Public Document Pack

Integrated Care Partnership Board

Date: **THURSDAY, 9 DECEMBER 2021**

Time: **10.00 am**

Venue: **MICROSOFT TEAMS**

Members: Randall Anderson
Marianne Fredericks
Ruby Sayed

John Barradell
Town Clerk and Chief Executive

AGENDA

1. **CITY & HACKNEY INTEGRATED CARE PARTNERSHIP BOARD AGENDA**

(Pages 3 - 194)

City & Hackney Integrated Care Partnership Board

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

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

Meeting in public on

Thursday 9 December 2021, 1000 – 1200

By Microsoft Teams

No.	Time	Item	Page number	Lead
1.	1000 (15 mins)	Welcome, introductions and apologies	Verbal	Chair
2.		Declarations of Interests	Paper to follow *Pages TBC*	Chair
3.		Minutes of the Previous Meeting & Action Log	Papers 3a & 3b *Pages 3-11*	Chair
4.		Questions from the Public	Verbal	Chair
5.		ICP Chief Officer Report	Verbal	Tracey Fletcher
6.	1015 (15 mins)	Risk Registers	Papers 6a & 6b *Pages 12-26*	Matthew Knell
For Decision				
7.	1030 (20 mins)	Anticipatory Care	Papers 7a, 7b, 7c & 7d *Pages 27-85*	Nina Griffith

For Discussion				
8.	1050 (15 mins)	Better Care Fund submission	Papers 8a, 8b & 8c *Pages 86-172*	Nina Griffith
9.	1105 (15 mins)	Update on the Voluntary and Community Sector assembly	Verbal	Susan Masters / Jessica Lubin
10.	1120 (20 mins)	Draft Health and Wellbeing Board strategy	Paper 10a *Pages 173-185*	Chris Lovitt / Sara Bainbridge
11.	1140 (10 mins)	Monthly Financial Report	Paper to follow *Pages TBC*	Sunil Thakker / Ian Williams
12.	1150 (10 mins)	Any Other Business	Verbal	Chair
For Information				
Integrated Commissioning Glossary			*Pages 186-191*	N/A
Date of next meeting: Thursday 12 January 2022 in person at location to be confirmed				

City & Hackney Integrated Care Partnership Board

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

Minutes of meeting held in public on 11 November 2021 by Microsoft Teams

Members:

Hackney Integrated Commissioning Board		
Hackney Integrated Commissioning Committee		
Cllr Chris Kennedy	Cabinet Member for Health, Adult Social Care & Leisure	London Borough of Hackney
Cllr Rob Chapman	Cabinet Member for Finance	London Borough of Hackney

City Integrated Commissioning Board		
City Integrated Commissioning Committee		
Marianne Fredericks	Member, Community & Childrens' Services Sub-Committee	City of London Corporation
Randall Anderson QC	Member, Community & Childrens' Services Sub-Committee	City of London Corporation
Helen Fentimen	Member, Community & Childrens' Services Sub-Committee	City of London Corporation

North East London CCG City & Hackney Area Committee		
Dr Mark Rickets	City & Hackney Clinical Chair	NE London CCG / City & Hackney Integrated Care Partnership
Sue Evans	Lay Member	NE London CCG / City & Hackney Integrated Care Partnership
Sunil Thakker	Executive Director of Finance	NE London CCG / City & Hackney Integrated Care Partnership

Integrated Care Partnership Board Members		
Caroline Millar	Acting Chair	City & Hackney GP Confederation
John Gieve	Chair	Homerton University Hospital NHS Foundation Trust

Tracey Fletcher	ICP Chief Officer and Homerton University Hospital NHS Foundation Trust Chief Executive	Homerton University Hospital NHS Foundation Trust
Ian Williams	Acting Chief Executive	London Borough of Hackney
Haren Patel	Clinical Director	Primary Care Network
Jenny Darkwah	Clinical Director	Primary Care Network
Honor Rhodes	Associate Lay Member	NE London CCG
Ann Sanders	Lay member	NE London CCG
Jon Williams	Executive Director	Healthwatch Hackney
Dr Sandra Husbands	Director of Public Health	London Borough of Hackney
Dr Stephanie Coughlin	Neighbourhoods & Covid-19 Clinical Lead	NE London CCG / City & Hackney Integrated Care Partnership
Jessica Lubin	Health Transformation Director	Hackney Council for Voluntary Services
Eileen Taylor	Vice Chair	East London NHS Foundation Trust

Attendees

Helen Woodland	Group Director – Adults, Health & Integration	London Borough of Hackney
Jonathan McShane	Integrated Care Convenor	NE London CCG / City & Hackney Integrated Care Partnership
Matthew Knell	Head of Governance & Assurance	NE London CCG / City & Hackney Integrated Care Partnership
Nina Griffith	Workstream Director: Unplanned Care	NE London CCG / City & Hackney Integrated Care Partnership
Stella Okonkwo	Integrated Commissioning Programme Manager	NE London CCG / City & Hackney Integrated Care Partnership

Apologies:

Deputy Mayor Anntoinette Bramble	Deputy Mayor & Cabinet Member for Education, Young People & Childrens' Social Care	London Borough of Hackney
Henry Black	Acting Accountable Officer	NE London CCG
Steve Collins	Director of Finance	NE London CCG
Ruby Sayed	Member, Community & Childrens' Services Sub-Committee	City of London Corporation

Paul Calaminus	Chief Executive	East London NHS Foundation Trust
Tony Wong	Chief Executive	Hackney Council for Voluntary Services
Laura Sharpe	CEO	City & Hackney GP Confederation
Susan Masters	Co-Director: Health Transformation, Policy and Neighbourhoods	Hackney Council for Voluntary Services
Paul Coles	General Manager	Healthwatch City of London
Andrew Carter	Director: Community & Childrens' Services Sub-Committee	City of London Corporation

No.	Agenda item and minute
1.	**Welcome, Introductions and Apologies for Absence** The Chair of the Integrated Care Partnership Board (ICPB), Randall Anderson (RA), opened the meeting, welcoming those present and noting apologies as listed above.
2.	**Declarations of Interests** The City Integrated Commissioning Board **NOTED** the Register of Interests. The Hackney Integrated Commissioning Board **NOTED** the Register of Interests. RA briefed the ICPB that a new declarations of interest system was still in the process of being implemented, which would allow members to self-manage their declarations. This was now planned to become available later in November, but had not been ready in time for this meeting of the ICPB.
3.	**Questions from the Public** Two members of the public were present at the meeting and no questions from the public were raised at the ICPB meeting.
4.	**Minutes of the Previous Meeting & Action Log** Ann Sanders (AS) noted that on page 14 of the circulated papers, Catherine Macadam (CM) had been indicated as being in attendance at the October 2021 meeting, while she was a member of the ICPB and asked for this to be corrected in the minutes of the meeting. **ACTION:** Catherine Macadam's membership of the ICPB to be reflected in the minutes of the October 2021 ICPB. The City Integrated Care Partnership Board otherwise **APPROVED** the minutes of the previous meeting and **NOTED** the action log.

	The Hackney Integrated Care Partnership Board otherwise **APPROVED** the minutes of the previous meeting and **NOTED** the action log.
5.	**Report from the ICP Chief Officer** Tracey Fletcher (TF) briefed the ICPB that Siobhan Harper (SH) had moved from the City and Hackney (C&H) system to Tower Hamlets, Newham and Waltham Forest (TNW) and that she would be taking on more of a leadership role across the place based team. Attendance at the North East London Clinical Commissioning Group (NEL CCG) would be taken up by either Nina Griffith (NG) or Amy Wilkinson (AW) to ensure messages and feedback flow between the central team and C&H colleagues. Discussions were underway with NEL CCG colleagues around the future leadership structure, including the creation of a Director of Delivery and Development role that would be advertised shortly. TF continued to outline that debate was underway across the whole of NEL on the strategy and development of the future Integrated Care System (ICS), with discussions taking place across a number of forums and involving many colleagues present in the ICPB.
6.	**Neighbourhoods - Progress in 2021/22 and Future Plans:** NG joined the ICPB and directed members' attention to the circulated papers, noting that the ICPB had discussed the outline proposals for approval of the continuation of the Neighbourhoods programme in the coming years at its previous meeting in October 2021. This proposal was also accompanied by a series of sustainability proposals, to support the movement of an existing programme from non-recurrent standing to a business as usual approach. Further proposals to support sustainability proposals for resident, community and voluntary sector engagement in the coming months. NG briefed the ICPB members on the progress made within the core Neighbourhoods programme, with multi-disciplinary teams working to deliver services at a neighbourhood level and new models of care being developed and delivered by the team. Work was now pivoting to look to the future of the programme to ensure its sustainability and that the teams work and services become embedded in the local health and care system as 'business as usual'. This new phase of work will involve the reduction of programme non-recurrent funding, and the mainstreaming of the model to be included in standard funding streams, without extra investment wherever possible. Some elements of the programme however were novel and new funding streams would need to be established, for instance to support the community pharmacy driven work and to support the resident, community and voluntary sector engagement. Business cases to cover recurrent funding for the engagement work will come to a future ICPB meeting and will be cast in light of the overall funding envelope and the Better Care Fund (BCF), while a proposal for the community pharmacy work was before the ICPB today. NG briefed the ICPB members on the proposal for funding for the Neighbourhoods programme in 2022/23 and the sustainability proposal for the Neighbourhood model for community pharmacy going forward. NG confirmed

	that the overall requested amount from the BCF in 2022/23 was £738,496, which would be drawn from the BCF as in prior years to cover core Neighbourhoods programme costs. NG flagged that this ask was a reduction on the sum requested for 2021/22 and that this number should be expected to decrease year on year in the future. NG added that the circulated papers both covered a look back at what the programme had achieved so far, but also a look forward at what changes would be required in the upcoming years to ensure that the work of the programme is mainstreamed into day to day working practices. NG presented the Community Pharmacy Neighbourhood leads programme, noting that these leads supported the involvement and collaboration with Primary Care Networks (PCNs). These leads (funded based on allocation of days) have a role in acting as Neighbourhood Pharmacy champions and communicating with community pharmacies in their Neighbourhood and taking a leadership role, working closely with wider system partners including PCNs and PCN Clinical Directors. A series of objectives had been put in place for the team, and their roles aligned with the BCF metrics. A total sum of £55,200 plus VAT was being requested for approval on a recurrent basis. Haren Patel (HP) thanked NG for the circulated material, noting that experience working with Neighbourhood teams had been positive. HP asked if similar structures, or an approach like Neighbourhoods was in place in other areas across NEL. HP flagged that there may be a risk of overlap with the Community Pharmacists work to support PCNs, for which there is an existing contract in place and asked if this was being mitigated. Sunil Thakker (ST) stated that these two initial proposals had been discussed and recommended by the City and Hackney Finance and Performance Sub Committee (FPSC) at its October 2021 meeting. ST flagged that the only point of contention had been that the CCG had not received formal notification of allocation for 2022/23 and therefore was unable to commit spend at this point, although was supportive of both proposals. ST continued that careful consideration of the evaluation and performance monitoring needs of this work needed to be undertaken, to ensure that benefits can be measured and articulated. NG thanked HP and ST for their questions, noting that the C&H team was working with colleagues across NEL, with the PCN structure in place across the whole of NEL, as it was nationally mandated, with much discussion underway on how to embed community services at a similar service level to support the work of PCNs. Ideas, learning and possible proposals were regularly shared between NEL colleagues, however the C&H approach was taking a broader look at addressing health inequalities and involved a wider range of partners in this work. NG recognised the risk in an overlap between the Community Pharmacists work to support PCNs and the work set out in the proposal before the ICPB, but informed the ICPB that the teams worked closely with the Medicines Management Team (MMT) to ensure that this didn't happen and that the contract was clear that this work was in addition to that undertaken elsewhere. NG flagged that each service line delivered through the Neighbourhoods programme was managed as an individual contract, with attached performance monitoring and metrics with the provider partner. Contract payment was also

	based on actual spend, supporting analysis of costs and performance. Cordis Bright were engaged to look at the broader programme driven outcomes, measures and performance and this would be updated on soon. Chris Kennedy (CK) asked whether the long term picture for this work involved the programme generating savings, which could be drawn down as Neighbourhood specific funding from NEL CCG, as funding through the BCF may not be sustainable in the long term. NG responded that there were a few elements to this, and that many aspects of the work covered by the Neighbourhoods programme were included in normal contracting arrangements with partner providers, and that there wouldn't be financial implications if this was the case. NG continued that some aspects of the new models of care were accompanied with new national funding, for instance that in place around anticipatory care, while other aspects would require local partners to take a view on possible investment, like the community pharmacy proposal under discussion at the meeting. A discussion with finance colleagues would be needed to investigate what the future may look like without the BCF, but in the meantime, the BCF was a recurrent funding stream option available to local partners. NG noted that despite the work underway to mainstream much of the Neighbourhood funding and services, it remained likely that a small, central fund to co-ordinate and drive improvement on an ongoing basis would be needed, but that discussions were needed with system partners on how to best meet this need, aligned with the PCN programme. ST agreed that the work within the Neighbourhood programme needed to be considered in upcoming funding and allocation related work for 2022/23 and form part of local planning requirements. Honor Rhodes (HR) thanked NG for the proposals, noting that care needed to be taken to ensure that local people and communities are bought into – and along with this work and that Neighbourhoods don't become a healthcare dominated programme of work, but consider the wider needs of local people. HR raised that the engagement proposals were vital to the success of the programme, and that without them, true co-production and co-design would not be possible. Metrics would be vital to ensure that this work remained a success, but not in terms of numbers, but instead to look at impacts, outcomes and what successes local people took away from the Neighbourhoods programme. AS noted that the circulated papers indicated that an evaluation framework would be in place by January 2022 and asked if resource had been set aside for further external review to support the programme. NG responded that further material on the engagement model would be coming to a future meeting of the ICPB for approval, work on which was being supported by HealthWatch partners. NG stated that work continued with Cordis Bright to develop an evaluation framework, and that once this work became available, a discussion on whether to continue with external support or internalise this work would take place, led by the framework that emerges. Helen Fentimen (HF) asked whether the impact of the anticipatory care work could be measured, particularly on whether individuals can identify changes in services and support available to them. Additionally, HF asked whether the financial impact of this work would be measurable, noting that this was key to indicate whether the services could be successfully mainstreamed and self-

	sustain in to the future. NG responded that Cordis Bright had supported the creation of an anticipatory care evaluation framework, which was being actively monitored in the currently running pilot, with early patient level outcomes being reported on. Work was also underway with the national NHS England and Improvement (NHSEI) team to make sure that the outcomes being realised locally align with those expected from the central funding allocated to this work. NG continued that community pharmacy proposal aimed to bring and engage local pharmacies, as trusted local health professionals, in working closely with their communities to help relieve pressure on other parts of the health system and engage with the health and care system as a whole as key partners and local leaders. Other work was underway within the PCN system to support prescribing best practice and to enable individual or cohort reviews of medication to ensure local patients are best supported. John Gieve (JG) thanked NG for the positive paper and indicated his support of the proposals. JG noted that it should be expected that, if the interventions under discussion were successful, that there would be a knock on effect on core funding flows across the system – for instance, increased social care support may result in less medical interventions being required. JG asked how these cross partner impacts, costs and outcomes could be explored and discussed as a group from a system point of view. NG responded that some elements of this discussion will become apparent on a service by service basis, and that the anticipatory care pilot that was currently underway was being closely monitored for exactly these kind of impacts, and that it was hoped work in this area would become clearer by March 2022. NG noted that a proposal for the use of central funding to support anticipatory care would be coming to a future meeting of the ICPB in the near future for approval, along with further information on this work. NG noted that services still probably needed to be assessed and considered under within their own specifications and stand on their own and justified to partners in the short to medium term. Mark Rickets (MR) confirmed that he had supported the proposals at the FPSC and continued to do so, noting that the Health and Wellbeing Board was in the process of reviewing its strategy and that elements of this work may impact on that project. MR continued to flag that the results of the evaluation work that Cordis Bright are producing could benefit from ICPB discussion when available and used to inform the future of the usage of metrics, outcomes and outputs across the local health and care system. **ACTION:** NG to ensure that Cordis Bright's work on Neighbourhoods evaluation and stock take is presented to the ICPB when available for discussion. HP raised that there were significant differences across the many community pharmacies in the local area in terms of readiness to support and engage with the work under discussion and that this needed to be kept in mind. Jessica Lubin (JL) flagged that it may be important to consider and measure the cost effectiveness of the anticipatory care pilots' impacts, potentially through benchmarking against similar costs across providers. RA supported this approach, noting this approach was likely to become more vital as local partners needed to prioritise funding and spend in the future. JL highlighted that much of the voluntary and community sector's (VCS) work tended to be financed through short term, non-recurrent funding and that there were further benefits to be

	gained by moving towards longer, more stable arrangements between local partners. **DECISION:** The ICPB approved the proposal for funding for the Neighbourhoods programme in 2022/23 through drawing down £738,496 from the Better Care Fund. As part of this funding, the ICPB approved the Sustainability proposal for the Neighbourhood model for community pharmacy for £55,200 plus VAT as recurrent funding and noted that further Sustainability proposals will be presented to the December 2021 ICPB meeting for the Neighbourhood model for resident involvement and community and voluntary sector engagement.
7.	**Any Other Business and Reflections** No further business was discussed.
	Next meeting: Thursday 9 December 2021

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

Ref No	Action	Assigned to	Assigned date	Due date	Status	Update
ICPBJul-2	Update on investment underpinning inequalities tools and resources to be brought back to ICPB.	Anna Garner	Jul 21	Jan 22	In progress.	Work is underway with colleagues across CCG & ELFT, planned to return to ICPB for discussion in January 2022.
ICPBNov-1	Catherine Macadam's membership of the ICPB to be reflected in the minutes of the October 2021 ICPB.	Matthew Knell	Nov 21	Dec 21	Closed	Minutes and distribution lists updated.
ICPBNov-2	NG to ensure that Cordis Bright's work on Neighbourhoods evaluation and stock take is presented to the ICPB when available for discussion.	Nina Griffith	Nov 21	Jan 22	In progress.	Placed on forward plan, initially for January 2022 meeting but will be reviewed nearer the time

Title of report:	ICPB Risk Register
Date of meeting:	Thursday 9 December 2021
Lead Officer:	Matthew Knell
Author:	Matthew Knell
Committee(s):	N/A
Public / Non-public	Public

Executive Summary:

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

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the report;

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the report;

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

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

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Communications and engagement:

N/A

Equalities implications and impact on priority groups:

N/A

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

N/A

Background and Current Position

The risks included in this report are those red risks which could impact on the wider system and risks in the amber range (all risks scored at 8 or above). Green and yellow rated risks are being managed at work stream and programme level.

In December 2021 we have 19 risks across 5 risk registers, including:

- One new amber risk (MH5)
- 2 risks that have increased in score and are in a red status (CYPMF11 & MH4)
- 7 risks that have remained unchanged in score, comprising 6 red risks (CYPMF6, MH3, PC5, PC7, PC9 & PRC1) and 1 amber risk (PC1)
- 9 risks that have decreased in score
    - Of those risks that have decreased in score, only 1 remains in a red status (PC2)
    - The other 8 decreasing risks have moved from red to amber status (MH1, MH2, PC4, PC6, PC8, PC10, PRC2 & UPC8).

More detailed information is available in the following presentation.

NHS
North East London
Clinical Commissioning Group

Risk Management Report for ICPB

December 2021

City and Hackney

Risk Update

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

- We have adopted a more system based approach to risk and risk owners have been encouraged to share the current risk registers across the system and at relevant meetings. Further information on risks can be requested by the ICPB from workstream teams and risk owners.

- The risks included in this report are those red risks which could impact on the wider system and risks in the amber range (all risks scored at 8 or above). Green and yellow rated risks are being managed at work stream and programme level.

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

- In December 2021 we have 19 risks across 5 risk registers, including:
    - One new amber risk (MH5)
    - 2 risks that have increased in score and are in a red status (CYPMF11 & MH4)
    - 7 risks that have remained unchanged in score, comprising 6 red risks (CYPMF6, MH3, PC5, PC7, PC9 & PRC1) and 1 amber risk (PC1)
    - 9 risks that have decreased in score
        - Of those risks that have decreased in score, only 1 remains in a red status (PC2)
        - The other 8 decreasing risks have moved from red to amber status (MH1, MH2, PC4, PC6, PC8, PC10, PRC2 & UPC8).

- Further information on risk changes are detailed on the next few slides.

Changes to risks

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

Risk	Changes in score	Changes in mitigations
CYPMF11 regarding increases in demand in children's mental health services	Increased from 15 (red) to 20 (red)	There is still a surge in CAMHS with a growing backlog and waits. CAMHS T4 beds are saturated, however we are no longer seeing young people aged 16-17 in MH adults beds. There is currently a regular discharge and flow group in place that is looking at bed blocking. We are also working with NEL LA collaborative to set up an in-housing placement hub for CYP with complex needs that include mental health. The investment round for 21/22 has been completed and this is currently being mobilised which will help alleviate some of the demand. However the new investments in CAMHS are small compared to the doubling of demand in many cases. The situation in the children's eating disorders service appears to be worsening owing to staff shortages on top of the doubling of demand. The service will only be able to see the most urgent cases within NICE timeframes. We are likely to see more access and waiting times breaches in this service over the coming months.
MH1 regarding increased demand for mental health services, particularly for more complex and high intensity treatments	Decreased from 15 (red) to 8 (amber)	New mitigations in place and covered in risk register
MH2 regarding the delivery of Serious Mental Illness (SMI) physical health checks	Decreased from 15 (red) to 12 (amber)	Mitigations being realised

Changes to risks

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

Risk	Changes in score	Changes in mitigations
MH4 regarding increases in cases of domestic violence through the pandemic and gap in provision of psychological therapies which could support victims	Increased from 12 (amber) to 15 (red)	New mitigations in place and covered in risk register
MH5 regarding reduction in residents being diagnosed with dementia, resulting in an increased risk of residents not accessing support available locally	New risk in December 2021	New mitigations in place and covered in risk register
PC2 regarding patients not being seen, diagnosed and treated within nationally mandated cancer performance targets	Decreased from 20 (red) to 16 (red)	H2 Guidance expects 20% increase in referrals to recover missed cancers - 2ww are running at approx 15% higher. Alliance need to identify the areas the missing referrals are from. Performance has deteriorated since April with targets for 62 days now in the 80% plus region. HUH contunues to perform well against 2ww and 31 days targets but 62 days is similar across all trusts. Cancer activiy is high and reducing the backlog is still the priority. Our key aims are to: ● minimise patients that do not present to primary care for referral ● Ensure our providers have Fast Track appointments available ● Diagnostics capacity will be available Diagnostics are in full operation at HUH and waits for endoscopy is now near the target levels. Cancer services have been maintained across NEL and continue to deliver.

Changes to risks

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

Risk	Changes in score	Changes in mitigations
PC4 regarding restoration and recovery of local services	Decreased from 20 (red) to 12 (amber)	Review monthly at system management group, looking at transformation and acute. GP referrals are overall at pre-pandemic levels Activity at HUH is high - back log is reducing (Over 18 weeks reduced significantly) Elective and day case is exceeding H2 guidance for providers Diagnostics - HUH is performing well and overall 98% within 6 wks achievement with only endoscopy being in the 70% plus area.
PC6 regarding potential COVID outbreaks at care homes and commissioned placements for residents with a learning disability	Decreased from 16 (red) to 10 (amber)	Mandatory vaccinations programme for staff; all staff at care homes will be double vaccinated; risk assessments in place where staff are exempt. Vaccinations & boosrters being encouraged. Most care homes have >75% double vaccination rate and booster programme in place. Regular testing & Standard Operating Procedures in place to address outbreaks. Arranging Restore2mini training to identify deterioration. The risk mitigation has achieved its target score - Close this risk now with consideration of brining back pending winter issues.

