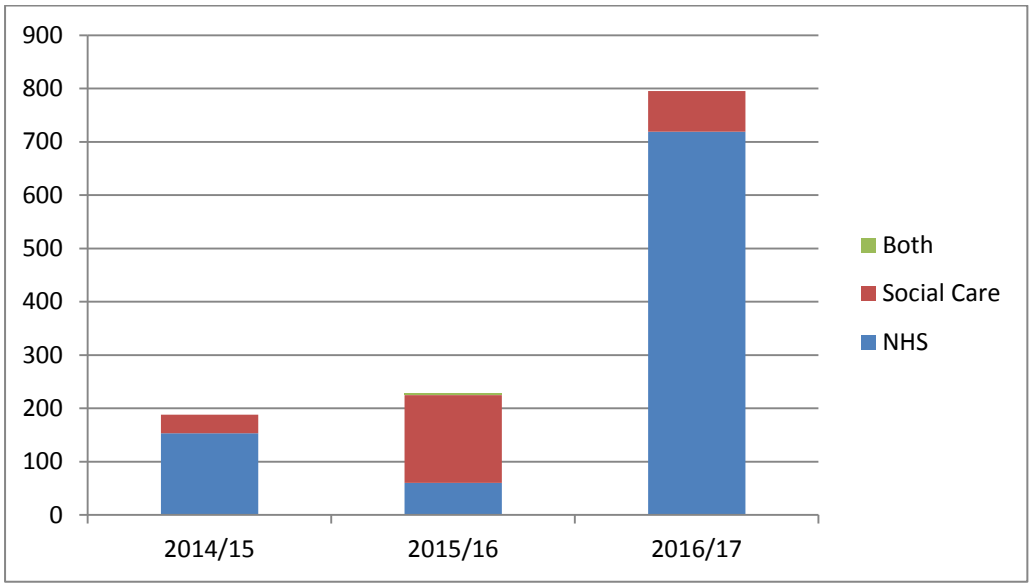
City of London Corporation  DTOC Plan

For City of London residents, delays attributable to social care have been minimal over the last three years and some of these have been contested as they have not matched local figures.  In the last financial year, there were increased numbers of delayed days in the non-acute sector attributable to the NHS.

*Delayed Transfers of Care (days) 2014/15 – 2016/17 – by Type of Care*




*Delayed Transfers of Care (days) 2014/15 – 2016/17 – by responsible organisation*



*DTOC Targets 2017 / 18*

| Quarter | Target |
|---|---|
| 1 | 91 (actual) |
| 2 | 80 |
| 3 | 34.5 |
| 4 | 31.5 |
| | |
| **Total** | **237** |

*DTOC Plan*

As noted earlier in this document, going forward, DTOCs will be seen as a system wide responsibility rather than that of an individual organisation and will be addressed as part of the integrated commissioning arrangements.

As can be seen from the graph above, in 2016/17 there were a high number of delayed days in the non-acute sector attributed to the NHS. The majority of these were in the mental health sector.

Through BCF funded and other services, the City of London Corporation aims to maintain its good performance on DTOCs and contribute to a system wide approach to minimising the number of DTOCs. Although the City of London has a number of schemes which are key in helping minimise the risk of any DTOCs, it has also developed a HICM Action plan and has identified a number of areas of further work contributing to the DTOC action plan

*Services and projects include:*

- A Care Navigator who supports safe hospital discharge through being involved in discharge planning, carrying out initial assessments which are then used by social workers and linking patients up with relevant community based support services
- A Reablement Plus scheme to facilitate out of hours and early hospital discharge where safe. The scheme can be used to facilitate discharge to assess
- Mental Health Reablement Project to support people living with long term mental health conditions to move into more independent living settings with links into community services to prevent admissions to hospital and as a result any Delayed Transfers of Care. As part of the contract the provider (East London Foundation Trust) is able to assist in discharge and attends ward rounds to be aware of City of London patients
- Free services and support networks out of hours for those discharged from mental health services. These are provided by East London Foundation Trust and include a 24 hour crisis helpline, a crisis café and a service user support network

- Working with rough sleepers who are to be discharged from hospital – referred through the Greenhouse Project, a specialist service for rough sleepers in Hackney or direct to the City of London Corporation which has its own accommodation pathways for those with City connections
- Support carers in their caring role so that they can accept people back home with support where necessary

Further areas of work (in addition to the High Impact Change Model Action plan below) are also underway:

- Review of DFGs, adaptations and assistive technology to identify if any pathways or processes could be strengthened to help facilitate discharge
- Mental health commissioning is being considered as part of the integrated commissioning arrangements with one area of work being improving discharges in the planned care workstream
- Work is currently underway with the Royal London Hospital to develop a protocol for the agreement of these figures before they are submitted to NHS England (this is already in place with University College Hospital).

The High Impact Change Model action plan can be found below.