Changes to risks

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

Risk	Changes in score	Changes in mitigations
PC8 regarding the impact of COVID on the health of the rough sleepers and asylum seeker populations	Decreased from 20 (red) to 12 (amber)	Rough Sleeper and Health Partnership Group in place to oversee response. ELFT Outreach Service providing outreach clinics to accommodation for rough sleepers and asylum seekers. Service extended until 31 March 2024. Proactive outreach being undertaken by LAs to ensure rough sleepers are offered accommodation. Severe Weather Emergency Protocol (SWEP) will be implemented as required with the weather turning cold. Vaccination efforts ongoing. Two bridging hotels have been stood up in the City of London as part of the Afghan resettlement programme. Additional health staff have been recruited by ELFT to support these sites. All system partners are involved in the response.
PC10 regarding financial pressures in the Adult Learning Disability service	Decreased from 20 (red) to 12 (amber)	Integrated Learning Disability Service is currently £2milion overspent this financial year. This is in part as a result of extra support needs around covid (e.g. increased 1:1 support). With the current Pandemic, it's highly unlikely that savings could be made. To note - Following a paper prepared for the ICB, the budget position has improved by several million £s than in previous years; however, as end of year overspend is >£1million risk remains at 20 (red) and will likely rise to 25 by next time when overspend is certain.

Changes to risks

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

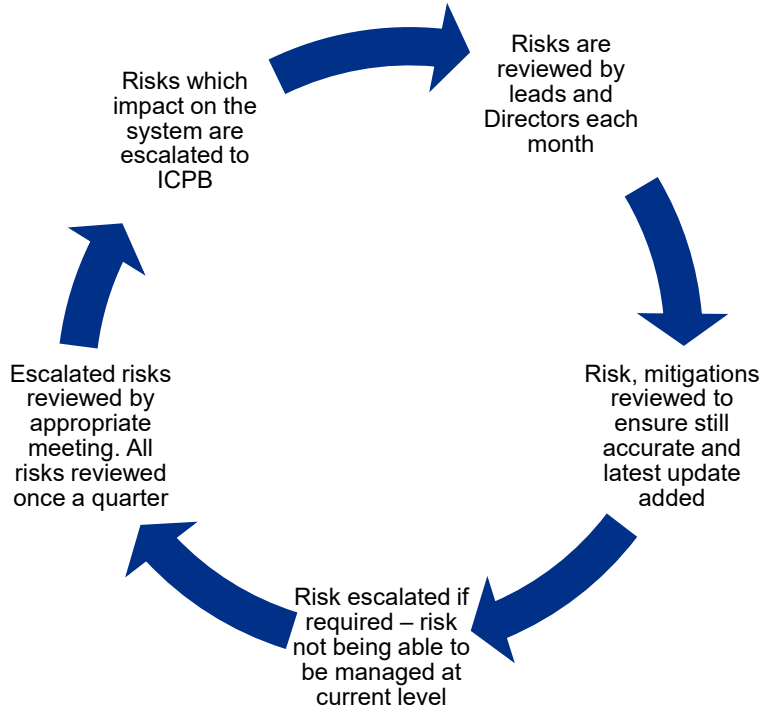
Risk	Changes in score	Changes in mitigations
PRC2 regarding the ability of primary care to cope with continuing peaks of Covid, particularly where these happen alongside seasonal pressures such as winter	Decreased from 15 (red) to 9 (amber)	Latest sit rep shows that all practices are open and are coping the best as they can RSV predicted to be an additional pressure but we are still not seeing this in C&H Discussion at Nov PCEGB on what else can be done to support practice National Winter Access Fund
UPC8 regarding potential increase in non-elective acute demand - either driven by a return to normal levels of admissions or a further peak in covid demand	Decreased from 16 (red) to 12 (amber)	Core winter plan in place and ongoing across all programmes Funded winter resilience schemes commenced / mobilising Ongoing oversight of system pressure via weekly SOCG Likelihood of high demand remains high but mitigations in place which will reduce the impact. Risk therefore reduced from 16 to 12.

Monthly risk cycle - CH ICP, NEL CCG

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

Each month:

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



ID no.	Date raised	Raised by (individual/ committee/ programme)	Initial risk score	Corporate objective	Local system objective	Risk description	Previous rating	Current rating			Target rating	Target completion date	Completed mitigating actions	Mitigating actions still to be completed	Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details	Updates/ comments - *add in month/year of update*	Close Down Status
								Likelihood	Impact	Risk Score (1-25)											
CYPMF6		CYPMF Strategic Oversight Group	15			Risk that low levels of childhood immunisations in the borough may lead to outbreaks of preventable disease that can severely impact large numbers of the population	15	3	5	15	4		1. Robust governance established across the Partnership with A.) a fortnightly COVID 19 Childhood Imms Task group with PH, CCG, HLT and Interlink members, B.) a C&H monthly steering group that also manages the flu strategy, and C.) a quarterly wider partnership oversight group with NHSE/PHE that will oversee the 2 year childhood imms action plan. 2. CCG NR investment in childhood immunisations - contract with GPC through which additional clinics and 'event' clinics are held in NE Hackney 3. Utilise NHSE training, data and shared learning opportunities	Continue to work with CEG / NHSE regarding improvements in data collection to support timely delivery; recruit to NR funded imms coordinator / programme manager posts ; restart the GPC delivered children's centre service for NE Hackney; develop our approach to vaccine hesitancy with a focus in NE Hackney with learning applied across C&H	Amy Wilkinson	Amy Wilkinson / Sarah Darcy	CYPMF SOG	Y	ICPB	Impact of further deterioration in coverage in Covid not yet redressed; use of NR funding planned, expected to mobilise end of Q2 / Q3. An immunisations coordinator for NE Hackney is due to start in January 2022; NR funding bid submitted to NHSE for dedicated project management support for NE Hackney (initially)	
CYPMF11		CYPMF Strategic Oversight Group	15			• Specialist (Tie3) CAMHS is currently seeing a doubling in referral demand. Waits are increasing from 4-5 weeks to 8 weeks with referral backlog increasing. • Specialist Eating Disorders service seeing a doubling of demand and increase waits – only able to see urgent cases within NICE waiting times • First Steps starting to see a doubling in demand and waits having increased to 6 months for 1 to 1 therapy. Referral backlog increasing • This doubling in demand pattern is mirrored at a national level. C&H's estimated prevalence of diagnosable Mental Health Conditions has risen from 10% to 18%. Based on local and national information, we are predicting that this new level of demand will be ongoing for at least the medium term. • Increase demand and backlog issues are being exacerbated by higher levels of staff sickness plus a recruitment issues. Despite new investment being available we are unable to fill posts owing to a national shortage of CAMHS clinicians. We are also seeing staff leave at a higher rate and this may be related to staff burnout and working in a complex and unintegrated system in C&H. • We are also seeing a shortage of T4 bed availability particularly specialist eating disorders beds. This is having an impact on the wider system with T3 CAMHS having to hold cases that would normally been admitted and also inpatient paediatrics having to hold cases that would otherwise be in a specialist unit. • CYP crisis presentations is also significantly higher than prepandemic levels and appears to be an ongoing pattern. • Owing to increase demand and waitlist backlog, we have seen our CYP autism assessment waits increase from 4 months to 8-10 months. Post diagnostic support is also seeing a similar backlog build up and corresponding wait time. • Off-Centre (16-25 service) has also seen a significant increase in referrals and wait times have increased beyond 6 months. As a result they have had to close their waiting list to new referrals.	15	5	4	20	9		There are a large number of developments in place in order to support CAMHS work, these are included in the CAHMS surge planning document. However, some of these are detailed here - CAMHS Alliance Support has been redeployed to support critical care. - HUH CAMHS to receive enhanced funding for additional senior clinician capacity plus enhanced duty system. - introducing enhanced LBH and Off Centre clinical offer to support surge in CAMHS crisis. - Maintain Crisis service operation 9am -9pm 7 days per week beyond April 2021 . - CAMHS Disability has implemented a Duty System including weekly meeting with CAMHS Alliance colleagues to consult on referrals. First steps have adopted to on line with groups and online resources. - WAMHS/MHST has continued to deliver a range of services to meet needs faced by schools, pupils and parents	1. Implementing CAMHS Single Point of Access 2. Wider CAMHS integration Programme. 3. LBH CAMHS Crisis Surge support offer 4. LBH embedded SW in CAMHS Crisis team 5. ASD backlog clearance initiative. 6. Winter pressures funding a. Additional Psychiatry b. Fixed Term SPA lead c. Off-Centre turnaround senior manager d. HUH CAMHS Locum e. ASD Tier 2 additional Capacity f. Additional RMN support for Starlight ward 7. Potential risk sharing offer to Starlight for locum support during times of extreme pressure	Greg Condon / Sophie McElroy	Dan Burningham / Amy Wilkinson	CYPMF SOG	Y	ICPB	There is still a surge in CAMHS with a growing backlog and waits. CAMHS T4 beds are saturated, however we are no longer seeing young people aged 16-17 in MH adults beds. There is currently a regular discharge and flow group in place that is looking at bed blocking. We are also working with NEL LA collaborative to set up an in-housing placement hub for CYP with complex needs that include mental health. The investment round for 21/22 has been completed and this is currently being mobilised which will help alleviate some of the demand. However the new investments in CAMHS are small compared to the doubling of demand in many cases. The situation in the children's eating disorders service appears to be worsening owing to staff shortages on top of the doubling of demand. The service will only be able to see the most urgent cases within NICE timeframes. We are likely to see more access and waiting times breaches in this service over the coming months.	

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								Likelihood	Impact	Risk Score (1-25)										
MH1	May-21	City and Hackney Psychological Therapies and Wellbeing Alliance	15	NEL Operating Plan IAPT Access Target	Meeting mental health demend	There has been an increasaed demand for mental health services since pandemic particulary for more complex and high intensity treatments with waiting lists building in IAPT for 1st and 2nd treatments and in ELFT SPS service. If the issue is not addressed there is a risk to patients of long waits for treatment and a risk of missing IAPT waiting time targets.	15	4	2	8	3	Jan-21	1. Improve referral pathways for people with Long Term Conditions, trauma, 18-25 year olds and for people with trauma and those in economically deprived areas. Engage the LBH to undertake marketing to better communicate the IAPT offer. 2. Agree staff WTEs and begin recruitment for 2022-23 staff 3. Improve access rates in ELFT and PCPCS supported by a review of the psychological therapies pathway in Q4.	Dan Burningham	Dan Burningham	Pychological Therapies and Wellbeing Alliance			2. Agree staff WTEs and begin recruitment for 2022-23 staff 3. Improve access rates in ELFT and PCPCS supported by a review of the psychological therapies pathway in Q4.	
MH2	01-Sep-21	Primary Care Mental Health Alliance	20	NEL Operating Plan SMI Physical Health check target	Better integrated care between mental health and physical health.	Since the pandemic primary care practices have found it difficult to delivery SMI physical health checks alongside other priorities such as vacinnation. With the blood bottle shortage this looks unlikely to change. The risk is the City and Hackney ICS will fail to reach its SMI physical health check target and that health risks in the SMI cohort will go undetected and that planning to improve health will not take place.	15	4	4	16	12	Jan-21	1. We are ordering POC test kits for six GP practices with the largest SMI populations. 2. We are increasing the capability of ELFT to undertake physical health checks by introducting POC into the EIS teams and also changing to ELFT HCA contract to include home visits and outreach work for people who have not had a health key elements of the health check completed in over two years. 3. To support this CEG will do seraches to identify this at risk cohort.	Dan Burningham	1. Amaia Portilli, 2. Cath Mcelroy 3. Jo Tissier	The Primary Care Mental Health Alliance				
MH3	01-May-21	City Suicide Prevention and Response Group, Suicided Prevention Stakeholder Group	20	Addressing crisis and avoiding inpatient admissions and harm	Addressing crisis and avoiding inpatient admissions and harm	Since the pandemic there has been a rise in adults experiencing a mental health crisis demontrated by increased crisis line calls, increased suicidal presentations and suicides.	20	4	5	20	12	Jan-21	1. Increase City of London Street Triage hours. 2. Increase ELFT crisis line capacity. Work with HLP and NEL to develop a NEL wide crisis line that links to 111.3. Improve prevention work around vulnerable groups e.g homlessnes and substance misuse	Dan Burningham	1. Claire Giraud 2. Andrew Horobin 3.	The Mental Health Co-ordinating Committee			Winter pressures funding will improve discharge pathways.	
MH4	10-Nov-21	Psychological Therapies and Well Being Alliance	15	Responding to local need and the effects of the pandemic on mental health	Responding to local need and the effects of the pandemic on mental health	Incidents of domestic violence have increase during the pandemic and there is a gap in the provision of psychological therapies which could support victims to make the right choices. As a result women could be at an increased risk of physical injury or psychological trauma.	12	5	3	15	12	Jul-22	1. CCG and Locaul Authorities to work together to find an integrated solution that brings together social and psychological support a 2. CCG nad LA to explore whether this could be funded through the network and/or NHS Transformation funding and/or another source.	Fawzia Baht	Jennifer Millmore and Dan Burningham	The Mental Health Co-ordinating Committee				
MH5	14-Jun-21	Dementia Alliance Programme Board/Dementia Alliance Stratgey Group	12	NEL Operating Plan Dementia Diagnosis Target	Meeting mental health demand	There has been a reduction in residents being diagnosed with dementia against the prevalance rates pre and post pandemic, resulting in an increased risk of residents not accessing support available locally via ELFT and the Azheimer's Socety. This could also result in residents presenting in crisis at A&E.	N/A	4	3	12	6	Jan-22	•City & Hackney CCG have recently funded additional clinician resource (August 2021) within the Dementia Service to help identify and diagnose people with dementia. Due to Covid recruitment has been delayed. •Main responsibilities will be: oRecall 268 people on the Memory Cognitive Impairment Register oProvide clinical coverage for all residential, care and supported living schemes. oProvide assessments from HUH Consultant Psycho-Geriatrician, GP and Dementia Service DNA list (all patients will be offered home visits) oIdentify and diagnose patients diagnosed with delirium with no dementia diagnosis oLiaise with neurologists to identify and diagnose patients i.e. people with Parkinson's disease are at higher risk of developing dementia oLiaise with Local Authority Social Adult Care services/teams to identify and diagnose patients where appropriate. •City & Hackney Dementia Clinical Lead is continuing to work with local GPs to improve dementia coding. This activity is ongoing. •City & Hackney Dementia Clinical Lead with Homerton's Dementia Lead Nurse will be delivering dementia training within care home settings. i.e. care homes, housing with care, supported accommodation. •CCG will be recruiting a Dementia GPwSI in the next 2 months to support with identifying patients in GP practices with high % of people over 65 with a low diagnosis rate. In addition to online training to support GPs diagnose less complex patients.	Fawzia Baht	Fawzia Bakht	Dementia Alliance Programme Board/Dementia Alliance Stratgey Group				

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PC1	May-21	Planned care team	12	Put patient experience at the centre of our delivery / Recover from pandemic and be prepared for future waves / High quality services for patients		Changes to services (e.g. services being moved out of area / hot-cold site changes, virtual consultations) have an impact on vulnerable residents and / or negatively impact those already most at-risk from the covid-19 pandemic. Vulnerable patient is defined as a patient who needs regular health input from primary care, who may struggle to access this due to COVID-19 service changes, For example, a patient with a long term condition who is having issues with managing it or a patient with a learning disability.	12	4	3	12	9	Apr-22	Face to face appointments are beginning to be introduced again. Risk stratification tool developed for identification of vulnerable patients in primary care - will enable prioritisation of review for those most at need. Preparing to roll tool out across C&H practices.	Develop tool for identification of vulnerable patients by primary care - feedback reports on use.Being rolled in Q3/4. / Process of review and active case management - primary care and community/enhanced services. Data capture and feedback thorugh CEG. Face to face appointments are beginning to be introduced again.	Charlotte Painter	Charlotte Painter / Laurie Sutton Teague				November 2021: Local services have undertaken a range of actions to mitigate the impact of COVID for vulnerable groups. GP Confed contract has been regeared to focus on vulnerable patients- utilising CEG searches to identify them. Community Services- ACERS, Lymphoedema, etc.- are actively managing patients on their caseload. Winter Pressures work is being undertaken by mwtc management team and primary care. Social prescribing teams and other ARRS roles within primary care are assisting with targetted work with vulnerable clients. Face to face offer in primary care has resumed. The LTC contract has been re-focussed on priority treatment areas to highlight the most at risk patients. Work is starting on planning the 2022/23 contract indicators. Also work is continuing on the roll out of tools to identify new patients and where patients have conditions which are less well controlled. A number of pilot projects are underway in primary care.	
PC2	Jul-21	Planned care team	20	Recover from pandemic and be prepared for future waves		Patients are not being seen, diagnosed and treated within nationally mandated cancer performance targets, leading to possible increased severity of illness and loss of local cancer service reputation and NHSE intervention.	20	3	4	16	9	Apr-22	North East London Cancer Alliance (NEL CA) in place and leads on NEL cancer performance and delivery. Monthly/weekly reviews of all areas and project development. This includes: - Trajectory and planning for recovery from COVID-19 (Clearance of waiting lists and delivery targets) - Performance of providers and primary care - National Targets (including support to screening) - Projects that will improve services The local CH Cancer Collaborative is in place and meets every 6 weeks. They support NEL CA in achieving cancer performance locally and develop local projects to improve cancer detection and treatment.	Local Projects to be started: - Cancer awareness campaign. - Screening projects (Bowel and Cervical) targeting people not coming forward for screening - improving patient experience (Mission remission) ● Fortnightly review of performance with Alliance and providers - identifying the issues and taking mitigating actions ● Monthly communications to primary care	Charlotte Painter	River Calveley				November 2021: H2 Guidance expects 20% increase in referrals to recover missed cancers - 2ww are running at approx 15% higher. Alliance need to identify the areas the missing referrals are from. Performance has deteriorated since April with targets for 62 days now in the 80% plus region. HUH continues to perform well against 2ww and 31 days targets but 62 days is similar across all trusts. Cancer activity is high and reducing the backlog is still the priority. Our key aims are to: ● minimise patients that do not present to primary care for referral ● Ensure our providers have Fast Track appointments available ● Diagnostics capacity will be available Diagnostics are in full operation at HUH and waits for endoscopy is now near the target levels Cancer services have been maintained across NEL and continue to deliver.	
PC4	Feb-21	Planned care team	20	Recover from pandemic and be prepared for future waves / High quality services for patients		Acute Alliance Elective Restart Programme - Restore full operation of all cancer services. - Recover the maximum elective activity NEL Outpatient Transformation - Recover Non admitted RTT - Trajectories for NEL outpatient recovery - Support ICP initiatives for NEL outpatient recovery	20	3	4	12	6	Apr-22	Regular service comms to GPs Work on increasing A & G completed and new systems being looked at Barts for Pilots PIFU plans for Homerton now implemented Trajectories for recovery completed and agreed Other project and transformation work in progress - Community Gynae Expansion and the PCN Pilot have been implemented.	Ongoing Elective recovery meetings with HUH fortnightly. Ongoing NEL Waiting time recovery meetings (Monthly) Further work on PIFU and increase in A & G are being implemented to meet H2 guidance. Transformation projects to be implemented: - SWM implementation - Otology project (ENT) - Phlebotomy appointments - Community Paed ENT - Increase in PCN community Gynae activity	Charlotte Painter	River Calveley				November 2021:Review monthly at system management group, looking at transformation and acute. GP referrals are overall at pre-pandemic levels Activity at HUH is high - back log is reducing (Over 18 weeks reduced significantly) Elective and day case is exceeding H2 guidance for providers Diagnostics - HUH is performing well and overall 98% within 6 wks achievement with only endoscopy being in the 70% plus area.	
PC5	Feb-21	Planned care team	20	Recover from pandemic and be prepared for future waves / High quality services for patients		Increase in mortality for residents with a learning disability as a result of COVID (Increase in Learning Disabilities Mortality Review (LeDeR) Programme reporting)	20	4	5	20	15	Apr-22	Vaccine offer and support to take it up - vaccine programme.	Infection control and self care resources for patients and their carers - constantly updating as online information and with changes to guidance. Get data from G.P on vaccination rates. Staff training to be in place to be able to recognise signs of illness in patients . Leder reviews in place (and learning from these). work being done to increase vaccination update in staff and those supporting learning disabled users.	Charlotte Painter	Penny Heron	ICPB / SOCG / HNCB			Nov 2021 - Vaccinations programme, includes the GP Confed Booster delivery to care homes and supported living: Current rates of double vaccinations is 69% in C&H for this cohort, but booster rates for clinically extremely vulnerable remains quite low at 29%. Primary Care are conducting checks, such as Annual Health Checks. GPs have clear guidance for identifying patients via CEG searches and protocol for what to discuss with patients when they are contatced. Resources have been promoted by the council and CCG- a new winter planning checklist has been shared with providers. Ongoing monitoring of LeDeR reporting. If vaccination rate increases, option to review risk score.	
PC6	Feb-21	Planned care team	16	Recover from pandemic and be prepared for future waves		Risk of COVID outbreaks at care homes and commissioned placements for residents with a learning disability	16	2	5	10	10	Apr-22	Vaccination of residents in care homes / Regular Testing/ Infection protection and control training and SOPs for care / share winter planning handbook	Support Resources for patients, staff and carers. Winter planning promotion in addition to the handbook. Ongoing work to promote vaccines uptake for staff - linking in LBH and public health and undertaking quality assurance.	Charlotte Painter	Penny Heron	ICPB / SOCG / HNCB			Nov 2021 - Mandatory vaccinations programme for staff; all staff at care homes will be double vaccinated; risk assessments in place where staff are exempt. Vaccinations & boosters being encouraged. Most care homes have >75% double vaccination rate and booster programme in place. Regular testing & Standard Operating Procedures in place to address outbreaks. Arranging RestorexDmni training to identify deterioration. The risk mitigation has achieved its target score - Close this risk now with consideration of brining back pending winter issues.	
PC7	Feb-21	Planned care team	16	Recover from pandemic and be prepared for future waves		Medium to long term health impact of Covid and Covid related suspension of usual care on people with Long Term Conditions. This may be due to failure to present to health care settings; reduction in proactive monitoring and care or difficulty in accessing services due to restrictions. Likely to have a significant adverse impact on especially vulnerable groups including those in deprived socio-economic groups, people with LD and people from BAME backgrounds. This may become a "rising tide" of people with worsening health outcomes and complications of diseases such as diabetes.	16	4	4	16	9	Apr-22	Risk stratification tool developed for use in primary care to identify and recall patients most at need of review. Preparing to roll this tool out across C&H practices.	Engage patients to collate qualitative feedback / Review services briefs to understand how this need can be met / performance against LTC contract metrics to be monitored to understand the scale of need in primary care	Charlotte Painter	Charlotte Painter / Laurie Sutton Teague	ICPB / SOCG / HNCB			November 2021: Ongoing monitoring in place to support planning for medium-long term. Development of data models will be scheduled for later in the year to understand the quantitative impact via health inequalities. Engagement and Listening Events also planned to be scheduled for later in the year to gain a qualitative understanding of local need. This will also focus on LTC recovery and how to manage the situation post-COVID. LTC contract 21/22 targets have highlighted priority groups. LTC contract discussions for 2022/23 are about to start including review of performance so far and comparison across NEL - (City and Hackney data show we have acheived better performance in treatment outcomes for LTC compared to other NEL areas however this is still not back pre-pandemic levels.	
PC8	Feb-21	Planned care team	20	Recover from pandemic and be prepared for future waves		Impact of COVID on the health of the rough sleepers and asylum seeker populations	20	3	4	12	9	Apr-22		Ongoing accommodation offer / Outreach services from council and ELFT / Out of Hospital Discharge Pathway / Vaccination implementation	Charlotte Painter	Cindy Fischer				November 2021 - Rough Sleeper and Health Partnership Group in place to oversee response. ELFT Outreach Service providing outreach clinics to accommodation for rough sleepers and asylum seekers. Service extended until 31 March 2024. Proactive outreach being undertaken by LAs to ensure rough sleepers are offered accommodation. Severe Weather Emergency Protocol (SWEP) will be implemented as required with the weather turning cold. Vaccination efforts ongoing. Two bridging hotels have been stood up in the City of London as part of the Afghan resettlement programme. Additional health staff have been recruited by ELFT to support these sites. All system partners are involved in the response.	
PC9	Feb-21	Planned care team	20	High quality services for patients		NCSO- Limited stock availability of some widely prescribed generics significantly drove up costs of otherwise low cost drugs. The price concessions made by DH to help manage stock availability of affected products, were charged to CCGs - this arrangement (referred to as NCSO) presents C&H CCG with an additional cost pressure. As a result of EU exit, there is risk of transport delays of medicines which could lead to limited stock availability of medicines (which could further drive up the cost of commonly prescribed drugs).	20	4	5	20	9				Siobhan Harper	Rozalia Enti				The NHS has put measures in place to help ensure stocks continue to be available even if there are transport delays. The national recommendation is that medicines should be prescribed and dispensed as normal and that medicines should not be stockpiled, the MMT has already shared the message regarding appropriate prescribing and ordering of medicines to prescribers and patients (through Healthwatch Hackney) during the first wave of the COVID-19 pandemic – Spring 2020 and again in Nov/ Dec of 2020. For 2020/21, as of January 2021 prescribing data is only available for April -October 2020. Based on the 7 months data, the estimated annual cost pressure for NCSO is £567,214 in addition to a cost pressure of £367,788 for the associated cost pressure of increased Drug Tariff pricing for drugs prescribed. An additional cost pressure from increased costs of category M products as a consequence of DH announcement to claw back £15M per month from CCGs by increasing the cost of these drugs from June 2020. The estimated cost impact for C&H CCG for this clawback is £412,090 over June2020 to March 2021. Previous low scores were due to it these cost pressures being fully mitigated by CIPP savings delivered, each year to 2019/20, by the Meds Management team in conjunction with practices. So in previous years prescribing budget has always remained break even or underspent.	
PC10	Feb-21	Planned care team	20	Put patient experience at the centre of our delivery / High quality services for patients		There are significant financial pressures in the Adult Learning Disability service which require a sustainable solution from system partners	20	3	4	12	9	Apr-22	realigned budgets which has reduced the overspend	Sept 21 - Joint Funding work is still ongoing - independent review needs to take place /looking at how provision of services work to offer xfm even if service pressures are going up, this has been affected by the Cyberattack too. S75 meetings will provide quarterly financial updates.	Charlotte Painter	Penny Heron				Nov 21 Integrated Learning Disability Service is currently £2million overspent this financial year. This is in part as a result of extra support needs around covid (e.g. increased 1:1 support). With the current Pandemic, it's highly unlikely that savings could be made. To note - Following a paper prepared for the ICB, the budget position has improved by several million £s than in previous years; however, as end of year overspend is >£1million risk remains at 20 (red) and will likely rise to 25 by next time when overspend is certain.	

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Primary Care - PRC1	Apr-18	Primary Care Enabler Group	16	New "digital first" practices have the potential to financially destabilise local primary care by attracting a healthier cohort of patients	16	4	4	16	TBC	TBC	• Ongoing monitoring of current numbers registering with other video providers • All practices offering consultations online • All practices offering video consultations (actual volume low) • City & Hackney providing high level of extended access weekday evenings and weekends • Duty Doctor contract in place to meet same day demand • Contract in place with GPC on demand management and digital working • Digital clinical lead in post • Practice triage champions in place • NEL online registration live in majority of practices, with remainder offering a similar service through alternative means	• Practices continue to be offered support to move to a total triage way of working (to increase capacity) • Six practices are actively taking up the support package; more being encouraged to follow suit • Champions sharing knowledge with PCN member practices in three PCNs; more to follow • PCNs continue to be supported through the GPC contract to develop PCN level digital plans • GPC QI team continue to offer support to practices to run digital related QI projects • Practices to audit their websites under the CCE contract to ensure all access options are really clear • Practices to undertake demand and capacity analysis through CCE contract	Richard Bull	Richard Bull	Primary Care Enabler Group Board (PCEGB)		Escalation not required (drop down box to left not working)	5th Nov 2021: • Website self-assessment tool currently on hold pending review of Healthwatch's report on practice websites	
Primary Care - PRC2	Oct-20	Primary Care Enabler Group	15	Primary care will not be able to cope with continuing peaks of Covid, particularly where these happen alongside seasonal pressures such as winter. Practices are also under additional pressure from higher levels of demand and are suffering from burn out and fatigue. To compound the situation locum cover is scarce and is increasingly expensive. Mutual aid is becoming less and less realistic. Further demands on practices from national vaccination programmes	15	3	3	9	TBC	TBC	• Implementation of any national measures (QoF, etc) • Temporary stepping down of additional services (which can create new pressures further down the line) • In C&H additional Winter and Summer resilience funding • National Covid Capacity Expansion Fund • IT infrastructure in place for remote working eg during periods of enforced isolation • Business continuity and mutual aid plans (but in effect limited as all practices under pressure) • 2021 winter resilience funding using underspend on previous programmes • Practice reflective sessions • NEL and local staff banks	• Continued support to practice to take up the offer of Summer resilience funding • Continued support to practices from DAS and pulse oximetry service; Hot Hub on standby • Covid and flu vaccinations for primary care staff	Richard Bull	Richard Bull	Primary Care Enabler Group Board (PCEGB)		Escalation not required (drop down box to left not working)	5th Nov 2021: -Latest sit rep shows that all practices are open and are coping the best as they can -RSV predicted to be an additional pressure but we are still not seeing this in C&H -Discussion at Nov PCEGB on what else can be done to support practice -National Winter Access Fund	

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UPC8	Jun-20	Workstream	20	Recover from the pandemic and be prepared for future waves		Risk that there is an increase in non-elective acute demand - either driven by a return to normal levels of admissions or a further peak in covid demand.	16	4	3	12	12		SOC are overseeing a range of plans to strengthen community support including Neighbourhood MDTs and Primary Care Long Term Condition Management / Working with 111 to improve usage of admission avoidance pathways through SDEC and ACPs - Pathways put in place, ongoing reporting and monitoring occuring via NHSD and 111 reports Review and development of 111 CAS and onward UEC pathways is key objective of the new NEL System Resilience and SDEC subgroups - working with partners to understand and optimise patient flow and manage demand across the system, away from hospital whenever possible/appropriate. - Implementation of ED direct booking via EDDI to smooth demand - SOC are overseeing a range of plans to strengthen community support including Neighbourhood Multi-Disciplinary Teams and Primary Care Long Term Conditions Management - Working with 111 to develop admission avoidance pathways through SDEC and Appropriate Care Pathways -Winter resilience funding agreed for comprehensive range of schemes(Health, Social Care and Voluntary Sector) to support : - acute health and social care services manage predicted demand (admission avoidance, flow and discharge) - vulnerable cohorts to stay well and avoid crisis over winter -Core winter plan in place across all programmes - mitigating actions underway to address key risks identified -Ongoing oversight of system pressure via weekly SOCG meeting with agreed escalation process for managing increases in pressure.		Nina Griffith	Nina Griffith / Anna Hanbury	SOCG / NEL UEC Sub-Group	Y	To be included in report to the ICPB as high level system risk	Work with 111 and Primary care to understand and increase utilisation of 111 bookable appointments in GP practices, hubs and wider primary care community. Ensuring sufficient urgent primary care capacity available to meet demand. SDEC - pathway for direct booking from 111 in 2 priority SDEC pathways agreed and work underway to implement. Further work underway to scope increased SDEC offer including frailty. Urgent community response - working with providers to ensure delivery of the 2 hour standard including direct referral from 111/999 to support management of appropriate patients in the community. Reconfiguration work required to pilot direct booking from 111 into Paradoc,is now underway. Continued work to increase utilisation of both core ParaDoc and ParaDoc Falls service by 999, 111, primary care and telecare. November Update - Core winter plan in place and ongoing across all programmes - Funded winter resilience schemes commenced / mobilising - Ongoing oversight of system pressure via weekly SOCG Likelihood of high demand remains high but mitigations in place which will reduce the impact. Risk therefore reduced from 16 to 12.	

Title of report:	*Anticipatory Care Update & Ageing Well Recommendations, December 2021*
Date of meeting:	9th December
Lead Officer:	Nina Griffith
Author:	Leah Herridge
Committee(s):	For Decision *The Neighbourhood Providers Alliance recommended the proposals on 9th November 2021* *The System operational Command Group (SOCG) endorsed the recommendation on the 18th November 2021.* *The Neighbourhood Health and Care Board approved the recommendations on the 23rd November 2021*
Public / Non-public	Public

Executive Summary:

ICPB was previously presented with a paper and proposal for use of NHSE Ageing well monies at the October 2021 meeting. As a reminder, Ageing Well is a national programme (2021/22 – 2023/24) which aims to deliver the following three national objectives in every system:

- **Enhanced health in care homes (EHCH)**
- **Two-hour community response**
- **Anticipatory care:** Anticipatory Care is designed to support those patients who are at high risk of unwarranted health outcomes to live well and independently for longer, through structured proactive care.

Through the Ageing Well Community Service Development Fund (SDF) there is significant investment in all three of these agendas. City and Hackney have been allocated £1.14m each year until 2023/24.

The ICPB has previously reviewed a proposal for Ageing Well spend on EHCH and two-hour community response. We are now in a position to bring an update on Anticipatory Care and the first of two proposals on the use of the Ageing Well money on implementing anticipatory care in C&H.

This paper specifically covers Anticipatory Care which is being delivered as part of the Neighbourhoods Programme. In C&H, with PCNs and key community-based services, we are developing our local model of Anticipatory Care, in line with what we expect to be mandated from NHSE. By 30 September 2022, each PCN must agree a plan with local partners (including acute, community and care providers), with whom the Anticipatory Care service will be delivered jointly from 1st October 2022.

Recommendations:

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

- To **NOTE** the report;
- To **APPROVE** the proposed Ageing Well Spend on Anticipatory Care from Ageing Well Community SDF funding allocation

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

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	Focus of our Anticipatory Care work has been on supporting people living with frailty. Focus on frailty (rather than age) provides us with an effective way of identifying people who may be at greater risk of future hospitalisation, care home admission or death.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	Locally in C&H we are describing Anticipatory Care as the delivery of a community based multi-disciplinary service that proactively identifies and supports people with rising needs in the community
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	Key component of anticipatory care is an effective multi-disciplinary team to proactively identified support for those individuals
Empower patients and residents	☒	Key component of anticipatory care is undertaking a proactive needs assessment including understanding what is important to the person identified, as well as having a personalised care and support planning discussion which is focused on what matters to the person as well as their clinical, social circumstances and holistic support needs

Specific implications for City

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

Specific implications for Hackney

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

Patient and Public Involvement and Impact:

Healthwatch held resident involvement sessions to help design and shape the assessment and tools for personalised care and support planning being used in the pilot.

Clinical/practitioner input and engagement:

Proposals were worked up with the Anticipatory Care Oversight group which includes lead clinicians and practitioners in the work.

The proposals are based on findings from the Practitioner Led Case Notes Review as well as the pilot which is being delivered by clinicians and practitioners from health, adult social care and the voluntary sector.

Communications and engagement:

In working up the final model for anticipatory care we will continue to consult with patient representatives via Healthwatch and key system partners, including PCNs, Acute and Community Health Services, Voluntary Sector and Adult Social Care. As part of the evaluation of the pilot taking place in January 2022, an independent researcher will be interviewing practitioners involved in the multi-agency approach and a sample of patients who have been through the pilot.

Comms Sign-off
We will be working with the Communications Lead in the Neighbourhood Programme to set out what Anticipatory Care is, and how the Neighbourhoods Programme is working with system partners to shape what the future model will look like in C&H.

Equalities implications and impact on priority groups:

As part of the pilot we are aiming to have a better understanding for the reasons why some patients have chosen not to take up the offer, and consider whether advocacy needs to be a component of the pathway. When considering cohorts to work with under the anticipatory care pathway, PCNs are reviewing health inequalities data to identify whether any specific groups should be focussed on.

Safeguarding implications:

Not applicable

Impact on / Overlap with Existing Services:

We will understand from the pilot the extent of unmet need and what implication this may have on an increase in referrals to existing services, and consider where a case is demonstrated whether Ageing well funding should be used to support the provision of capacity required for key services.
We will work to align the primary care Proactive Care Contracts to the Anticipatory Care Model.

Supporting Papers and Evidence:

1. Anticipatory Care Draft Pathway
2. Case Notes Review
3. Evaluation Framework

Sign-off:

This proposal has already been signed off by the System Operational Command Group, the Neighbourhoods Health and Care Board and the CCG Finance Sub-committee
As such it has full sign off from all of the constituent partners in the borough.

Integrated Care Programme Board – Anticipatory Care Update & Ageing Well Recommendations, December 2021

1. Context & Timescales

ICPB was previously presented with a paper and proposal for use of NHSE Ageing well monies at the October 2021 meeting. As a reminder, Ageing Well is a national programme (2021/22 – 2023/24) which aims to deliver the following three national objectives in every system:

- **Enhanced health in care homes (EHCH)**
- **Two-hour community response**
- **Anticipatory care:** Anticipatory Care is designed to support those patients who are at high risk of unwarranted health outcomes to live well and independently for longer, through structured proactive care.

Through the Ageing Well Community Service Development Fund (SDF) there is significant investment in all three of these agendas. City and Hackney have been allocated £1.14m each year until 2023/24.

The ICPB has previously reviewed a proposal for Ageing Well spend on EHCH and two-hour community response. We are now in a position to bring an update on Anticipatory Care and the first of two proposals on the use of the Ageing Well money on implementing anticipatory care in C&H.

This paper specifically covers Anticipatory Care which is being delivered as part of the Neighbourhoods Programme.

Key Timescales – DES Delivery

(i) **By 30 September 2022**, each PCN must agree a plan with local partners (including acute, community and care providers), with whom the Anticipatory Care service will be delivered jointly.
(ii) **By 1 October 2022**, each PCN must have, in partnership with relevant local providers, commenced the operation of the service in line with the agreed plan.

Key Timescales – Anticipatory Care Programme

In C&H, with PCNs and key community-based services, we are developing our local model of Anticipatory Care, in line with what we expect to be mandated from NHSE (the operating guidance is expected to be released in Q4 2021/22 and at the very latest by March 2022). We have kept in close contact with NHS England and we are confident that our current draft pathway will meet the expected demands of the DES and the key components Anticipatory Care. In order to develop our local model, we are testing our approach in a pilot in Springfield PCN.

- Pilot September 2021 – March 2022
- Pilot Evaluation January – February 2022
- **Recommended Anticipatory Care Model - March 2022**
- **Ageing Well Spend Agreed for Anticipatory Care Model - March 2022**
- Align Proactive Care Contracts to Support Anticipatory Care - April 2022
- **Staged Roll out of Model to All Neighbourhoods – April 2022 to September 2022**

2. Anticipatory Care (AC) & What it Means Locally in C&H

(a) AC Key Components

Locally in C&H we are describing Anticipatory Care as the delivery of a community based multi-disciplinary service that proactively identifies and supports people with rising needs in the community. Whilst the national requirements for anticipatory care have not yet been released we are expecting that it will require five key areas to be delivered and have included those key components with the pilot model:

Key Components of AC	Inclusion within our Draft Pathway
Population Cohort Identification: Identifying the cohorts that will benefit most from proactive care in the community	Current focus on frailty - over 65s with 3+ LTCs with an eFI (electronic frailty index) score of moderate (0.23 – 0.36) or severe (<0.36) frailty
Proactive Care Needs Assessment: Undertaking a proactive needs assessment including understanding what is important to the person identified	Care Coordinator carries out holistic telephone assessment including clinical frailty diagnosis (using Rockwood Scale), what matters to me conversation and further assessment questions based on mini CGA
Multi-Disciplinary Teams: An effective multi-disciplinary team to proactively identified support for those individuals	A fortnightly hour long 'huddle' with care coordinator, social prescribing, mental health, geriatrician, adult social care, therapies
Personalised Care and Support Planning: Having a personalised care and support planning discussion which is focused on what matters to the person as well as their clinical, social circumstances and holistic support needs	Personalised Care and Support Plan worked up between Care Coordinator and resident. Currently saved on EMIS but not accessible to system. Digital will be a key enabler for PCSP to be shared with services & patient
Care Coordination: The care coordinator role will ensure patient health and care planning is timely, efficient, and patient-centred. The role will include responsibilities for the coordination of the patient's journey. The care coordination role is part of the Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS).	As part of the pilot we have recruited a full time Care Coordinator employed by Homerton Hospital

(b) AC Cohort - Frailty

Central to the work in developing the model is identifying the cohort(s) that will benefit most from proactive care, and have unmet need identified which can be supported through the anticipatory care pathway. In terms of cohort, so far NHSE have said that this is likely to be *predominantly, but not necessarily exclusively, older people living with frailty, may also include those living with multi-morbidity or those who are frequent users of health and care provision. The cohort will exclude those who are care home residents, who are supported through the Enhanced Health in Care Homes arrangements.*

Locally, to date the focus of our Anticipatory Care work has been on supporting people living with frailty. Frailty is where someone is less able to cope and recover from accidents, physical illness or other stressful events. It should be treated as a long-term condition throughout adult life. Focus on frailty (rather than age) provides us with an effective way of identifying people who may be at greater risk of future hospitalisation, care home admission or death. Furthermore, it is associated with a series of evidence-based assessments and interventions, for example, falls risk assessment, medicines optimisation and cognitive assessment, with consideration of modifiable psychosocial and environmental factors also being important.

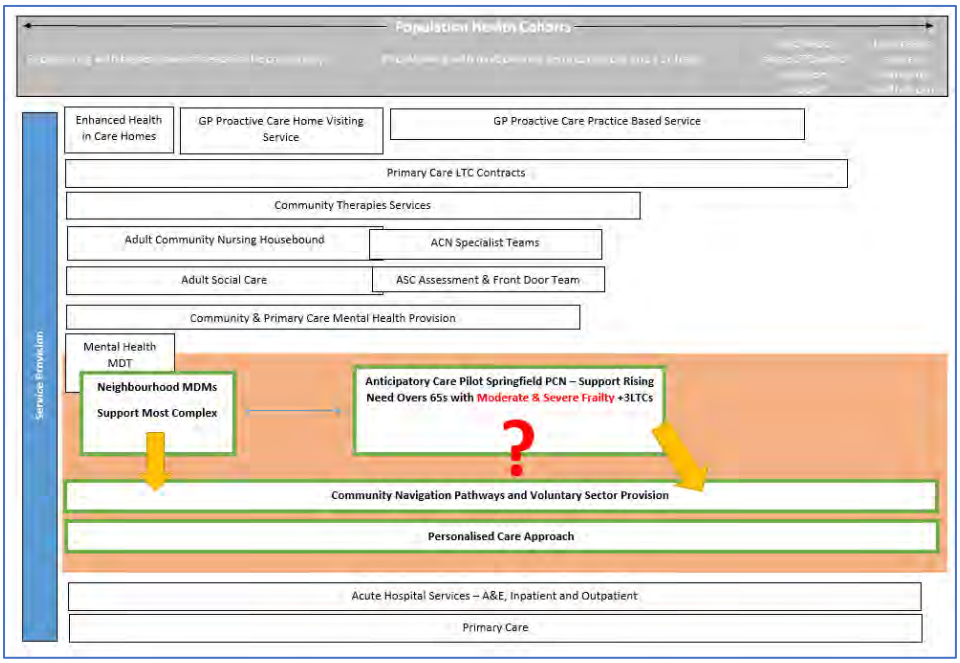
The pilot originally set out with a criteria of over 65s with 3+LTCs and an eFI (electronic frailty index) score of moderate frailty (0.25 – 0.36). This is a predicted frailty diagnosis of moderately frail. The vast majority of patients falling into this criteria have been referred into community navigation services and stepped down from the service. We have therefore recently extended the criteria for the pilot to now include patients with an eFI score of both moderate and severe (<0.36) frailty. Over the last couple of weeks we have focussed on patients with an eFI of severe frailty and so far, patients, whilst patients have been diagnosed with moderate frailty post assessment, there has been more unmet need identified, benefit in multi-agency discussion and recommended work up of full personalised care and support plans with case management. While further learning is needed from the pilot, and wider engagement with system partners, there is more confidence that we are identifying suitable patients for anticipatory care.

There is ongoing work to engage with all PCNs to support their delivery of Anticipatory Care, where possible developing a consistent service delivered across all Neighbourhoods, but with a degree of flexibility to adapt to local needs. Whilst the majority of PCNs are supportive of working with frailty as the cohort of Anticipatory Care, **there is the potential risk that individual PCNs will wish to focus on different areas. This presents the risk that there is insufficient cohesion to develop a scalable model**. Learning from the pilot, and the evidence base nationally, we are working through with PCNs and

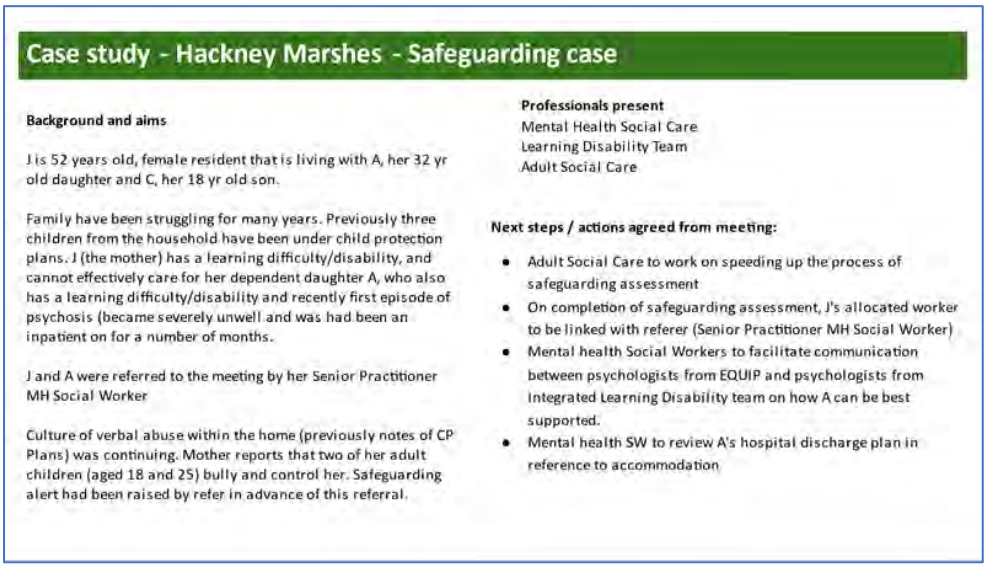
key community services what advantages and disadvantages of supporting different cohorts, whilst trying to develop a model that enables some flexibility, but is scalable across all PCNs.