City of London Corporation High Impact Change Model Action Plan

| Impact Change | Summary | Objective | Actions | Status | Lead | Timescale |
|---|---|---|---|---|---|---|
| Early discharge planning | Early discharge planning is good and begins as soon as a notification is received from the hospital. Care navigator visits all these patients on the ward and carries out the initial assessment.<br><br>Default to reablement service for all unless full social care assessment needed straight away.<br><br>Reablement Plus service (up to 72 | Develop placement without prejudice | • Discuss with two relevant CCGs<br>• Establish protocol, provision and process for placement without prejudice | In progress | City of London Corporation | • December 2017 |
| | | Strengthen relationships with Royal London Hospital | • Establish relationships with appropriate discharge staff<br>• Provide details of pathways for City residents in terms of discharge<br>• Work with provider to ensure they provide Sitrep | In progress | City of London Corporation | • October 2017 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | hours of 24 hour care) can be provided for out of hours or urgent discharge.<br><br>Ongoing issues about communication with some providers and technical issues around securely sharing information.<br><br>Limited access to bed based intermediate care which can be an issue for the City where the structure and status of some residential properties make it difficult to provide intermediate | | data to City for sign off before submission | | | |
| | | Identify if any additional services required to deal with discharge from A&E | • Undertake review and profile of number of City residents discharged from A&E<br>• Consider potential measures if issue identified e.g. take home and settle type service | To start | City of London Corporation | • December 2017 |
| | | Ensure access to equipment does not hinder discharge | • Review access and processes for hospital staff to have access to City of London equipment at weekends | To start | City of London Corporation | • December 2017 |
| | | Identify if there is anything that Adult Social Care can do to assist with NHS | • Review the City of London NHS attributable delays and | To start | City of London Corporation | • December 2017 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | care at home | attributable delays | identify profile and any particular issues<br>• Identify measures to address any issues identified e.g. more information and advice to self-funders | | | |
| | | Identify if assistive technology can play greater role in facilitating discharge | • Undertake review of current use of AT (completed August 2017)<br>• Build into assessment and support planning processes<br>• Realign commissioning around preventative offer including AT | In progress | City of London Corporation | • August 2017<br>• December 2017<br>• 2018 |
| | | Identify if DFG | • Undertake | In progress | City of | December |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | and adaptations can play greater role in facilitating discharge | review of process and DFG use | | London Corporation | 2017 |
| | | Explore options for bed based intermediate care where required | • Explore feasibility of a care hub in the City of London | In progress | City of London Corporation | December 2017 |
| Systems to monitor patient flow | Not applicable as there is no acute hospital within the City of London boundaries | *No actions required*<br>*The City of London is part of the Integrated Discharge Project comprised of the C&H CCG, London Borough of Hackney, Homerton University Hospital Foundation Trust and East London Foundation Trust. Broad actions of this group, and the CCG's winter plan will support systems to monitor patient flow within the wider health system.* | | | | |
| Multi-disciplinary, multi-agency teams (including voluntary and community sector) | There is good multi-disciplinary team working including reports from the hospital OT to ASC on the needs of person being discharged, ASC and care navigator attending practice MDTs | Ensure access to wider range of voluntary sector services which could help facilitate discharge e.g. house clearance | • Consider as part of development work around the neighbourhood model | In progress | Unplanned Care Board | TBC |
| | | Identify in patients who may benefit from preventative services | • Carry out review of profile of inpatients and A&E attenders | To start | City of London Corporation | • 2018 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | and specific mental health MDT and regular meetings with housing and estate managers to help people maintain tenancies<br><br>Voluntary sector in City of London is small but there are a number of commissioned services who provide support to people upon discharge. | | • Develop process and provision of preventative services to this group | | | |
| Home First / Discharge to Assess | The City of London has a Reablement Plus service which can provide 24 hour social care support (with clinical support alongside if | Raise more awareness amongst professionals of the Reablement Plus service | • Awareness raising campaign using variety of channels | In progress | City of London Corporation | • Ongoing |

| | | | | | | |
|---|---|---|---|---|---|---|
| | required) for up to 72 hours to facilitate out of hours discharge, urgent discharges and admission avoidance.<br><br>Where people are discharged urgently or out of hours, social care is provided until the next working days when a social care assessment can take place.<br><br>Residential and nursing placements straight from hospital are rare and discouraged where support has not been tried at home | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | first. | | | | | |
| Seven-day services | The social care out of hours service is provided by the London Borough of Hackney on behalf of the City of London Corporation<br><br>The Reablement Plus service can facilitate out of hours and weekend discharges | No actions required | | | | |
| Trusted Assessors | In terms of social care trusted assessors, the Care Navigator carries out assessments of people being discharged from hospital which are then used by the Social | Joint assessments are being considered as part of the wider system's work and City of London Corporation is linked in with the work that the London ADASS network is co-ordinating to streamline discharges. | | | | |

| | | |
|---|---|---|
| | Workers as the basis of an assessment when necessary.<br><br>The Reablement Workers are trusted assessors for basic equipment.<br><br>The City of London Corporation is very responsive in carrying out assessments once aware of discharge. | |
| Focus on choice | There are no residential or nursing homes within City of London boundaries so there is no choice for residents who wish to remain within the City of | No actions required |

| | | |
|---|---|---|
| | London. However the national choice guidance is applied to people who need a placement. There is a spot purchase arrangement for residential care which means that there is no constraint in relation to a block contract as long as it meets the choice directive policy. The City of London Corporation also offers choice and a personalised focus through personal budgets and | |

| | | |
|---|---|---|
| | direct payments. | |
| Enhancing health in care homes | Not applicable as there are no care homes within the City of London boundaries. | No actions required |