(c) Neighbourhood Multi-disciplinary Meeting (MDMs)

The drawing below explores where Anticipatory Care sits within our own local system and in particular its relationship with Neighbourhood MDMs. It is helpful to distinguish between the cohort referred into Neighbourhood MDMs and the expected cohort under the Anticipatory Care pathway which is likely to focus on frailty. Both Neighbourhood MDMs and the Anticipatory Care Pilot will identify patients suitable for Community Navigation Pathways.



The cohort support by Neighbourhood MDMs, tends to be a younger cohort, with an average age of 63, but with over half this number appearing in the 0-65 years of age bracket. Patients discussed at MDMs tend to require more specialist input, for example from housing, and have higher levels of social complexity. The MDMs arose from previous safeguarding adult reviews having highlighted challenges with multi-agency working. These residents and their families may have serious unmanaged conditions and be falling between the gaps of multiple services, they may also be experiencing recurrent crises or frequent incident reports. An example of a typical case discussed at a Neighbourhood MDM is set out below:



Case study - Hackney Marshes - Safeguarding case

Background and aims

J is 52 years old, female resident that is living with A, her 32 yr old daughter and C, her 18 yr old son.

Family have been struggling for many years. Previously three children from the household have been under child protection plans. J (the mother) has a learning difficulty/disability, and cannot effectively care for her dependent daughter A, who also has a learning difficulty/disability and recently first episode of psychosis (became severely unwell and was had been an inpatient on for a number of months.

J and A were referred to the meeting by her Senior Practitioner MH Social Worker

Culture of verbal abuse within the home (previously notes of CP Plans) was continuing. Mother reports that two of her adult children (aged 18 and 25) bully and control her. Safeguarding alert had been raised by refer in advance of this referral.

Professionals present
Mental Health Social Care
Learning Disability Team
Adult Social Care

Next steps / actions agreed from meeting:

- Adult Social Care to work on speeding up the process of safeguarding assessment
- On completion of safeguarding assessment, J's allocated worker to be linked with referer (Senior Practitioner MH Social Worker)
- Mental health Social Workers to facilitate communication between psychologists from EQUIP and psychologists from Integrated Learning Disability team on how A can be best supported.
- Mental health SW to review A's hospital discharge plan in reference to accommodation

(d) Neighbourhood MDMs versus Anticipatory Care Huddle

The MDMs and the AC Huddle are both multi-agency discussions which operate on a neighbourhood footprint. The table below provides a summary of each, both aim to keep what is important to resident central to discussions.

Where patient requires more complex discussion with specialist input, theoretically a resident could be referred from anticipatory care into MDM, however we have yet to test how this works in practice in the pilot as it has not yet been required.

	Neighbourhood MDMs	**Anticipatory Care Huddle**
Frequency	Monthly	Fortnightly
Membership	Specialist input brought in tailored to resident concerns	Core Huddle Members
Complexity	For complex residents requiring in depth multi-professional discussion including specific professionals who know the resident	Lower complexity residents (eFI moderate – severe frailty + 3LTCs)
Situation	Usually in crisis/about to enter crisis & usually known to most community services	Not in crisis/close to crisis. Residents not usually known to multiple services
Discussion Time	20 discussion per patient	Discussion short and focussed. Aiming for up to 10 minute discussion per patient (testing if feasible in pilot)
Discussion Focus	Some actions/referrals may be generated but usually around problem solving/having conversation with correct professionals/shared responsibility of risk	Discussion whether resident requires CGA, medication review, falls assessment (evidence based interventions for frailty) and support required. Action focussed on what may benefit resident.
Responsibility	Resident handed back to referrer after MDM. Not role of MDM to case manage	Resident case managed by care co-ordinator where applicable
Post Huddle	No care plan generated	Care plan generated

(e) AC & Neighbourhood Structures

When we talk about Neighbourhoods in C&H, it isn't a single service, pathway or a specific organisation, it's a structure, and a way of working, and it lays the foundations for better integration and multi-agency working.

Anticipatory care is being piloted in Springfield PCN. To date, the pilot has focussed on Spring Hill Practice, but will be rolled out to Cranwich Road Practice (15th November) and Stamford Hill Practice (29th November). The Anticipatory Care Service / Pathway being developed will operate on a Neighbourhood footprint, as does the Neighbourhood MDMs.

3. Key Pilot Update

We are testing the draft pathway, and are taking a test and learn approach, making amendments to the pathway as we progress based on how the pathway has worked practically on the ground. Homerton will provide QI support into the pilot from mid-November.

Key Headlines

- Utilising non-recurrent Ageing Well funds we recruited to a 6-month Care Coordinator post specifically for the pilot and they started on the 20th of September 2021.
- Anticipatory Care Coding Template created on EMIS with CEG
- Documents finalised for pilot (e.g. letter & leaflet to residents, assessment, Personalised Care and Support Plan PCSP) updated following resident feedback & learning from pilot
- Proactive Needs Assessment with 21 residents from Spring Hill Practice (eFI moderate & severe), all but one over telephone and one f2f

- A further 18 residents have not been contactable (various reasons, no answers via letter or telephone or via NoK, patient abroad etc)
- A further 8 residents have declined and 1 resident identified from EMIS search has been determined to be inappropriate by GP as no unmet need and so patient not contacted
- All residents to date have, after assessment, been given a moderate frailty diagnosis
- 8 huddle discussions held virtually over MS Teams
- Recruitment of PCN wide Clinical Lead for Pilot (Dr Ciara Yeates)
- Approximately 50% of calls have needed interpretation and translation via language line

4. Key Learning to Date

During October we undertook a Case Notes Review on 27 patients to supplement the learning from the pilot, which will help to inform our local anticipatory care model across all of C&H and future investment decisions. The purpose of the case notes review was:

- To understand the extent to which patients are already known to existing community, mental health and social care teams
- To have a clinical & practitioner assessment of what support & interventions these patients may have benefited from or patients in a similar cohort could benefit from in the future in order to stay healthy, independent & happy longer

Together with the learning from the pilot, our current recommendations are detailed in the table below. However there is still significant learning to come out of the pilot and further engagement with both PCNs and key services which will inform the recommended model and accompanying investment proposals.

Area	Recommendations
Culture Shift	A lack of careful consideration and early attention to culture risks the capability of Anticipatory Care being effectively embedded and sustainable. Ensure the programme focuses and specifically combines work on culture amongst services alongside the development of the model. **Work up proposal on how we facilitate a culture shift across the system**, including • The case notes review highlighted the restraints practitioners across the system have in thinking in an 'anticipatory way' supporting patients with rising need, earlier, not just when they hit crisis point, and putting in place support or interventions which may better support, slow or prevent expected deterioration. The foundations must be right for pathway to work successfully. • The case notes review of moderately & severely frail patients has highlighted how little we know about what matters to the patient. We need to consider how across the system we can ensure that the patient's voice is listened to, heard & acted upon. Embedding personalised care within mainstream provision, including digitally shared care planning and understanding what really matters to the patient (eg. ensuring that non-medical holistic discussions are taking place where time has been funded for more in depth discussion such as proactive care services in primary care) • Thinking how practitioners work together differently across the system in a more joined up way
Robust Identification of Cohort	Ensuring that we **identify patients who will most benefit from the pathway** and where we will best utilise the skills and resource available is vital. One of the biggest challenges of this programme of work is to identify which cohort(s) we should consider locally. Learning from the pilot and case notes review should feed into decisions on this, including - The pilot has identified that the majority of patients under original pilot criteria of eFI of moderate frailty were managing well either in primary care or under a specialist service. Referral to community navigation / voluntary sector provision most common outcome. Early hypothesis that patients with an eFI score of moderate frailty may be best met by strengthening our voluntary sector provision & moving away from medical model. For the pilot we have

	now extended our criteria to include patients with an eFI score of severe frailty and will focus on this cohort over the coming weeks while we consolidate learning. - The case notes review showed a slightly higher proportion of patients who were diagnosed as severely frail versus moderately frail considered as potentially benefitting from Anticipatory Care, although numbers small and not huge difference. - Discussion with practitioners has identified that there is significant variation within eFI moderate frailty and this requires more detailed breakdown before being helpful indicator. - Both the pilot and case notes review has identified a potential duplication of work with Dementia Team in both multi-agency discussion and care coordination. Further exploration is required to understand risk of duplication and whether dementia patients would be excluded from AC search criteria. - The case notes review identified that some severely frail patients are too complex for the AC pathway and required tailored Neighbourhood MDM support. Explore whether there is an optimum eFI severely frail score which most likely to include patients suited to AC pathway. - The case notes review identified that for some patients under Proactive Care Home Visiting PCHV with intensive GP support, in essence already had a care coordinator in place. Explore whether patients already under PCHV should automatically be included within the AC search criteria or whether this would be referral in on a case by case basis. - The case notes review identified that Anticipatory Care is likely to be beneficial to support someone who might end up caught between services, eg. Borderline memory, pain, never quite meeting thresholds but clearly needing support. Consider how we can better identify this cohort. - The case notes review identified a number of housebound patients which were considered appropriate for the AC pathway. Consideration of whether housebound should be included in the model (not currently being tested in pilot, although this can change) is needed. - The case notes review identified that for those patients that were considered as likely benefitting from AC pathway, they were more likely to be patients that had lower attendance at primary care (average of 12 per annum) versus those which had higher attendance in primary care (average of 21 per annum). Consider whether healthcare utilisation should be an indicator used to identify appropriate cohort.
Triage	Given that many of the patients with eFI moderate frailty seen so far in the pilot have been managing well and often unmet need difficult to identify, it has shown the importance of robust identification & triage of patients for the pathway (patients who will benefit most from pathway). Even when using frailty diagnosis (not eFI scoring) the case notes review showed that only 52% considered appropriate for anticipatory care. **Ensuring that we have timely and effective triage of patients identified as potential is key to ensuring that we use scarce resource as well as possible.** This triage may be something that requires clinical input early in the pathway and could not be managed solely by the care coordinator (band 4). Two stages of triage may be required, (i) identification of those patient meeting search criteria which should be invited to the pathway, and (ii) decision on which patients must be discussed by the huddle versus which patients can be managed outside of the huddle by predominantly by a care coordinator.
Clinical Supervision / Training for Care Coordinators	Early on from the pilot we have identified that clinical supervision/training for care co-ordinators if they remain band 4 (as some discussions with residents who have severe frailty can be complex) is absolutely key to the success of the pathway. Currently a geriatrician is providing support to the care coordinator, this was not factored into the pilot originally. It has been discussed that a senior therapist may be most appropriate role to provide support in a future model.

Administrative Time	Administrative time was not factored into the pilot model and we have learnt quickly that this is required. Likely admin role needed alongside care co-ordinator to allow maximum number of residents to be case managed.
Community Navigation Pathways	Many patients discussed in the pilot were not necessarily suitable for statutory health and social care services but would benefit from the holistic, person centred and non-medical support that community navigation pathways can offer. Furthermore patients that have been considered appropriate for statutory provision have been assessed as benefiting from non-medical support. Absolutely key that we ensure that links into the Community Navigation pathways are strengthened and that services included have a sustainable offer. Nearly two thirds of patients discussed in the case notes review were considered as potentially benefiting from social prescription. It is recommended that based on the case notes review and pilot, expected demand for the service should be modelled to consider if sufficient capacity is within the system.
Components of the Pathway	The case notes review challenged idea that all patients will receive full anticipatory care package, it is clear that some patients only need specific components. Pathway needs to be developed in a way in order to allow for a tailored approach for each patient. As part of this there needs to be considerable thought into how one-off referrals into Neighbourhood MDMs and our Anticipatory Care pathway alongside one another and feed into one another where applicable.
Mental Health Transformation work & Attendance at Huddle	Mental health assessment for a variety of services, as well as potential referrals into IAPT made up a large proportion of suggestions for interventions which may be beneficial. Central to the work in development of an Anticipatory Care pathway for predominantly but not exclusively older adults must include consideration of the mental health transformation work being undertaken at a NEL level. Development of an over 65 mental health neighbourhood MDT model is currently at the early stage of discussions. We must understand the cross over between provision of support. Given the level of mental health need identified, ensuring that we have the right mental health practitioner involvement in the huddle is key. We are in the process of liaising with colleagues in mental health to explore this further.
Framing Anticipatory Care to Patients	The case notes review discussion raised a key challenge of anticipatory care, how to convey a message to the patient that they may benefit from proactive care and support even though they might not feel that they need it now. To ensure that we come up with a model which has higher level of engagements, particularly when working with harder to reach groups, as part of the pilot we need to consider testing how we frame this in a way which is palatable for the patient and effective in encouraging the patient to participate.
Comprehensive Geriatric Assessment	Since we have expanded the cohort to eFI severely frail there have been a number of patients who would benefit from a comprehensive geriatric assessment, however the patients have not been under existing statutory services and so are not on relevant caseloads. Consideration needs to be given as to how CGAs will be delivered, where and by whom, as well as what resource and training will be needed for this.
Capacity within Key Statutory Services	Since we have expanded the cohort to eFI severely frail there have been a number of patients who would benefit from referral to statutory provision, however referral times for these services may be significant. If we are working with patients with rising need and aim to intervene earlier then we need to consider what resources will be required to take on new patients from the AC pathway.
Resources to Carry out Actions generated	Since expanded the cohort to eFI severely frail we have found that there is often work generated for Primary Care post Huddle discussion. In order to support Primary Care to manage this, **alignment of the Proactive Care Services** to the AC pathway is essential.
System Approach to Frailty	The case notes review identified that if we proceed with frailty as the cohort for AC, we should consider a whole system approach to frailty. Frailty is currently being being tested in A&E, utilised in Therapies, and there is a frailty pathway in SDEC (same day emergency care), and it is likely that many other services focus on functional assessment but may not use the same terminology. Consistent use of frailty across C&H in assessment and measurement will support a patient's frailty to be tracked and supported accordingly dependent on their frailty diagnosis.

5. Ageing Well Money - Proposals

This section presents initial proposals for the use of the **Ageing Well Community Service Development Fund (SDF)** on Anticipatory Care. The System operational Command Group (SOCG) endorsed the recommendation on the 18th November 2021. The Neighbourhood Health and Care Board approves the recommendations on the 23rd November.

Via the Community SDF a significant amount of money has been committed nationally to support delivery of Ageing Well. Whilst NHSE have been clear that the **money is intended for community services**, they have not provided further definition on this, therefore the money could be invested in NHS, voluntary and independent sector services.

This amounts to £9.4m in NEL in 2021/22, with an ongoing funding commitment until 2023/24. From this, City and Hackney have been allocated £1.14m in 21/22. Given anticipatory care is not yet defined by NHSE, it was agreed by SOC **that £500,000 per annum from Ageing Well Funding has been held back to support Anticipatory Care.**

Given that the anticipatory care operating guidance is still under development by NHSE & the pilot in Springfield PCN is recently underway, to ensure that we can optimise learning, it is proposed that at this stage we set out an initial ask for how we utilise the funding for the current financial year (2021/22), and future years where possible. Given, the stage of the pilot, we are not yet in a position to define the full use of the funds, and will return to system partners before year end with a proposal. However at this stage the key areas of potential investment are emerging, including

- If we are going to roll out the Huddle pilot approach, from discussions with key services, to ensure a sustainable model we will need to resource the huddle.
- Investment in community based services where we find that there will be insufficient demand to meet a projected rise in referrals
- Infrastructure for supporting the care coordinators including supervision & administrative support
- Delivery of comprehensive geriatric assessments where required

We expect that there may be a small amount of additional funding for primary care via a Primary Care Network (PCN) Direct Enhanced Service (DES) contract from NHSE. There has been an expectation that PCNs also use the Additional Roles Reimbursement Scheme (ARRS) posts to support delivery of these agendas. We envisage being in a position to supplement any DES funding locally though existing and ongoing underspends on the Proactive Care Practice Based contracts. We are working with the GP Confederation to ensure that the Proactive Care Contracts aligns to and supports the AC model.

Proposal 1: Funding Neighbourhood MDMs

Neighbourhood MDMs are not part of Anticipatory Care but are a complimentary ‘service / pathway’ within the Neighbourhood structure. Previously agreed funding ends on 31st December 2021/22 and Ageing Well Funding will ensure we can fund from 1st January 2022 to the end of March 2024.

Engagement with stakeholders, and review of patients both in the pilot and the case notes review, demonstrates that monthly Neighbourhood MDMS are still needed in addition to the Anticipatory Care Pathway & serve a more complex cohort with specialist input into a patient’s care.

Feedback from the Neighbourhood MDM’s has been extremely positive, bringing together the right people involved in supporting the residents to agree actions and foster closer working relationships. Effective leadership and designated resource to chair meetings has enabled them to grow and develop, with a structure that supports accountability and a commitment from members. We have heard from practitioners they believe the MDM’s have helped foster a sense of shared responsibility, they have made connections with each other that would have been impossible before. In addition, they tell they have learnt a great deal about each other’s roles and approaches to supporting residents.

The Central Neighbourhood Team have worked with Homerton colleagues to draw up a plan for how these roles and function can be hosted by Homerton Hospital. Homerton have acknowledged that the full 0.6 WTE is unlikely to be required for management of two administrators only, however will provide

administrator cover for annual lave and sick leave and be utilised broadly across Ageing Well to support evaluation and data collection, implementation of projects and potentially provide administrative support for care coordinators if in the future they were employed by the Homerton.

		Q4 2021/22 Delivery	2022/23 Delivery - *funded from 2020/21* money	2022/23 Delivery	2023/24 Delivery
Management / Support	0.6 wte b5 admin	£6,048	£24,193	NA	TBC
MDM chairs	various	£4,500		£18,000	£18,000
Administrators	2 x b4	£17,997		£71,990	£71,990
Nonpay – Start Up Costs	laptops/phones/cpd	£2,000		NA	NA
overheads	10%	£3,054	£2,419	£8,999	£8,999
	TOTAL	**£33,599**	**£26,612**	**£98,989**	**£98,989**

Proposal 2: Single Point of Access (SPOA) for Community Navigation

The early learnings of the pilot, and learnings from the case notes review, has demonstrated the importance of holistic and non-medical support that community navigation pathways can offer. And has highlighted that for Anticipatory Care to successfully offer a proactive and person-centred approach it is key that we ensure that links into the voluntary sector are strengthened and that the services themselves can build a sustainable offer.

The proposal is to fund Single Point of Access (SPOA) for Community Navigation for 12 months from April 2022 at £153,000. This will be provided by Shoreditch Trust. This would be using accrued 2021/22 Ageing Well money and will be funded for 2022/23 only.

The proposal builds on learning from work led by Shoreditch Trust as part of the COVID-19 humanitarian response. A clear pathway to community navigation support will be provided for key services (including Adult Social Care, Community Nursing, Community Therapies) where this is currently lacking. They will have an option of a single 'front door' through which people can access a range of community navigation provision. A further year is needed to test, deliver sustainability & understand costs going forward. It is not clear at this stage where recurrent funding will come from for future provision but a pilot period is needed to build stronger case & clearer position.

	Q4 2021/22 Delivery	2022/23 Delivery - *funded from 2020/21* money	2022/23 Delivery	2023/24 Delivery
SPOA 12 Months **Shoreditch Trust**	NA	£153,000	NA	NA

Proposal 3: Advocacy

The Anticipatory Care Oversight Group were in support of testing whether Advocacy is needed as part of the Anticipatory Care pathway. However, at this early stage it was not clear where within the pilot, an advocate would be most beneficial. Voluntary Sector representation has suggested that the best approach currently will be too ensure that we gather intelligence over the course of the pilot to inform if and how advocacy could benefit the Anticipatory Care pathway or more broadly be part of neighbourhood structures.

Age UK have a trained advocate in Springfield PCN where the Anticipatory Care pilot is taking place. The Proposal is that Age UK is funded for half a day a fortnight for the duration of the pilot (up until end of March 2022) to undertake the following activities:

- Attendance at the fortnightly huddle meeting where the advocate can (i) make suggestions as to where existing advocacy services may benefit the patient being discussed (ii) allow the system to gain a better understanding on where and when in the pathway advocacy may be beneficial
- Meet with the care coordinator at agreed points in time to consider those patients that have not engaged or not been possible to contact and consider how an advocate or another practitioner may work to better engage patients. The care coordinator would not have capacity to implement these ideas within the pilot, but Age UK will use this intelligence gathered to make recommendations on how non-engagers can be better supported in the future model
- Work up, aligned to anticipatory care timescales, a proposal, if the intelligence suggests a need for it, on how and when advocacy could be beneficial within the pathway or based within neighbourhoods more broadly

The cost of funding an advocate in Age UK fortnightly for the duration of the huddle, including NI and overheads is **£796 (November 2021 – March 2022**).

	Q4 2021/22 Delivery	**2022/23 Delivery - *funded from 2020/21* money**	**2022/23 Delivery**	**2023/24 Delivery**
Age UK Advocate	£796	NA	NA	NA

Proposal 4: Culture Shift OD Work

Culture and ethos are fundamental to the success of the Anticipatory Care model, and the case notes review really highlighted the importance in a shift of thinking and ways of working including 'thinking and acting proactively', 'delivering personalised care which has at its heart what is important to the resident' and 'working in a much more joined up way with other services and professionals'.

A full proposal on this has not yet been worked up, but failing to give careful consideration and early attention to culture, risks the capability of Anticipatory Care being effectively embedded and sustainable. The proposal is that the programme focuses on culture shift, combining this work alongside the development of the model. Development of this work could either be funded through 2021/2022 Ageing Well money, and / or could be supported by the wider Neighbourhood Workforce Enabler Programme.

Proposal 5: Anticipatory Care Project Support

The following project support is required for delivery of the Anticipatory Care Programme.

Post	**WTE**	**Q4 2021/22 Delivery**	**2022/23 Delivery - *funded from 2020/21* money**	**2022/23 Delivery**	**2023/24 Delivery**
Occupational Therapist – work up of Therapies input in AC Model**	0.6 B8a WTE	£16,587			
Geriatrician Lead	0.3 WTE		£33,107*		
Therapies Lead	0.14 WTE		£10,615*		
Project Manager	1.0 WTE		£75,000*		
Total		**£16,587**	**£118,722**	**NA**	**NA**

*Costs have been based on 21/22 neighbourhood costs **London weighting + 10% overheads

Summary of Proposed Spend

Proposal	Q4 2021/22 Delivery	2022/23 Delivery - *Funded from 2020/21* money	2022/23 Delivery	2023/24 Delivery
Proposal 1 Neighbourhood MDMS	£33,599	£26,612	£98,989	£98,989
Proposal 2 SPOA	NA	£153,000	NA	NA
Proposal 3 Advocacy	£796	NA	NA	NA
Proposal 4 OD Culture Shift	tbc	tbc	tbc	tbc
Proposal 5 Anticipatory Care Project Support	£16,587	£118,722	tbc	tbc
Total	**£50,982**	**£298,334**	**£98,989**	**£98,989**
Total Spend 2021/22 against £500K Allocation	**£349,316**			

Any underspend on the 2021/22 Anticipatory Care Ageing Well Allocation will be considered as part of the full suite of Ageing Well funding and proposals brought to SOC & NHCB in December for consideration.

We are working towards setting out our **recommended model of Anticipatory Care by end of March 2022** along with our **proposed investment plans for 2022/23 & 2023/24**, and will return to SOC & NHCB at this point.

6. Evaluation Framework & Plan

An Evaluation Framework which builds on the work completed by Cordis Bright sets out the key questions which we need to answer in order to confidently develop our local Anticipatory Care model and the range of sources which will be used to do this. A further evaluation will need to be planned and undertaken in order to measure impact once the model has been in place over the two-year period.

7. Summary of Request to ICPB

ICPB are asked to (i) note the recommendations on the development of the model to date & (ii) approve the proposed Ageing Well Spend on Anticipatory Care

Anticipatory Care Evaluation Framework

1. Background

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

- Enhanced health in care homes: Providing proactive primary and community health care services to residents in care homes, including regular MDTs and a weekly primary care round
- 2 hour community response: Delivering a community based rapid response service that will support people in their own homes within two hours of referral
- **Anticipatory care:** Delivering a community based multi-disciplinary service that proactively identifies and supports people with rising needs in the community. So far NHSE have said that this is likely to be *predominantly, but not necessarily exclusively, older people living with frailty, may also include those living with multi-morbidity or those who are frequent users of health and care provision. The cohort will exclude those who are care home residents, who are supported through the Enhanced Health in Care Homes arrangements*

ICSs have lead responsibility for coordination of Anticipatory Care for their system. By 30 September 2022, each PCN must agree a plan with their ICS and local partners (including acute, community and care providers), with whom the Anticipatory Care service will be delivered jointly. By 1 October 2022, each PCN must have, in partnership with relevant local providers, commenced the operation of the service in line with the agreed plan.

In C&H we are developing our local model of Anticipatory Care, in line with what we expect to be mandated from NHSE (the operating guidance is expected to be released at the very latest by March 2022). In order to do this we are testing our approach in a pilot in one PCN, with the pilot fully operational from October 2021 to March 2022. As part of the pilot we have recruited a full time Care Coordinator.

An evaluation of the pilot will be delivered by the end of January 2022, including data from October 2021 to the end of December. The estimated number of patients which will have been through the pilot anticipatory care service by the time of the evaluation is 40. The pilot evaluation will need to take place at this time in order to feed into the development of our local Anticipatory Care Model and recommendations on utilising of Ageing Well Funding to support the model, by the end of March 2022. The remainder of the pilot will be used to further test and refine details of the pathway.

Given the length of the pilot, the evaluation will be solely based on extracting learning from the implementation of the pilot, but will not include resident outcomes (due to short timescales).

2. What can we use for the evaluation?

Given the small number of patients that will have been through the pilot at the point of evaluation it is important that we pull on a wide range of resources, including those outside of the pilot itself to support our learning:

- Springfield Park Pilot pathway activity (pilot activity is being coded on an Anticipatory Care EMIS template with SNOWMED codes, as well as a patient monitoring spreadsheet for data which cannot be coded on EMIS)
- Pilot Case Studies / Vignettes
- Interviews with a sample of patients involved in the pilot (either on a 1:1 basis and/or as a group discussion)
- Interviews with MDT members in the pilot (either on a 1:1 basis and/or as a group discussion)
- Interviews with practitioners working Spring Hill GP Practice (majority of patients in pilot will be registered at Spring Hill)
- Case Notes Review which included multi-disciplinary discussion of 27 patients who had either a moderate or severe frailty diagnosis recorded on EMIS and considered if and how anticipatory may have supported them or could support now.

- Proactive Care Services (delivered by each GP Practice) Desk Based Review (better understand alignment of anticipatory care with GP proactive care provision
- Published Research & Evidence on Anticipatory Care
- Best practice & examples of delivery of anticipatory care from elsewhere in the country
- Population Health Data (where available)
- CEG EMIS Data
- Stakeholder Engagement with PCNs and System Partners (Voluntary Sector, Adult Social Care, Mental Health, Community Therapies, Community Nursing, Community Geriatricians)
- PCNs learning where Care Coordinator already recruited
- NHS E Guidance and Anticipatory Care Operating Model (due to be released q4 2021/22)

3. Evaluation Questions

The section below sets out what we need to answer via the evaluation in order to inform a recommended model of anticipatory care.

The sub-questions set out how we will answer the questions.

Area	**Population health Management**	**Source**
Question 1	**Which cohort(s) of patients will benefit most from anticipatory care? Where should our focus be?**	**Multiple**
Sub-questions	***Shaping the Pathway***	
	How are we defining anticipatory care?	• Research & Evidence • Best Practice • Stakeholder Engagement • NHS E Guidance
	How are we hoping this will benefit patients?	• Research & Evidence • Stakeholder Engagement
	Can we articulate the differences between community navigation and the care coordinator role and which role is most suited to which cohort?	• Stakeholder Engagement • NHS E Guidance
	What tools / methods are helpful in identifying patients that might be suitable?	• Pilot Activity • Case Notes Review • Research & Evidence • Best Practice • Stakeholder Engagement
	How much should identification be led by clinical insight and how much by tools available (is there a good enough understanding of anticipatory care to do this?)	• Pilot Activity • Interviews with GP Practice staff
	What triage process do we need in place?	• Pilot Activity • Interviews with GP Practice staff • Discussions with huddle members
	Is there a spectrum of patients (with different needs) that we can support in an anticipatory way?	• Pilot Activity • Case notes review
	Can patients be referred into the pathway or are they identified via segmentation and cohort identification?	• Case notes review • Stakeholder engagement
	Do we have the right data to understand enough about our population with ‘rising need’?	• Population Health Data
	How might this work affect health inequalities (positively or negatively)? What specific actions might we need to	• Pilot Activity • Population Health Data

	take to address health inequalities and the needs of groups/communities with protected characteristics?	
	Learning from the Pilot	
	What unmet need has been identified in the pilot cohort?	• Pilot Activity • Pilot Case Studies • Case notes review • Proactive Care Desk Based Review
	Which patients have only needed referrals or signposting to community navigation pathways? If majority of patients are only needing referrals or sign posting have we identified the right cohort?	• Pilot Activity • Case notes review • Stakeholder Engagement
	Which patients have been identified as needing evidence based support or interventions & personalised care and support planning?	• Pilot Activity • Case notes review • Interviews with MDT members • Interviews with patients
	Which patients have been considered appropriate for multi-agency discussion / huddle?	• Pilot Activity • Case notes review • Interviews with huddle members
	Which patients have been considered appropriate for care coordination?	• Pilot Activity • Case notes review • Interviews with huddle members
	What cross over is there between patients identified for anticipatory care and patients on proactive care registers? Does this matter?	• Pilot Activity • Population Health Data • Stakeholder Engagement
	Are these patients on existing caseloads? If so how will we add value to them with an additional anticipatory care pathway?	• Pilot Activity • Case notes review • Stakeholder engagement • Interviews with MDT members
	Are we tackling health inequalities? Are those with protected characteristics equally able to benefit from this work?	• Pilot Activity • Population Health Data

Area	**Quantifying the activity in the pathway**	**Source**
Question 2	**What capacity will be required to deliver this pathway to the cohort identified? And is that capacity possible within resources and funding available?**	**Multiple**
	Shaping the Pathway	
	Does the pathway allow the care coordinator to work with patients long enough for meaningful engagement?	• Interviews with MDT members • Interviews with patients • Pilot Activity

Sub-questions	What is the optimum number of patients that the care coordinator can hold at any one time?	• Interviews with MDT members • Interviews with patients • Pilot Activity
	Learning from the Pilot	
	For each PCN, what proportion of the cohort will the model support? Is this high enough?	• Pilot Activity • Stakeholder Engagement
	Per population size how many WTE care coordinators are needed to deliver this model? Needs to be tailored to each PCN	• Pilot Activity • Stakeholder Engagement
	How many patients should and can be discussed per huddle?	• Interviews with MDT members • Pilot Activity • Stakeholder Engagement
	What is the average and optimum length of appointment with the care coordinator? What factors may make an assessment take a shorter or longer amount of time?	• Interviews with MDT members • Interviews with patients • Pilot Activity

Area	**Assessment**	**Source**
Question 3	**How best to assess people within the cohort to identify their needs?**	**Multiple**
Sub-questions	***Shaping the Pathway***	
	What tools are most appropriate to assess need?	• Interviews with MDT members • Best Practice • Stakeholder Engagement
	Is the care coordinator the appropriate practitioner to assess clinical frailty score (or other tools to be used)? Can the further assessment (questions based on brief CGA) be competently completed by a care coordinator?	• Interviews with MDT members
	What needs to be captured as part of the assessment for a decision to be made on whether pathway appropriate and if so, for huddle to have beneficial discussion?	• Interviews with MDT members
	How much significance should frailty take in the assessment of need?	• Interviews with MDT members • Pilot Activity • Case Notes Review
	Does assessment need to be f2f? How do we make the most of the conversation – establish trust, build rapport etc?	• Stakeholder Engagement • Interview with MDT members • Interview with patients
	How do we assess and record non-medical aspects. What Patient Reported Outcome Measures are best used?	• Interviews with MDT members • Pilot Activity
	Learning from the Pilot	
	What conversational and coaching/ interaction techniques have been used and are most useful as part of the assessment process?	• Pilot activity • Interviews with MDT members

		• Best practice
	Is the assessment process identifying unmet need?	• Pilot Activity • Interviews with MDT members • Interview with patients
	How long does the assessment take? Do we understand why some take longer than others? Is this feasible outside of a pilot?	• Pilot Activity • Stakeholder Engagement • Interview with patients • Interviews with MDT members
	Did the patients feel able to share what matters to them and what their needs are? And what helped facilitate this or what were the barriers?	• Interview with patients • Interview with huddle members
	Did patients feel able to adequately prepare for the 'what matters to me' discussion?	• Interview with patients •
Discussion Question	What if none of the needs raised are clinical, is a need identified as being important to the patient enough for this pathway? NB. there is community navigation pathway as alternative	

Area	**Huddle/MDT Working**	**Source**
Question 4	**What value is the huddle/MDT working adding?**	**Multiple**
Sub-questions	***Shaping the Pathway***	
	What is needed to support the huddle to operate in an 'anticipatory way'?	• Interviews with MDT members • Stakeholder Engagement
	Who are the right practitioners to be in the huddle? Do we need specialist input or more important to have regular core members?	• Pilot Activity • Interviews with MDT members
	What impact does the cohort have on the makeup of the huddle?	• Interviews with MDT members
	What proportion of patients were identified as needing discussion into the huddle?	• Pilot Activity • Case Notes Review
	Was outputs came from the huddle/MDT discussion patient?	• Interviews with MDT members • Pilot Activity • Case Notes Review
	For the huddle to be effective, does it need administrative support?	• Interviews with MDT members
	When would a patient benefit from an MDM rather than a huddle in the anticipatory care pathway? How should the two operate together / align / feed into one another	• Interviews with MDT members • Engagement with Stakeholders
	Do we need the huddle for all patients or can triage identify patients most appropriate? Who would be needed for the triage?	• Pilot Activity • Interviews with MDT members • Engagement with Stakeholders
	Learning from the Pilot	
	Can we demonstrate the value added from each service who were part of the huddle?	• Pilot Activity • Interviews with MDT members
	Was the frequency and length of the huddle right?	• Interviews with MDT members

		• Pilot Activity
	Can services demonstrate benefit of their own team being part of the discussion?	• Interviews with MDT members • Stakeholder Engagement
	What preparation is needed in advance of the huddle in order for it to be effective?	• Interviews with MDT members
	Did the huddle identify support and interventions which the patient felt fitted their needs? Did the patient feel that the huddle had listened to what the patient had described as being important to them?	• Interview with Patients

Area	**Support and Interventions Identified**	**Source**
Question 5	**How do we make sure that we are getting the most appropriate and most impactful support and interventions?**	**Multiple**
Sub-questions	***Shaping the Pathway***	
	If support or interventions have really long waiting times, do we lose any benefit of it being anticipatory? Do we need ring fenced resource? Do we need to put additional funding and resources into them?	• Pilot Activity • Interviews with MDT members • Stakeholder Engagement
	How can we utilise community and voluntary sector provision to support when patients do not meet criteria for statutory services this and how do we ensure they have sufficient capacity for this?	• Interviews with MDT members • Stakeholder Engagement
	Learning from the Pilot	
	Are the support and interventions identified very different for different cohorts? Does this make a difference for the model - can we successfully manage a spectrum of patients on one pathway?	• Pilot Activity • Case Notes Review • Stakeholder Engagement
	Are there patients that we think would benefit from support and interventions from teams eg. ASC, ACRT etc but do not meet the criteria as not complex enough? How do we manage this?	• Interviews with MDT members • Stakeholder Engagement
	Were there support and interventions identified as being beneficial which we do not have available locally?	• Interviews with MDT members • Case notes Review • Stakeholder Engagement
	What are the key support and interventions?	• Interviews with MDT members • Pilot Activity • Case Notes Review • Interview with Patients
	Does the patient feel that the intervention recommended met their needs or not? And did the support and interventions offered met their expectations? How did the reality compare to their understanding of what the service could support them with?	• Interview with patients

Area	**Comprehensive Geriatric Assessment**	**Source**
Question 6	**Is full a comprehensive geriatric assessment needed and feasible as part of the pathway?**	**Multiple**
	Shaping the Pathway	

Sub-questions	How should we determine whether a CGA is needed?	• Interviews with MDT members
	Is there additional resource needed in order for CGAs to be completed?	• Interviews with MDT members • Stakeholder engagement • Pilot Activity
	Who did undertake the CGAs when one was completed?	• Pilot Activity
	Learning from the Pilot	
	Proportion of patients that needed a comprehensive geriatric assessment & was there a difference with cohort?	• Pilot Activity • Interviews with MDT members • Research and evidence base
	Who was the most appropriate member of the huddle / service to take on the CGA?	• Interviews with MDT members
	How was the need for a CGA decided in the pilot? i.e was this always based on need or capacity and feasibility to deliver?	• Pilot Activity • Interviews with MDT members
	To what extent had CGAs/or equivalent already been completed already in primary care or elsewhere? *But perhaps not called CGA*	• Interviews with MDT members • Stakeholder engagement

Area	**Care Coordination**	**Source**
Question 7	**What level of care coordination do we need & what does this look like?**	**Multiple**
Sub-questions	***Shaping the Pathway***	
	What activities need completing as part of care coordination?	• Interviews with MDT members • Learning from PCN experience on Care Coordinators in post • NHS E guidance • Best Practice
	Where patients are under multiple existing services, what added value can the care coordinator actually bring?	• Interviews with MDT members • Interview with Pilot GP Practice • Interview with Patients
	Who is best placed to undertake the care coordination?	• Interviews with MDT members • Stakeholder engagement • Interview with Patients
	Learning from the Pilot	
	Have patients needed care coordination? Has this been different dependent on cohort?	• Pilot Activity • Research and evidence base • Learning from PCN experience on Care Coordinators in post
	What proportion of patients identified as needing care coordination are actually already under multiple services?	• Case Notes Review • Interviews with MDT members
	What training and support does the care coordinator most benefit from?	• Interviews with MDT members

		• Learning from PCN experience on Care Coordinators in post • NHS E guidance • Best Practice
	If the patient was supported by care coordination in the pathway, did the patient feel they were able to build a rapport with their care coordinator? Did the patient feel that the care coordinator helped coordinate the patients journey or help them navigate the care they were receiving?	• Interviews with patients

Area	**Personalised Care and Support Planning**	**Source**
Question 8	**What care and support planning does this cohort need?**	**Multiple**
Sub-questions	***Shaping the Pathway***	
	Does a PCSP actually add value when it is just an additional plan on top of all the other plans that patients have? Including whether the patient felt like it helped them?	• Interviews with Patients • Research and evidence base • Interviews with MDT members • Stakeholder Engagement
	Who is the most appropriate person to work up the PCSP with the patient and what skills do they need?	• Interviews with MDT members • Research and evidence base • Stakeholder Engagement • Interviews with patients
	What makes for an effective personalised care and support planning approach and plan itself? What does a good plan look like & how does it differ from condition specific plans?	• Interviews with MDT members • Interview with Patients • Research and evidence base
	To what extent will members of the MDT utilise the person-centred care and support plans created? And how will they share & access it?	• Interviews with MDT members • Stakeholder engagement
	How (and how often) should the personalised care and support plan be reviewed?	• Interviews with MDT members • Pilot Activity • Interviews with patients
	Once the patient is stepped down from the pathway who is responsible for checking in with the patient on the PCSP?	• Interviews with MDT members • Stakeholder Engagement
	Learning from the Pilot	
	How many patients on the pathway were identified as needing a PCSP and did this differ with the cohort?	• Pilot Activity
	Did the patient have sight of their plan and feel like they had ownership of their personalised care and support plan?	• Interview with patients

	If and how did residents utilise the personalised care and support plan? What if anything did it help with? What would have been useful on the plan that wasn't there?	• Interview with patients

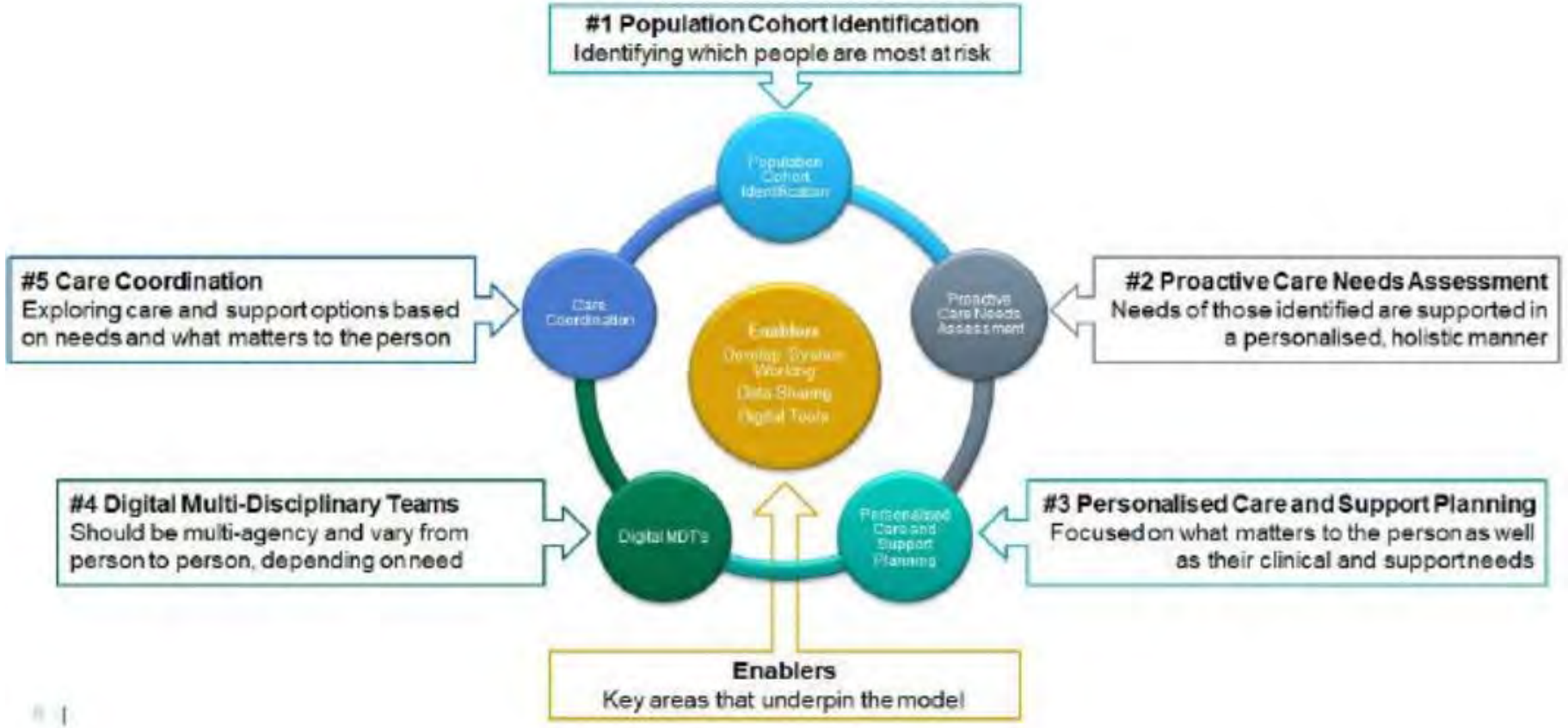
Area	**Stepping patient down from Pathway**	**Source**
Question 9	**How and when do we step down or discharge patients from the pathway?**	**Multiple**
Sub-questions	***Shaping the Pathway***	
	In order to support enough patients on the pathway what is the optimum time for a patient on the pathway? Or will it vary patient to patient? If this is the case how do we manage expected caseload?	• Interviews with MDT members • Engagement with Stakeholders
	Did patients feel comfortable with being stepped down from the pathway and were they / should they be involved in the decision?	• Interviews with MDT members • Interview with Patients • Stakeholder Engagement
	What happens to a patient when they are off the pathway? What if they deteriorate?	• Interviews with MDT members • Stakeholder engagement
	Learning from the Pilot	
	Who makes the decision to step the patient down from the pathway?	• Interviews with MDT members
	How long did patients stay on the pathway and did this differ with cohort?	• Pilot Activity
	How was it decided when a patient should be stepped down from the pathway? i.e Is it once the referrals / signposts done and for more complex patients the PCSP is done? Or does patient stay under care coordinator until goals achieved?	• Interviews with MDT members
	What information should be provided to residents when they are stepped down from the pathway? What happens if circumstances changes etc / routes back into the service	• Interview with patients • Interviews with MDT members • Stakeholder engagement

Anticipatory Care Pilot
DRAFT Pathway v.11

What is anticipatory care?

The aim of anticipatory care is to support people to remain healthy and independent and at home for longer. It is preventative and targeted at people living with multimorbidity, frailty and/or complex needs at an earlier stage.

Anticipatory care is about developing a model of community based, multi-disciplinary care for people with rising needs including close working between primary care, community nursing, community geriatricians, therapies, adult social care, ELFT community teams and the wider voluntary sector.



Pilot for Springfield Park – Service Aim

Development and delivery of a:

- **proactive**,
- community based,
- multi-disciplinary,
- care model for **moderately or severely frail over 65s** *(see note below)*
- which **focuses on what matters** to residents
- to improve their health and wellbeing
- via **proactive care needs assessment** and **evidence-based interventions**

What matters to the resident, as well as their clinical and support needs will be documented within a **personalised care and support plan,** owned by them and accessible to those supporting the resident.

The pathway will support PCNs and community partners with the delivery of the future DES for anticipatory care. Whilst the pathway has been designed specifically with the Springfield Park pilot (moderately frail cohort), many of the steps in the pathway could be relevant for other cohorts if required.

The Pilot Pathway in Summary

A focus on what matters to the patient, understanding their aspirations and goals throughout with an emphasis on shared decision making with them and with their carers.

1. Identify population cohort
2. Contact residents identified as suitable for anticipatory care
3. Proactive Care Needs Assessment (including functional assessment) & discussion to identify resident needs
4. Informal Neighbourhood Team Huddle take multi-agency approach and determine support interventions needed
5. Personal Care & Support Plan (PCSP) & evidence-based interventions & support for residents who will benefit
6. Review progress against PCSP & step down from anticipatory care pathway

There are six key stages to the anticipatory care pathway that will be tested during the pilot phase.

The detail for each of these six steps is shown on the following slides.

1. Identify Population Cohort and Triage

*NHS E confirmed that for Anticipatory Care DES, any patient under the Enhanced Health in Care Home DES (i.e in CQC registered home) cannot be included

GP Practice to ensure eFI scoring on EMIS **for all over 65s**

→

Practice Manager to run search on EMIS:*

✓ eFI scoring moderate frailty (eFI 0.25 - 0.36)
✓ eFI scoring of severe frailty (eFI <0.36)
✓ Must have 3+ LTCs
X exclude housebound & patients on EOLC register

→

Care Coordinator to check EMIS/EPR for recent consultations/notes

→

Care Coordinator to check in with patient's GP to see if known already, GP to provide guidance on whether patient too complex for anticipatory care or is perhaps already is managing well. Where Pt is not well known, invite onto pathway to better understand circumstances.**

**If we find there is not enough capacity to invite all patients identified then consider alternative ways of identification & triage eg. identification of rising need through increase in number of GP consultations over specific time period

2. Contact Residents on the Anticipatory Care Worklist

Care Coordinator (CC) sends letter (and leaflet) with GP Practice headed paper to residents identified, includes number for resident to call CC

CC proactively follows up each letter/text with a phone call to the resident in order to book telephone assessment

Resident does not answer call nor phone CC or GP Practice

1. Check correct contact details (check NOK for contact details) & attempt to recall resident
2. If still unable to make contact, CC to undertake desk based review to see whether resident frequently admitted/high A&E attendances or has recently attended primary care to try and establish contact
4. If cannot make contact mark for review in 6 months & code on EMIS
6. CC to flag on EMIS that if this patient contacts the practice then invite them to book a call with the CC

Contact made with resident & does not wish to arrange appointment with CC

1. CC to explore barriers to engagement with resident, consider involving advocate/NOK as needed
2. If still not agreeable, code on EMIS
3. CC to flag on EMIS that if this patient contacts the practice after deciding they do wish to enrol on anticipatory care pathway, book a call with the CC

Contact Made & Resident Engages

Resident responds to letter or text or phone call

If resident contacts GP Practice then book scheduled appointment (in EMIS) with CC

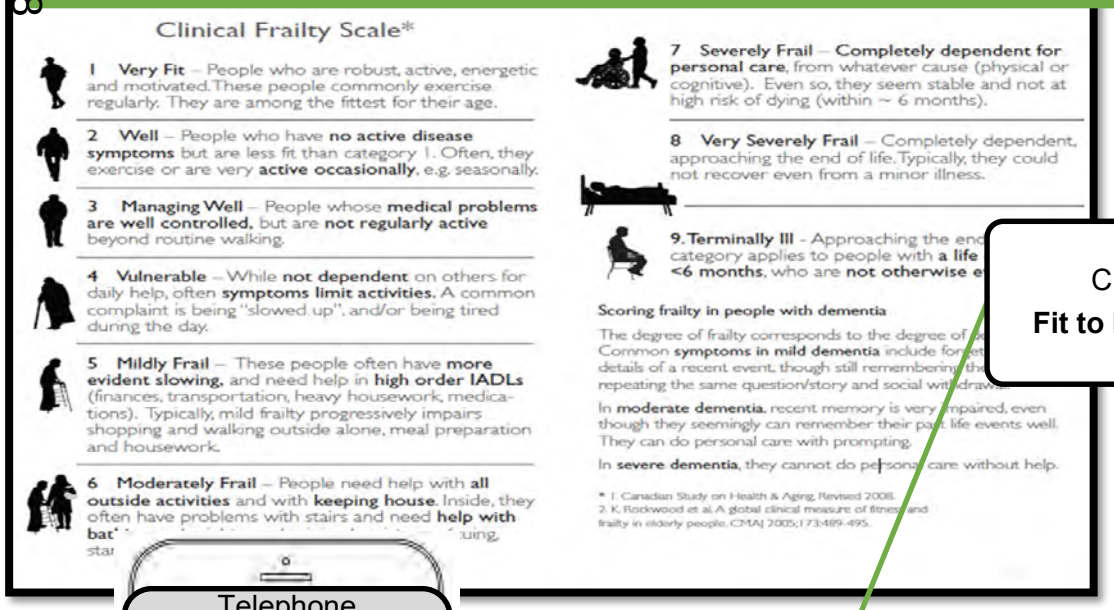
Telephone / MS Teams appointment arranged between Care Coordinator and Resident for Proactive Care Needs Assessment

If patient does not have access to a telephone and prefers f2f, arrange for appointment in practice.

Where appropriate ensure translation services available.

Prompts on the leaflet to encourage pt to think about what matters to them

3. Care Coordinator Proactive Care Needs Assessment (including Clinical Frailty Score)



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with**

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end
category applies to people with **a life**
<6 months, who are **not otherwise e**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of
Common **symptoms in mild dementia** include for
details of a recent event, though still remembering th
repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Telephone Appointment Care Coordinator (CC) & Resident

Proactive Care Needs Assessment (Holistic Assessment)

Code in EMIS

Functional Assessment using Clinical Frailty Score (CFS) carried out via telephone

CFS 1- 4

Fit to Mild Frailty

While on telephone CC to complete with resident ***'Concerns and Goals -*** *what matters to me'* conversation to identify unmet need

If assessment identifies unmet need consider suitability of 5 key **Community Navigation Pathways.** Where applicable CC to refer into service(s), ensuring that details of residents concerns & goals are handed over.

Update CFS on EMIS & record referrals made.

CC to advise resident to contact GP if significant change in functional ability

CFS score 5 or above

Moderate Frailty / Severe Frailty / Unknown Frailty Status

While on telephone CC completes with resident (or arranged follow up call if resident prefers)

(ii) **Residents Concerns and Goals** – What Matters to Me conversation (used as basis of future PCSP)

(i) **Further Assessment** (areas not covered under CFS including medication, falls, home environment, social interaction, mood, nutrition, elimination, sleep & health attitude)

Resident on Anticipatory Care Pathway (code in EMIS)

Referred to the Informal Huddle for discussion IF assessment identifies unmet need which requires multi-agency discussion & resident wishes to proceed

If multi-agency discussion not required, care coordinator to support resident via contact with services needed & relevant referrals made. Once completed step patient down from pathway.

4. Informal Neighbourhood Huddle

CC undertakes preparation for informal huddle in order to present summary of residents for discussion

- CFS Score & key points of assessment
- Desk based review on existing services / interventions / health care usage (EMIS/eLPR)
- Check if resident recently reviewed by other MDT (eg. HIU, Discharge, MDM)
- Medical conditions, drug history etc identified from EMIS
- Residents goals & what's important to them
- Pre-huddle CC check in with resident GP for input & ask whether GP would like to attend huddle
- Circulate names of residents for discussion to huddle members in advance of meeting so they can check their systems & bring details to huddle

Care Coordinator to present each resident to the huddle members & huddle chair is on rotation

Clinical Pharmacist

Care Coordinator (CC)

Community Geriatrician

Fortnightly

Informal Huddle
Purpose of the huddle:

- ✓ Agree pathway based on clinical & support needs & what matters to resident
- ✓ Agree on any assessments required
- ✓ Identify appropriate interventions & support based on identified needs & what matters to the resident
- ✓ Allocate most appropriate case holder
- ✓ Agree huddle review timescales

Agreed over one or multiple huddles

Therapies
ACRT Link Worker

Adult Social Care

Voluntary Sector Social Prescribing (Family Action TBC)

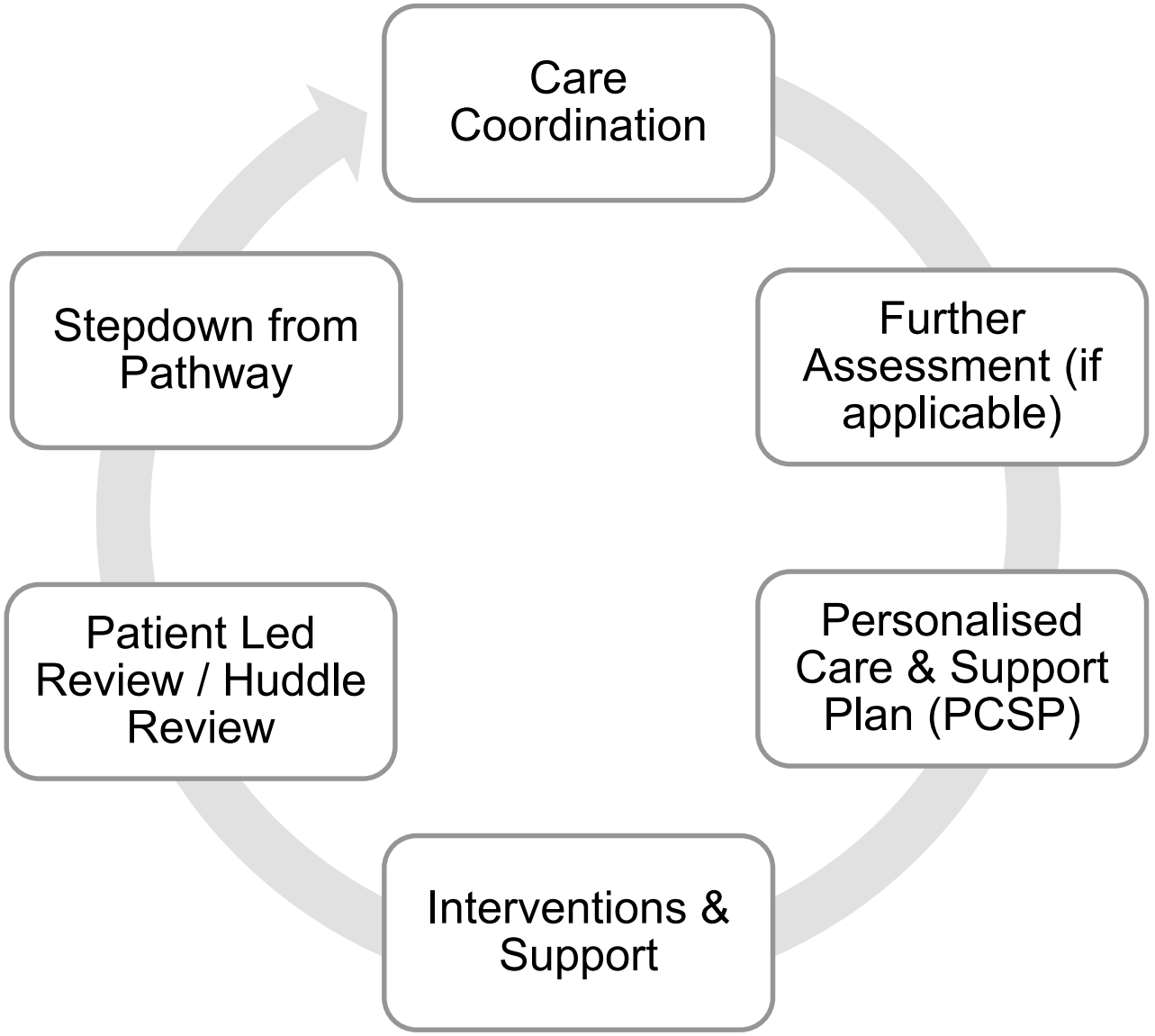
Mental Health OP Team
(Clinical Psychologist TBC)

Pathway 1
Identified needs to be managed via referral to service(s) on community navigation pathway
CC to discuss with Resident next steps

Pathway 2
Resident needs identified that require multiagency working/support & work up of PCSP.
CC to discuss with resident next steps

Pilot exploring whether when the resident is on an existing caseload if it is appropriate that the service will be allocated as case holder. Where resident not on a case load, CC to be case holder.

Pathway 2 - Anticipatory Care Pathway - Summary



5/6. Pathway 2 - Anticipatory Care Pathway - Detail

Case holder undertakes or arranges any **further assessments** required where applicable, including eg.
Full CGA undertaken at residents home, Psychiatric Assessment, Care Needs Assessment, Carer's Assessment.
Feeds back outcome of assessment to huddle for review.

Case holder undertakes **quality of life measure** with resident at start of pathway.

The pathway will be reviewed as the pilot progresses & amended as our learning develops

Over a series of facilitated conversations allocated case holder & resident develop **personalised care & support plan** inline with PCSP Checklist (NHSE), building on the residents concerns & goals discussed at the initial assessment. Focussed on what matters to the resident as well as their clinical and support needs. PCSP shared with members of the Huddle.

CMC Urgent Care Plan updated by Case Holder or CC where applicable

Case holder takes responsibility for Care Coordination, ensuring interventions and support identified by huddle & agreed by resident are undertaken by most appropriate professionals.

Where appropriate **review by members of core huddle** team, eg. therapy or referral to **specialist teams**

Evidence Based Interventions (as appropriate)
- Falls review (PCN Pharmacist or Practice Nurse)
- Falls prevention (OTAGO)
- Structured Medication Review (PCN Pharmacist)
- CBT, Psychotherapy, Psychological Therapies
- Nutrition optimisation
- Resistance based strengthening exercises

Where appropriate refer for additional support under **Community Navigation Pathways** including
- Social Prescribing (6-8 sessions, often focus on social isolation)
- Health & Wellbeing Coaches (8 sessions, goal orientated)
- Well Family Plus (up to 8 sessions, follow on 3 months, emotional & practical support)
- Engage Hackney (crisis & 6-12 months, housing, debt, skills etc)

Where applicable, Adult Social Care

Formal Package of Care

- Resident led progress reviews against PCSP with case holder
- Review resident in huddle as appropriate (timeframe for review, if review required, to be agreed by huddle)

Once PCSP in place, interventions have been undertaken or initiated and progress against plan has been made, resident to be **stepped down** from pathway, assessed as no longer requiring care coordination. **Step down** to be agreed by case holder & huddle (?) in consultation with resident. Length of pathway will vary depending on resident.

Case holder to carry out second **quality of life assessment** with resident when stepped down from pathway

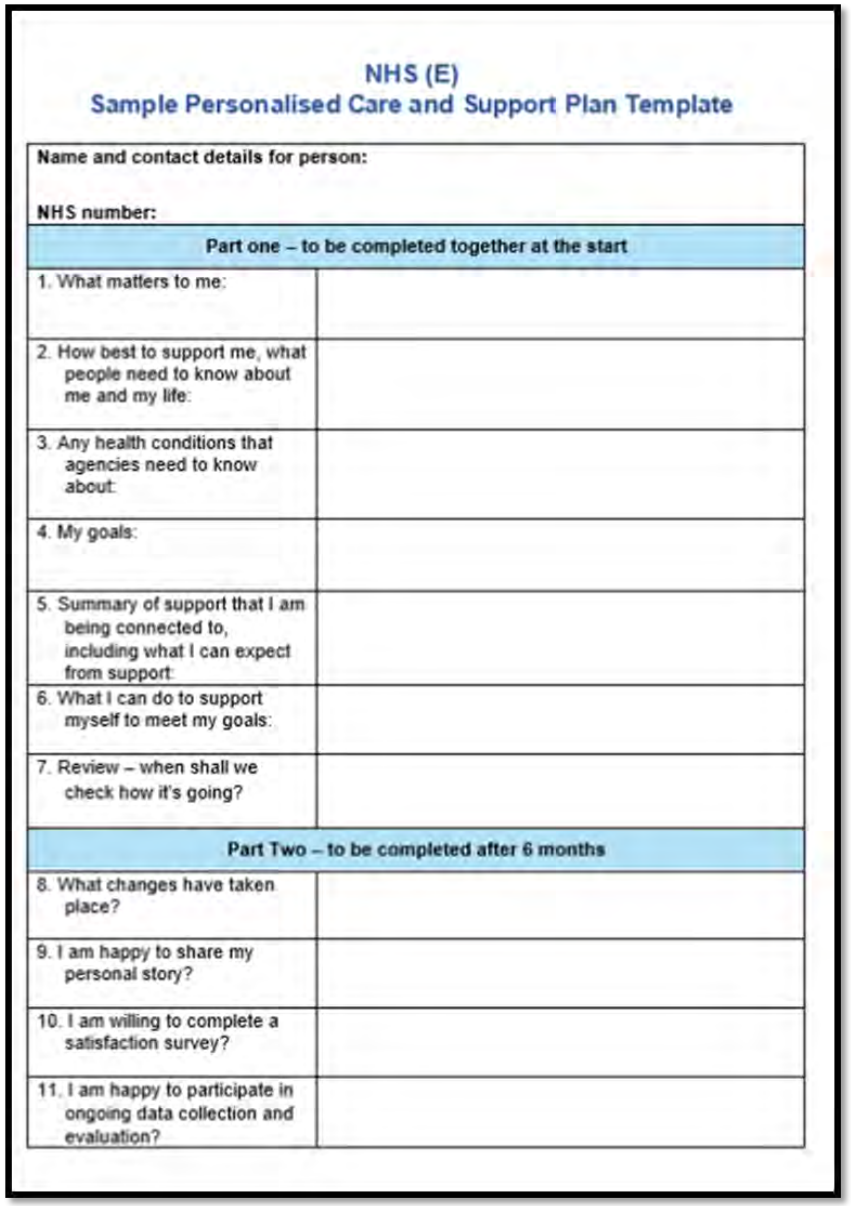
Documents Used in Pilot

1. Letter and leaflet to resident

1. Proactive Care Needs Assessment (and initial person-centred care and support plan) – and associated guidance
2. Proforma for CC preparation for huddle

3. Proforma for recording huddle discussion

4. Person-centred care and support plan (PCSP) template



NHS (E)
Sample Personalised Care and Support Plan Template

Name and contact details for person: NHS number:	
Part one – to be completed together at the start	
1. What matters to me:	
2. How best to support me, what people need to know about me and my life:	
3. Any health conditions that agencies need to know about:	
4. My goals:	
5. Summary of support that I am being connected to, including what I can expect from support:	
6. What I can do to support myself to meet my goals:	
7. Review – when shall we check how it's going?	
Part Two – to be completed after 6 months	
8. What changes have taken place?	
9. I am happy to share my personal story?	
10. I am willing to complete a satisfaction survey?	
11. I am happy to participate in ongoing data collection and evaluation?	

The role of the care coordinator in this pathway is to:

Functions	Included in national JD for care coordinator?
• Identify a cohort of patients within EMIS for the anticipatory care pathway and work with GP Practices within the PCN to refine the list	Yes
• Make proactive contact with the resident to arrange for a person-centred discussion with them	Yes
• Carry out a functional assessment with the resident and identify whether they would benefit from the anticipatory care pathway	In part
• Discuss what the resident wants from their care and start to include that within the person-centred care and support plan	Yes
• Arrange and support the informal MDT huddle – ensuring that the date for the huddle is in the diary and MDT members are aware of the meeting	Yes
• Bring to the MDT informal huddle residents identified that would benefit from the anticipatory care pathway – prepare information in advance of the huddle that MDT members would benefit from	Yes
• Where identified by the MDT, act as a the allocated case holder for the resident – 1). Carry out a person-centred care and support plan and share this with members of the MDT / 2). Help people to manage their need, answering their queries and supporting them to make appointments	Yes

Anticipatory Care Case Notes Review

1. Introduction

The aim of anticipatory care is to support people to remain healthy and independent and at home for longer. It is proactive and targeted at people living with multimorbidity, frailty and/or complex needs at an earlier stage.

Locally in C&H we are developing a community based multi-disciplinary anticipatory care model that proactively identifies and supports people with rising needs in the community, including primary care, community nursing, therapies, adult social care, ELFT community teams and the wider voluntary sector.

2. Aim of Case Notes Review

We are currently piloting an anticipatory care pathway in Springfield PCN. This case notes review supplements the learning and will help to inform our local anticipatory care model across all of C&H and future investment decisions.

The purpose of this case notes review is:

- To understand the extent to which patients are already known to existing community, mental health and social care teams
- To have a clinical & practitioner assessment of what support & interventions these patients may have benefited from or patients in a similar cohort could benefit from in the future in order to stay healthy, independent & happy longer

3. Process

For pragmatic reasons, the monthly Neighbourhood MDM meetings in October were utilised as the structure and forum of the case notes review practitioner discussions.

Patient Consent

A representative from the GP Confederation identified a practice from each PCN to be part of the Anticipatory Care case notes review. Practices were contacted and asked to identify patients registered at their practice who were over 50 years of age and had a diagnosis of moderate or severe frailty recorded on EMIS. Practice staff contacted these patients via telephone to ask for their consent for their data to be used in the review. Patients were selected from the list, until approximately 6 patients from each practice had consented. This was recorded in EMIS and a letter sent out to patients acknowledging and explaining how their data would be used and anonymised.

Well Street Common PCN chose not to participate in the case notes review. As Springfield PCN were already involved in the pilot they were not asked to be involved in the case notes review.

Preparation

Once consent was gained from patients, practice staff noted, electronic frailty index (EFI), clinical frailty diagnosis, medications, long term conditions, number of primary care contacts in the last 12 months, presence of a Coordinate My Care plan, and details of primary care register(s) the patient may be on. This information was then securely passed to the Homerton Information services team (via the neighbourhood MDM administration email), who collated relevant information from the Homerton medical records. This included Emergency department (ED) attendances, emergency or planned admissions (length of stay and reason for admission), outpatient attendances and specialism(s) the patient may be under. This was then collated by the MDM administrators and distributed to Neighbourhood MDM core team members to review ahead of the discussions detailed below.

Case Notes Review

A General Practitioner presented the residents information anonymously in the meeting and chairs facilitated the discussions to answer the questions set out ahead of the meeting. These were noted down by the MDM administrators. At each case notes review the 7 questions were considered by the review group members, the template used is included in appendix 1.

Participating GP Practice	Neighbourhood	Date	Chair
Sandringham Road Practice	London Fields	04/10/2021	Dr Aimee Henderson
Lower Clapton Group Practice	Hackney Marshes	05/10/2021	Heggy Wyatt
Nightingale Practice	Hackney Downs	06/10/2021	Dr Sana Mufti
Heron Practice	Woodbury Wetlands	07/10/2021	Dr Ben Saw
Lawson Practice	Shoreditch Park & the City	07/10/2021	Dr Ben Saw
Barton House Group Practice	Clissold Park	13/10/2021	Dr Moira McAllister

A range of participants were involved in the meetings these included, Community Therapists (Physio, OT, Dieticians), Community Nurses and Matrons, General Practitioners, Geriatricians, Social Prescribers, Health and Wellbeing Coaches Wellbeing Practitioners, Social Workers, Primary Care Liaison Practitioners (mental health) and Community Psychiatric Nurses, a Practice Nurse, Anticipatory Care Project Managers (to observe) and MDM administrators.

4. Key Findings

The section below sets out the key findings and key themes which came out of the discussion. A more detailed write up of the key points of the discussion can be found in appendix 2.

There were **27 patients** discussed during the case notes review, 7 patients with moderate frailty and 20 patients with severe frailty. Key to note here is that this is based on frailty diagnosis with clinical judgement which is then coded on EMIS and not predicted frailty using the electronic frailty index (eFI) which can often over inflate diagnosis scores.

The paper will note throughout where we are referring to frailty diagnosis versus eFI score. Where eFI score is discussed, patients with a score of between 0.25-0.36 have a predicted frailty score of moderate, and patients with an eFI score of <0.36 have a predicted frailty score of severe.

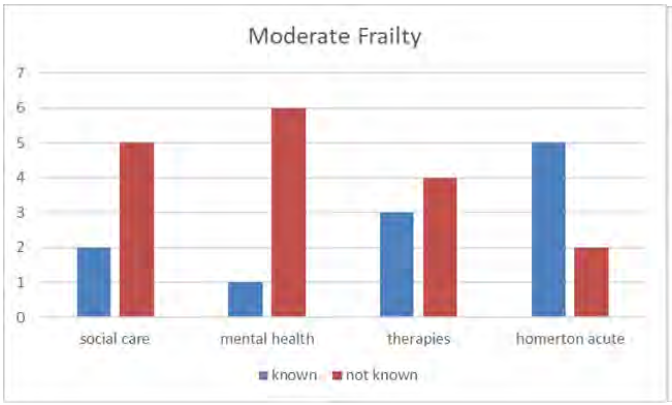
a) Known to Services (Acute and Community)

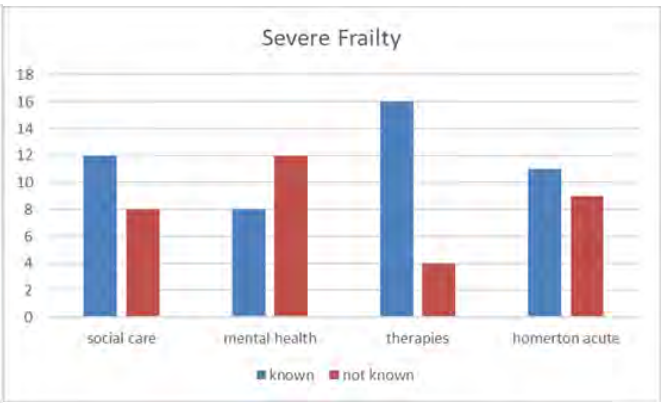
The following organisations and services confirmed whether the patients were currently on the caseload or have been in recent years (previous 3-4 years):

- Homerton Acute (detailing if patient under been under the care of any specialisms)
- Homerton Community Nursing
- London Borough of Hackney Adult Social Care
- Homerton Therapies
- ELFT Mental Health Community Older Peoples Team (MHCOP)
- ELFT Dementia Services

Cohort	Average Number of Services Patients Known to
Moderate Patients	2.7
Severe Patients	4.1
All patients (7 moderate and 20 severe)	3.7

The graphs below set out whether patients were known or not known known to services, broken down by frailty diagnosis. Note that the graphs are missing data for commumity nursing and this will be added once collated.





Key Findings

- As expected **on average** patients with a diagnosis of severe frailty are **likely to be known to a higher number of services** than patients with moderate frailty
- For patients with a diagnosis of moderate **frailty**, the majority of patients **were not known to Adult Social Care** (60%) or **mental Health services** (86%). However, most **were known to Homerton Acute Specialisms** (71%), which is expected given that on average patients discussed had four long term conditions
- For patients with a **moderately frail diagnosis** discussed in the case notes review, just **under half were known to Community Therapies**, this is higher than what we have identified so far within the pilot
- For patients with **severe frailty diagnosis**, the **overwhelming majority** (80%) of patients are **known to Community Therapies**
- For patients with **severe frailty diagnosis**, the **majority were known to Adult Social Care** (60%), whereas the majority of patients were **not known to Mental Health Services** (60%)
- The average number of services that the patient is known to **increases from 3.7 to 4.6** for patients that were considered as most likely **benefitting from care coordination**
- The average number of services that the patient is known to **increases from 3.7 to 4.7** for patients that were considered as most likely **benefitting from multi-agency input/huddle discussion**

If we define anticipatory care as being proactive care to patients with rising needs in the community, where assessment of unmet need can identify interventions which can better support, delay or prevent expected deterioration, then arguably it would make sense for an anticipatory care pathway to work with a cohort who are not already known to multiple services. The findings show that on average patients with diagnosed moderate frailty are known to fewer services than patients who have severe frailty diagnosis, and potentially we have greater scope to identify support and interventions which could improve their trajectory. However, given that the case notes review only includes 7 patients with a diagnosis of moderate frailty, it is difficult to draw conclusions and the findings must be considered alongside learning from the pilot and national evidence base. Furthermore, further on in the review we find that many patients with a diagnosis of severe frailty, were also considered by the reviewers as potentially benefitting from anticipatory care.

The findings on whether patients in the moderate and severe diagnosis cohorts were known to services or not, have potential implications for considering the type of role which services will play in multi-agency support in the anticipatory care pathway, particularly their function with the 'huddle'. The 'huddle' currently undertaken fortnightly in the pilot is a multi-agency team made up of the care coordinator, social prescribing, geriatrician, adult social care, therapies, mental health older peoples team, and on occasions a practice pharmacist.

If the cohort(s) we choose to work with under the future Anticipatory Care Model are largely not known to statutory services and not on their current caseload, this draws practitioners into discussions away from their mainstream commissioned provision with the aim of where possible delaying or avoiding need for a referral into their service in the future, or potentially identifying patients who do meet referral criteria, but may have been picked up earlier and therefore better supported. For a sustainable model operating with this input, although services are being

reorganised on a neighbourhood footprint, to offer this, over and above work on their existing caseload it is likely that this multi-agency assessment and input would need to be funded.

b) Known to Services – Proactive Care Services (Primary Care)

The GP Confederation holds the contract for two primary care services which focus on proactive care to patients, these are:

- **Proactive Care Home Visiting Register** (for patients who are housebound, with a minimum of 2, but an average of 4 GP delivered appointments in the patient's home (roughly 40 minutes each), with creation and review of CMC care plan, holistic assessment and structured medication review)
- **Proactive Care Practice Based Service** (two 30 minute appointments for patients in the GP Practice or over the telephone which can be delivered by practice pharmacist or nurse, including creation and review of CMC care plan, holistic assessment and structured medication review

All patients in the case notes review who were housebound (13) were on the proactive care home visiting register.

However, for the remaining patients (14) only 5 patients were on the proactive care practice based register. All 5 patients had an eFI score of severe frailty and clinical frailty diagnosis of severe frailty. There were a number of patients who were considered as suitable for proactive care practice based, and the group felt would have benefited from having a CMC care plan in place. Alongside the work on the Anticipatory Care pathway we are exploring how we ensure that the proactive care practice based contract is fit for purpose, and can align with and support the Anticipatory Care model.

c) Interventions

We asked the review group to consider interventions that could have or could be put in place to better support, slow or prevent expected deterioration for the patients discussed.

The table below sets out the what was suggested as potential support and interventions for the **27 patients** that were discussed in the review.

Interventions or Support Suggested	Number of times recommended
Social Prescription	8
Mental Health Needs Assessment, including MHCOP or Dementia, or psychiatric assessment	7
IAPT	6
Referral to Therapies	4
Wellbeing Practitioner	4
Buddying	3
Community Exercise Programmes (e.g. including Ability Bow, Free Gym sessions)	2
Falls Assessment	2
Carers Referral	2
Dietetics (including support in voluntary sector as some patients wouldn't meet criteria for statutory provision)	2
Structured Medication Review (SMR)	1
Pain Clinic	1
Adult Cardiorespiratory Enhanced and Responsive Service (ACERS)	1
Referral to Engage Riverside	1
Referral to Stroke Project	1
Advance Care Planning	1

Key findings & Learning

Area	Key Findings & Learnings
Social Prescribing	Nearly a third of patients were considered to potentially benefit from social prescribing. In C&H Social Prescribers are employed by Family Action, they give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support. The Anticipatory Care Pathway could lead to an increase in the number of referrals to social prescribing and consideration needs to be given to how we manage potential rise in demand and ensure that we are utilising each Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS) role as effectively as possible, avoiding any duplication in the system.
Mental Health	A significant proportion of patients were identified as benefiting from either a mental health assessment, including the older people's team, dementia service or psychiatric provision, or a referral to Improving Access to Psychological Therapies (IAPT). It was also noted there could be enhanced communication between mental health services supporting patients over a long period of time and primary care. Currently within the Anticipatory Care Pathway we have the MHCOP (mental health community older people's team) in attendance and we are considering who would be most appropriate to attend in the future model. We are currently liaising with the IAPT team to see whether it would be possible for them to the attend. It is thought that that older adults are under referred to IAPT and we would need to explore suitable access arrangements for this cohort of patients.
	For one patient the review group identified that Mental Health intervention which supports both the patient and their family is needed. Provision which identifies the family and friends' network and takes a systemic approach, building on the assets the patient has and teaching the family/friends in techniques (such as grounding techniques) in order to support the patient. This should provide a more sustainable approach. Feedback to mental health commissioning.
Dietetics	Two patients were identified as needing dietetics support, however weren't considered as suitable for meeting the threshold for referral into the service A better understanding of dietetics support provided by the voluntary sector is needed.
Culture	A really key observation from all review groups was that the overwhelming majority of reviewers found the concept of considering patients proactively, challenging (those who may not yet meet the thresholds for their services). The groups discussed that much of our healthcare provision is reactionary and relentless and there is little space for frontline workers to consider earlier intervention may prevent or slow deterioration. A lack of careful consideration and early attention to culture risks the capability of Anticipatory Care being effectively embedded and sustainable. Ensure the programme focuses and specifically combines work on culture amongst services alongside the development of the model.

d) Barriers or Obstacles for Patient or Practitioners/Clinicians

We asked the review groups to consider what barriers or obstacles might arise for the patient or practitioners/clinicians being able to access or refer into the services, interventions and support suggested.

Key findings & Learning

Area	Key Findings & Learning
Risk of False Reassurance	A number of review groups discussed a potential problem with false reassurance. If a patient is open to a service, we often assume that the patient is receiving what is needed and therefore don't consider further interventions or support. It was also noted that services may not be aware of the other services involved in a patients care, although improved access to HIE may help with this.

	The review group also considered that when we feel secure in relationships the patient has and the competence of those around them, we don't always probe further into their circumstances. This could be a barrier to the patient receiving the support they need. Perceived support networks seem to be a significant determinant into the level of need identified and therefore the subsequent support/interventions patients are offered.
Framing Anticipatory Care	Anticipatory Care is a new model of working, as such it is more challenging to convey a simple and effective message to the patient about what it involves and how they may benefit from it. Especially as some may feel they don't need any support at present. As part of the pilot we need to consider testing how we frame this in a way that works for the patient and encourages them to engage.
Impact of Covid-19	The majority of the review groups identified patients have a lost confidence in going outdoors and in their mobility generally as consequence of the pandemic. This could prevent patients from accessing services and maintaining their independence and quality of life.
Mental Health	Mental health a barrier to engaging and attending appointments.
Limited by Poor Communication	A number of the review groups discussed the difficulties in providing the patient the best support possible because poor communication between teams can be a limiting factor. A number of examples were discussed during the review and are included in the case notes review summary. Anticipatory Care requires a culture shift in the way which teams interact and communicate with one another.

e) What Matters to the Patient

The review groups were asked, whether from the patient's notes and any interactions with services represented, was it possible to tell what is important to the patient.

For the overwhelming majority of patients discussed, from examining the notes the review group were not in a position to relay what mattered to the patient or what their wishes were. This was often the case even where the patient was known to a particular service or individual in the group.

On a number of occasions some members felt that anticipatory care would be appropriate, but mainly to better understand what is important to the patient. Others were not sure if this was solely a reason to start the patient on the anticipatory care pathway and questioned whether these conversations could have been had by services the patient was under. For example, where a patient was housebound and under the Proactive Care Home Visiting Service in primary care, as this service is funded to include a holistic assessment with discussions on what patients' needs and wishes are and considerations of non-medical interventions and support, perhaps a better understanding on what matters to the patient could be identified during the home visits with the GP.

It was acknowledged that practitioners need time and space for building a rapport with the patient and properly understanding what is important to the patient, with workload and pressures on resourcing this isn't always practical or possible. An Anticipatory Care 'service' was discussed as provision which could allow 'what matters to me' discussions to take place, and considered this could be a role for the care coordinator in our future model. However, a reliance on the care coordinator having these discussions will limit the number of patients which the care coordinator can support on the pathway. Alongside this, it is recommended work is established to better equip practitioners across the system to be having these conversations with patients, personalised care is not specific to the Anticipatory Care pathway and should underspin the way we work across C&H.

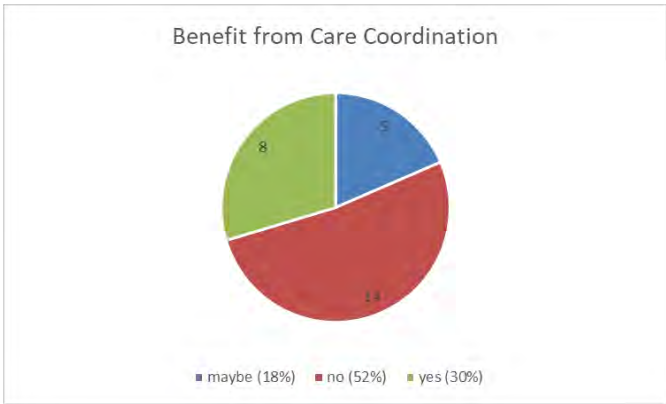
f) Care Coordination

Care Coordination is considered a key component of Anticipatory care. Care coordinators can proactively identify and work with people, including the frail/older adults and those with long-term conditions, to provide coordination, navigation and join up care.

Data Analysis

The group were asked to consider whether the patient would benefit from care coordination and more than half of patients were not expected to benefit from it, either because they were not under multiple services, already had a care coordinator in place (whether that be the GP or another service) or they were considered too complex to be supported by a band 4 care coordinator.

Given the small numbers it was hard to identify any particular trends, although it can be noted that whilst patients with a moderate eFI score of 0.25-0.36 made up 37% of the cases, when looking at patients that were considered not suitable for care coordination, they made up 43% of cases. On its own the numbers are too small to draw conclusions, however when coupled with learnings to date from the pilot, there is a suggestion that patients with an eFI score of moderate frailty 0.25-0.36 are less likely to benefit from care coordination.



Key findings & Learning from Discussion

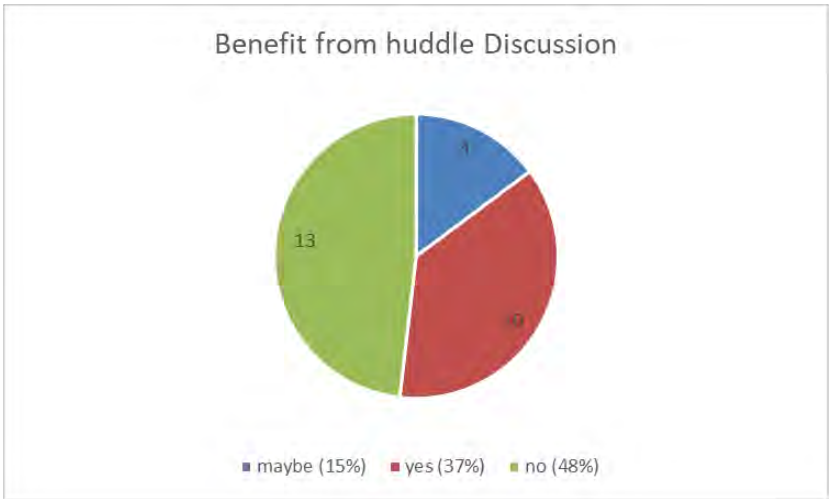
Area	Key Findings & Learning
Components of Anticipatory Care	The review group identified some patients would benefit from care coordination but not from a huddle discussion and vice versa. Not all patients need all elements of the pathway and so we need to consider how patients can be identified and entered onto the pathway for specific components which they would most benefit from.
Dementia	The review group often found that patients with dementia were being well managed by the Dementia Team. The Service is well set up and has access to access adult social care and housing etc, they have roles in place which undertake care coordination. Furthermore, the review group considered whether the anticipatory care, care coordinator would be equipped to care coordinate someone with dementia. We are currently exploring this within the pilot and have agreed that if a patient is under the Dementia team then before inviting patient on the Anticipatory Care pilot, the care coordinator should liaise with the Dementia team first to consider the merits of this.
GP as Care Coordinator	On occasions where the patient was under the proactive care home visiting service, the review group questioned whether there needed to be an additional care coordinator when the GP is essentially carrying out this role. However, this was not conclusive across all patients who were under the proactive Care Home Visiting service.

g) Multi-Agency Discussion / Huddle

Multi-disciplinary working is a key feature of Anticipatory care. As part of the pilot a group of practitioners (working in the Neighbourhood) hears what matters to the resident and collectively discusses and agrees on the support & interventions which could help the patient. We are currently testing a fortnightly ‘huddle’ in the pilot.

Data Analysis

Members were asked whether the patient would benefit from being discussed at a 'huddle' and why, as well as who would be key members of the huddle. Similarly to care coordination a large proportion, in this case 48% were considered as unlikely to benefit from multi-agency discussion. Given the small numbers it is hard to identify any trends for either eFI score of clinical frailty diagnosis.



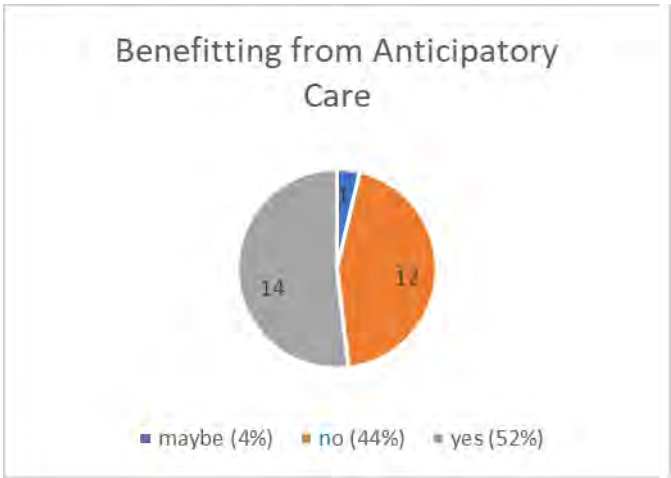
Key findings & Learning from Discussion

Area	Key Findings & Learning
Cohort Identification	Importance of robust identification as not all patients suitable. Various ways of doing this including understanding more about a patient's circumstances from primary care colleagues (currently testing this in the pilot).
Triage	Some patients were identified as not requiring a huddle discussion but could benefit from the care coordinator liaising with one other system partner, but wouldn't need multiple practitioners collectively discussing the patient. The patient could still benefit from the pathway but robust triage would need to be in place to identify those suitable for huddle and those which can be managed by care coordinator outside of the huddle meetings.
Huddle – Key Professional Groups	Difficult to conclude key findings on who is best placed to be in the huddle, we had asked the review groups to consider this but it wasn't picked up, and focus was in deciding whether patient would benefit or not. There was greater contribution from group members where the patient had either previously been on their caseload, was currently on the caseload or wasn't but would meet the criteria. Lack of contribution from review group members where the patient was not known to them, doesn't necessarily denote that the professional group would not provide valuable input into an anticipatory care huddle, but perhaps is a sign of the difficulty practitioners have in inputting into a case in a proactive way, with a different mindset they may have felt more confident to make suggestions for provision or support outside of their own specific service. Further work is needed to explore who will be the core huddle team, which we hope to pick up via the pilot.
Multiple declines or non-engagement	One of the reasons often cited for the benefit in multi-agency discussion is that there isn't anyone that looks at patients declining referrals or non-engagement with a service in totality.
Too complex	Some patients were considered too complex for a huddle discussion as they would need specific services in attendance which would not be present at a huddle. For a tailored multi-disciplinary approach, it was suggested that the patients would be more suitable for a Neighbourhood MDM discussion rather than an anticipatory care huddle. For some patients however, it was felt that they would benefit from care coordination, therefore we need to consider the relationship between the Anticipatory Care pathway and the MDMs. It will be key to work through whether or not a patient that requires a tailored discussion at an MDM can still be supported along the Anticipatory Care Pathway.

h) Benefit from Anticipatory Care

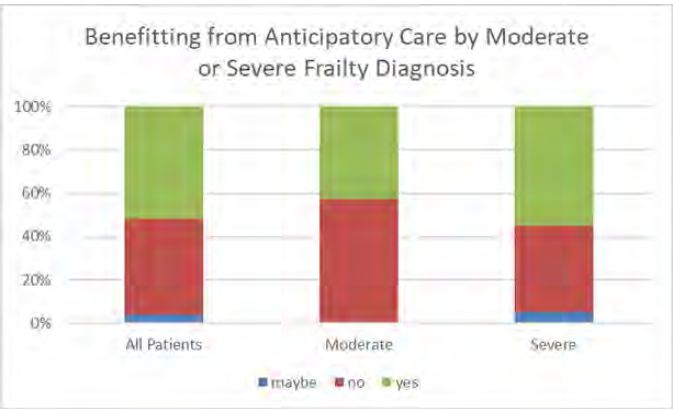
Data Analysis

At the end of each discussion, the review groups were asked whether overall, they felt that the patient would benefit from being on an anticipatory care pathway and what are the reasons why. Just over half the patients were considered appropriate for anticipatory care.

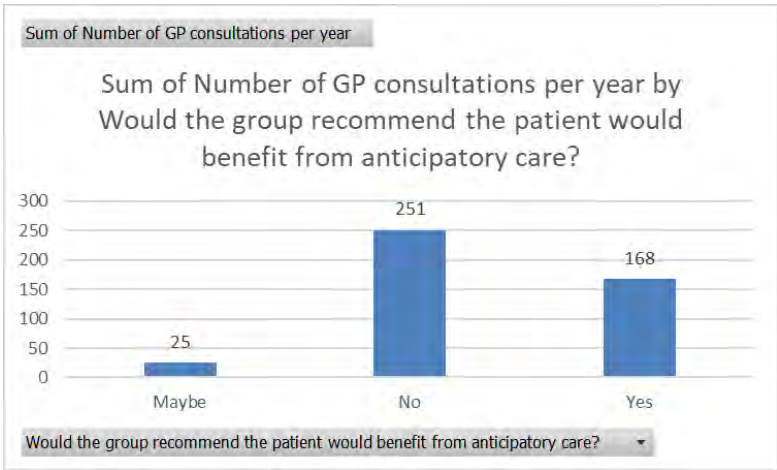


Given the small numbers it is hard to identify any obvious trends for either eFI score of clinical frailty diagnosis, there were patients with a wide range of eFI scores and patients with a diagnosis of both moderate and severe frailty.

The graph below shows the breakdown of patients by frailty diagnosis and whether or not patients were considered more or less likely to benefit from anticipatory care.



A clear trend identified between those patients which the case notes review identified would potentially benefit from anticipatory care was on the number of GP consultations per year. For patients that were considered as potentially benefitting from anticipatory care, the average number of GP appointments per year was 12, for patients considered as unlikely to benefit from anticipatory care, the average number of GP appointments per year was 21. The graph below illustrates this point with total number of GP appointments per annum. This suggests that where patients are already high users of primary care services they are less likely to benefit from the anticipatory care pathway as they are already receiving significant support from their GP Practice.



The pilot is not currently including housebound patients within the search criteria. There were 13 housebound patients included within the case notes review and nearly half (6) of these patients were considered as potentially benefitting from anticipatory care, because of this, it is suggested that there is further exploration of whether or not housebound should an exclusion/inclusion criteria for the pathway.

With a larger number of patients in the case notes review we may have been able to draw more meaningful conclusions on the likelihood of either eFI score or frailty diagnosis predicting whether a patient may benefit from anticipatory care, or indeed whether it is other factors which play a significant role in some patients being considered suitable and others not. While each case notes review group had standardised questions to work through and broadly consistent professional roles, it should be acknowledged that there will have been variation in the thresholds which each group used to establish whether or not a patient would have likely benefited from anticipatory care or not.

Key findings & Learning from Discussion

Area	Key Findings & Learning
Moderate Frailty Diagnosis	With some moderately frail diagnosis (not eFI score) patients there was a real sense that identifying them at this point in time, while the patient was still able to function, would be very beneficial and could provide good outcomes from anticipatory care.
Caught between Services	Anticipatory Care can support someone who might end up caught between services, eg. borderline memory, pain, never quite meeting thresholds but clearly needing support.
Dementia Team	The review group often found that patients with dementia were being well managed by the Dementia Team. The Service is well set up and has access to access adult social care and housing etc, they have roles in place which undertake care coordination. Mixed opinion as to whether patients already under the dementia service should be prioritised for Anticipatory Care pathway. If not then links with Long Term Condition (LTC) management services may need to be strengthened.
Unexpected Patients	Patients who practitioners may have initially questioned whether they would be suitable for Anticipatory Care, as they had moderate frailty with lower levels of complexity, where the patients GP may have felt they were managing well, actually after discussion turned up to be good potential candidates. This provides caution and counterbalance on too heavy reliance upon patients GP assessment as to whether the person would benefit from anticipatory care. However, this may change in time with a better understanding across the system on who is suitable for anticipatory care and who can most benefit from the pathway.
Housebound	The pilot does not currently include housebound patients however a number of patients within the case notes review were housebound and were considered suitable for anticipatory care. Recommend that this is reconsidered for future model, although consideration will need to be given on the capacity of care coordinator to undertake home visits. It was suggested within the review that a joint visit between a GP and the Care Coordinator may be beneficial. Neighbourhoods Team are meeting with Community Nursing to consider inclusion of housebound patients in the future.
Personalised Care and Support Plans	On an occasion where a GP did understand what mattered to the patient and how they wished their support to be provided, the patient had been very clear that they did not want

	yet another care plan as they already had multiple plans in place. Important that consideration is given to the added benefit of a personalised care and support plan developed under the anticipatory care plan, and how this differs from other care plans which the patient already holds.

i) Other Findings

System Approach to Frailty

One finding which was not directly specific to Anticipatory Care but related, was on tracking and flagging of frailty across the system. Currently the pilot is utilising frailty as a key indicator for consideration for the pathway (patients with a moderate or severe eFI score plus 3LTCs are considered). In one of the review groups the members discussed a patient which had come out of an inpatient episode in hospital, significantly frailer and housebound, but this was not flagged to the GP by discharge team.

The review group discussed the importance of documenting the level of frailty and functional status, including this on discharge summaries if possible, and most importantly flagging a major change with the GP and community teams so that they could plan care and provisions accordingly. One GP suggested that in the same way that we do a medicines reconciliation upon discharge from an inpatient episode, there should be a functional reconciliation and if needed a plan for rehab in the community.

This specific example feeds into a wider suggestion that we should consider a whole system approach to frailty. Frailty is currently being utilised in the Anticipatory Care pilot, being tested in A&E, utilised in Therapies, and there is a frailty pathway in SDEC (same day emergency care), and it is likely that many other services focus on functional assessment but may not use the same terminology. Consistent use of frailty across C&H in assessment and measurement will support a patient's frailty to be tracked and supported accordingly dependent on their frailty diagnosis.

5. Summary of Key Recommendations for Development of Anticipatory Care Model for C&H

Area	Recommendation
Culture Shift	Work up proposal on how we facilitate a culture shift across the system, including - The case notes review highlighted the restraints practitioners across the system have in thinking in an 'anticipatory way' supporting patients with rising need, earlier, not just when they hit crisis point, and putting in place support or interventions which may better support, slow or prevent expected deterioration. The foundations must be right for pathway to work successfully. - Embedding personalised care within mainstream provision, including digitally shared care planning and understanding what really matters to the patient (eg. ensuring that non-medical holistic discussions are taking place where time has been funded for more in depth discussion such as proactive care services in primary care) - Thinking how practitioners work together differently across the system in a more joined up way
Robust Identification of Cohort	Ensuring that we identify patients who will most benefit from the pathway and where we will best utilise the skills and resource available is vital. One of the biggest challenges of this programme of work is to identify which cohort(s) we should consider locally. Learning from the case notes review should feed into decisions on this, including - Slightly higher proportion of patients who were severely frail versus moderately frail considered as benefitting from Anticipatory Care, although not huge difference and numbers of moderately frail patients probably too low to draw conclusions - Patients with an eFI of moderate frailty suggested as less likely benefiting from care coordination - Many patients with both moderate and severe frailty are well managed within existing services and LTC management in primary and community care - Potential duplication of work with Dementia Team - Patients with a higher number of primary care appointments may be less likely to benefit from the anticipatory care pathway

	- Some severe patients too complex for pathway and required tailored Neighbourhood MDM - For some patients under Proactive Care Home Visiting with intensive GP support, in essence already had a care coordinator in place - Anticipatory Care beneficial to support someone who might end up caught between services, eg. borderline memory, pain, never quite meeting thresholds but clearly needing support. - Consideration of whether housebound should be included in the model (not currently being tested in pilot)
Triage	Even when using frailty diagnosis (not eFI scoring) the case notes review showed that only 52% considered appropriate for anticipatory care. Ensuring that we have timely and effective triage of patients identified as potential is key to ensuring that we use scarce resource as well as possible. This triage may be something that requires clinical input early in the pathway and could not be managed solely by the care coordinator (band 4). Two stages of triage may be required, (i) identification of those patient meeting search criteria which should be invited to the pathway, and (ii) decision on which patients must be discussed by the huddle versus which patients can be managed outside of the huddle by predominantly by a care coordinator.
Social Prescribing Capacity & Links with Voluntary Sector	Nearly two thirds of patients discussed were considered as potentially benefiting from social prescription. Based on case notes review and pilot, expected demand for the service to be modelled to consider if sufficient capacity is within the system. Many patients were not necessarily suitable for statutory health and social care services but would benefit from the holistic, person centred and non-medical support that community navigation pathways can offer. Absolutely key that we ensure that links into the voluntary sector are strengthened and have a sustainable offer.
Components of the Pathway	The case notes review challenge idea that all patients will receive full anticipatory care package, it is clear that some patients only need specific components. Pathway needs to be developed in a way in order to allow for a tailored approach for each patient. As part of this there needs to be considerable thought into how one-off referrals into structured MDMs and our Anticipatory Care pathway alongside one another and feed into one another where applicable.
Mental Health Transformation work & Attendance at Huddle	Mental health assessment for a variety of services, as well as potential referrals into IAPT made up a large proportion of suggestions for interventions which may be beneficial. Central to the work in development an Anticipatory Care pathway for predominantly but not exclusively older adults must include consideration of the mental health transformation work being undertaken at a NEL level. Development of an over 65 mental health neighbourhood MDT model is currently at the early stage of discussions. We must understand the cross over between pathways/provision of support. Given the level of mental health need identified, ensuring that we have the right mental health practitioner involvement in the huddle is key. We are in the process of liaising with colleagues in mental health to explore this further.
Framing Anticipatory Care to Patients	The case notes review discussion raised a key challenge of anticipatory care, how to convey a message to the patient that they may benefit from proactive care and support even though they might not feel that they need it now. To ensure that we come up with a model which has higher level of engagements, particularly when working with harder to reach groups, as part of the pilot we need to consider testing how we frame this in a way which is palatable for the patient and effective in encouraging the patient to participate.

Appendix 1 (Case Notes Review Discussion Template)

Anticipatory Care Case Notes Review Questions

The aim of anticipatory care is to support people to remain healthy and independent and at home for longer. It is preventative and targeted at people living with multimorbidity, frailty and/or complex needs at an earlier stage.

Anticipatory care is about developing a model of community based, multi-disciplinary care for people with rising needs including close working between primary care, community nursing, therapies, adult social care, ELFT community teams and the wider voluntary sector.

We are currently piloting anticipatory care in Springfield PCN. This case notes review supplements the learning and will help to inform our local anticipatory care model across all of C&H and future investment decisions.

The purpose of this case notes review is:

- To understand the extent to which patients are already known to existing community, mental health and social care teams
- To have a clinical & practitioner assessment of what support & interventions these patients may have benefited from or patients in a similar cohort could benefit from in the future in order to stay healthy, independent & happy longer

	Questions	**Case Notes Review Group**
	Patient number	
	Patient GP Practice	
	Clinical Frailty Diagnosis	
1	**What services is the patient known to / Primary Care Registers?** Detail which services and whether the patient is currently on the caseload or has been in recent years (previous 3/4 years)	
2	**What interventions could have or could be put in place to better support expected deterioration, or slow down a deterioration in their physical health, mental health, function?** Eg. Falls prevention or early intervention from a mental health service	
3	**What barriers or obstacles would there be for the patient or practitioners/clinicians being able to access or refer into the services, interventions and support suggested?** Eg. Service not available/commissioned, service has insufficient capacity	
4	**From the patient's notes and any interactions with services represented in the review, can we tell what is important to the patient?** **If not, what is missing and would an anticipatory care approach help support this?**	
5	**Care Coordination** can be a component of Anticipatory care. Care coordinators can proactively identify and work with people, including the frail/older adults and those with long-	

	term conditions, to provide coordination, navigation and join up care. **How would this patient benefit from care coordination? (might not be needed)** **If care coordination needed, who do you think is best placed to do this? Eg. Care Coordinator or service (if patient on caseload)**	
6	**Multi-disciplinary working** is a key feature of Anticipatory care. As part of the pilot a group of practitioners (working in the neighbourhood) hears what matters to the resident and collectively discusses and agrees on the support & interventions which could help the patient. We are testing a fortnightly 'huddle' in the pilot. **Based on this patient record, would this patient benefit from being discussed at a 'huddle' and why?** **If yes, who would need to be the key members of the huddle?** **If no, and this patient could be managed by an individual practitioner/service, who would this be?**	
7	**In summary would this patient benefit from being on an anticipatory care pathway and what are the reasons why?**	

Appendix 2 - Summary of Case Notes review

Patient number	GP Practice	neighbourhood	Clinical Frailty Score	Would the patient benefit from care coordination	Would the patient benefit from a huddle/multi-agency discussion	Would the group recommend the patient would benefit from anticipatory care	Support / interventions what could have helped now and what could help in future	Other comments
1	Lower Clapton	Hackney Marsh	Moderate	No, could benefit from just speaking with one partner, wouldn't be multiple	Possibly, dependent on what CC found out. Perhaps because no one was looking at the declines in totality	YES Yes, patient continues to decline offers, helpful to better understand patient needs and ascertain what patient would find helpful. Care coordinator discussion would be helpful.	Social prescription Mental health needs assessment	Patient said she didn't want yet another care plan. Members asked where is the professional curiosity on understanding on declining of services.
4	Lower Clapton	Hackney Marsh	Moderate	Yes, care coordinator can pull all strands together	Yes, multiple practitioners involved and a huddle discussion would be useful	Yes, a number of interventions identified as result of multi-agency approach	Wonder about low mood and felt this should be explored further, potentially via IAPT Ability Bow - https://www.abilitybow.org/ Gym support with network Discussion on what would happen if her partner died?	Problem with false reassurance – if the patient is open to a service, we can't necessarily assume that the patient receiving what is needed. Potential barrier is that when we feel secure in patients relationships or competence we don't probe further and this could be a barrier to the patient accessing the support they need i.e partner is nurse

6	Lower Clapton	Hackney Marsh	Severe	Yes, would benefit from care coordination	No, probably not appropriate for huddle. Need specific services and planning ahead on key partners and individuals. Would be appropriate for an MDM discussion.	No, benefit from an initial discussion with care coordinator and potential care coordination but perhaps too complex for anticipatory care pathway. Suitable for MDM	Falls assessment Social prescribing MHCOP or IAPT Buddying	ASC and LD not communicating. Patient could have been better supported through improved and earlier communication between teams. Perceived support networks seem to be a significant determinant in what level of need is considered and therefore the support and intervention a patient is offered. Lack of professional curiosity.
3	Lower Clapton	Hackney Marsh	Moderate	Potential benefit from care coordination, person centred approach.	Possible, not sure until discussion with care coordinator, but probably yes	Yes, would benefit from starting a different type of conversation. Identifying her now feels like good timing, still able to function now but may be able to make a difference with anticipatory care. Need time and space for conversations to build rapport and put the patient at the centre.	Carers referral Dietetics but wouldn't meet criteria so something with lower threshold Referral for mood - IAPT SMR	How do you get across the message that the patient may benefit from proactive care and support even though they might not feel that they need it now? How do you frame this in a way which is palatable for the patient?
2	Lower Clapton	Hackney Marsh	Moderate	No	No	No, wouldn't prioritise for discussion with care	Nothing	

						coordinator or anticipatory care. Patient is managing very well.		
5	Lower Clapton	Hackney Marsh	Severe	Yes, could case hold, keeping GP in loop	Yes, reviewers asked lots of questions asked and felt patient would benefit from huddle	Yes, sounds like someone who might end up caught between services, borderline memory, pain, never quite meeting thresholds but clearly needing support – good one for anticipatory care Care Coordinator will be in position to piece things together and explore multiple declines in more detail.	Pain clinic Mood - IAPT	Not open to ASC, but did have brief contact at the time of bereavement (2019) and didn't use that opportunity to think with her about her needs. What's really important here is the approach – conversation with resident as to what matters to them. Care coordinator cuts across specialisms and takes holistic approach and has the time to ask questions, explore and be curious.
2	Nightingale	Hackney Downs	Severe	No, GP undertaking care coordination and only known to a few services	No, however this is because patient has said that he is content. However he is at risk of deterioration.	No, no unmet need identified	ACERs	Needs f2f appointments because of hearing. Question mark around advocacy as potentially patient feels pressure from family to say he is managing ok.
3	Nightingale	Hackney Downs	Severe	Possibly, would need to see after initial discussion	Possibly, would need to see after initial discussion	Yes, a conversation about her needs and wishes to better understand wider issues and take holistic approach.	Social Prescribing	Lacking in understanding on what is important to the patient. No sense of holistic understanding. No understanding outside of medical.

						Although before invitation would need a discussion with GP and Renal Team as to what is appropriate. Particularly with end stage renal failure.		Poor communication between renal team and GP, no dialogue or sharing of key information. Patient in for dialysis 3x a week but still not clear on what her needs and wishes are, how do we capitalise better on these opportunities.
4	Nightingale	Hackney Downs	Severe	No	No	No, has dementia, bed bound and ASC involved. Seen by right people, has care plan in place, things are working for her and dementia team are case holding, managing and coordinating.	None	Review group considered whether band 4 care coordinator on anticipatory care pathway would be equipped to care coordinate a patient with dementia. Care Coordination already taking place under dementia team.
5	Nightingale	Hackney Downs	Severe	No	No	No, patient has advanced dementia and is being managed by dementia team and is under ASC.	None	As above and not much information on what matters to the patient, this should have been better understood earlier in life.
6	Nightingale	Hackney Downs	Severe	Possibly, depends, previously had lots of other services involved,	Possibly	Yes, some members felt that a conversation may be helpful on what is important.	None identified	But not sure if this is a reason to have on anticipatory care. Could this be done by GP? If this patient is housebound and PCHV why isn't GP having holistic discussions

				hard to say until better sense of what patient wants		GP didn't know if any unmet need or what matters to the patient.		that are non-medical? Patient on home visiting register. The patient is housebound but has been considered suitable for anticipatory care.
1	Sandringham	London fields	Severe	No not at this stage	No, not necessarily as quite straight forward	Possibly, borderline. Potentially proactive things that could be looked at, she is managing well currently but potential support could be given to maintain this. At least initial discussion with resident – patient has walking aid and had a fall recently.	Social prescribing Gym membership Wellbeing walk Pain clinic Some to check in regularly – buddy (?)	Didn't know persons needs and wishes
2	Sandringham	London fields	Severe	Potentially	Potentially	Yes, but light touch. Polypharmacy, had a fall, in touch with lots of different services, lots of hospital appointments for various things. Potential social isolation.	Falls assessment Social Prescribing IAPT potentially	No one had any idea about wishes
3	Sandringham	London fields	Severe	No care coordination needed as under Dementia Team.	No, already got ASC, dementia navigator, elderly care and GP involved.	No, would have benefited earlier in life but now too complex. Under dementia team currently	None	Now doesn't have capacity to make decisions and should have understood what was important to patient earlier. We could have anticipated this

					Not appropriate for huddle. If earlier in pathway would have benefited form group discussion			deterioration she was always going to get worse and we would have known this – should have collected wishes, help with finances etc
4	Sandringham	London fields	Severe	Potentially	Yes, identified potential referrals to be made where we could intervene earlier	Yes, merit in patient being on the pathway. Potentially early dementia.	Referral to MHOP team for assessment Potentially for physio around mobility	Patient wishes not known Patient didn't have CMC and not on proactive care registers
5	Sandringham	London fields	Severe	No	Yes, huddle would be helpful as MDM group identified lots of potential support	Yes, would benefit from assessment and proactive referrals and sign posting	Support with reading letters and attending appointments Regular check in phone calls, buddying? Referral to Engage Riverside? Stroke project?	No CMC care plan in place nor on proactive care registers
6	Sandringham	London fields	Severe	No need for care coordination as family supports but could be needed if no family	No	No, very well supported by family, otherwise probably would have benefited form care coordination. No specific needs identified.	None	Didn't show wishes and this should have come through
1	Lawson	Shoreditch park and city	Moderate	No, reviewers considered	No. Potentially in future but need mental	No, probably not, although could benefit	Mental health referral for psychiatric review	Mental Health intervention which helps her and her family, she

				Care coordinator could have role if the patient started attending the patients more.	health support first.	from wellbeing practitioner	Carers assessment for family	can't do it on her known, teaching family members grounding techniques, a systematic approach – looks like we don't have this available. Mental health a barrier to engaging and attending appointments.
5	Lawson	Shoreditch park and city	Moderate	No. GP currently sees himself as care coordinator	No. Potentially patient would benefit from huddle as lots of discussion at MDM case notes review but patient doesn't want to engage.	No not in this instance. Ordinarily a patient with this description would potentially benefit but this patient is very proud of her independence and doesn't think she needs to work on anything with dietetics or nutrition and wouldn't want referrals to any community navigation services.	Build her strength and confidence Nutritional support Referred her to ACRT today	
1	Heron	Woodbury wetlands	Severe	Yes	Yes, as various ideas in MDM discussion	Yes, chronic diseases, frail and deteriorating	MH input? Dementia navigator Alzheimer's support Support with understanding diagnosis End of life conversations – advance car plan	

2	Heron	Woodbury wetlands	Severe	No, either GP or Parkinson's nurse	No, is managing ok	No, already under Parkinson team and close working with GP	There isn't anything that isn't working for her, no unmet needs identified. She is under the Parkinson team. She is known to ASC. She is going through home exercise programme and with ACRT.	
6	Lawson	Shoreditch park and city	?	No, probably not	No, potentially more like MDM with specific specialist input	No. perhaps not anticipatory care but wellbeing practitioner?	Wellbeing Practitioner IAPT or CMHT	Case didn't necessarily show holes in what we're doing but it kind of showed that we sometimes we hold on to people where other practitioners could be better placed to help them.
1	Barton house	Clissold Park	Severe	Possibly but not under many services currently	Yes, good to understand the range of services and activities available in local area, specific to patient's community and culture	Yes, prevention of deterioration of mobility	Adult community rehab ACRT / physiotherapy Day centre / lunch clubs Social prescribing Wellbeing practitioner – CBT approach	LTCs well managed in primary care, under PCHV
4	Barton house	Clissold Park	Severe	No	Yes, potentially therapies or physio or wellbeing practitioner	Yes, to explore what a good day looks like and to explore what can be done to help her stay independent	Therapies / Physio Thinking about how to keep mobility Social prescription	No idea on what matters to the patient

							Joint appointment with care coordinator and GP for patients on PCHV – link chronic pain with what patient likes and known to local areas Wellbeing practitioner, to build a rapport	
3	Barton house	Clissold Park	Severe	No, already has one, it would be confusing to add another into mix	No	Not suitable for anticipatory care. Already has a care coordinator under the community mental health team. Needs better communication between GP and care coordinator.	Potential social prescribing could help with isolation could be of benefit but patient known to be a risk	Calls GP more than 40 times a day – what can be done to support frequent attenders in primary care 6 home visits by GP GP didn't know that community mental health team were going in every week and this is been happening for 2 years – poor communication. GP also visiting but this could be linked with MH team. GP didn't know he had 4x a day adult social care
2	Barton house	Clissold Park	Severe	Yes, because she has had a significant deterioration in her function this year and is now severely frail	Lots of people involved and so discussion would help	Yes	Referral to memory clinic	Patient came out of hospital significantly frailer & housebound but this was not flagged to GP by discharge team. Importance of documenting the level of frailty and flagging with the GP if there is a change

								in this. Eg. Therapies contact the GP. Include level of frailty on discharge summaries and particularly flag if there has been a change.

Title of report:	Better Care Fund (BCF) Submission 2021-22
Date of meeting:	9 December 2021
Lead Officer:	Nina Griffith
Author:	Cindy Fischer
Committee(s):	• Unplanned and Planned Care Workstream Directors, CCG Accountable Officer and Local Authority Directors of Adult Social Services – Sign-off submission 16 November • Submission to NHS England on the 16 November • The City of London Health and Wellbeing Board approved the submission on the 26 November. • Integrated Care Partnership Board – for Information 9 December • London Borough of Hackney Mayor Philip Glanville and Cllr Christopher Kennedy (for HWB) -sign-off sought 22 December.
Public / Non-public	Public

Executive Summary:

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from CCG allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), and the improved Better Care Fund (iBCF).

The BCF Planning Requirements for 2021-22 were published 30 September 2021 and systems were required to submit BCF plans by the 16 November 2021. Approval can be sought by Health and Wellbeing Boards (HWBs) after the November deadline, however, plans cannot be formerly approved and section 75 agreements cannot be finalised until sign off by the HWB.

The national CCG contribution to the BCF has been increased in line with average NHS revenue growth from 2019 to 2024 (5.3%). Local allocations are based on the BCF allocations formula, which uses both the local government relative needs formula (RNF) and the core CCG allocations formula. This means that percentage uplifts at HWB level will vary from area to area.

City and Hackney's minimum contribution change was 5.3% for a total minimum contribution of £23,901,000.

Recommendations:

The Integrated Care Partnership Board is asked: • To note the report.

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

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☐	
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	One of the national conditions for the BCF is an agreement to invest in NHS-commissioned out-of-hospital services.
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	The BCF continues to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital.
Empower patients and residents	☐	

Specific implications for City

The City received an increase of 12.8% to the CCG contribution for a total of £799,980. The DFG and iBCF grants bring the total pooled budget to £1,151,215.

Specific implications for Hackney

Hackney received an increase of 5.4% to the CCG contribution for a total of £23,100,819. The DFG and iBCF grants bring the total pooled budget to £40,979,074.

Patient and Public Involvement and Impact:

The plan is predominantly a continuation of existing service provision and has not had patient and public involvement in its entirety. Individual programmes of work such as the Neighbourhoods Programme and Discharge have regular engagement with service user representatives and Healthwatch. It is not anticipated that the content of the report is likely to impact on public and patient perceptions of service providers.

Clinical/practitioner input and engagement:

Clinicians have been involved in the development of specifications for the services included within the BCF. Individual programmes of work such as the Neighbourhoods Programme and Discharge have regular contribution from clinicians/practitioners.

It is not anticipated that the content of the report is likely to impact on clinicians/practitioners.

Communications and engagement:

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

This report does not require communications and engagement as it is a narrative and expenditure plan for submission to NHSE. Individual schemes would engage or communicate as appropriate.

Equalities implications and impact on priority groups:

The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

Safeguarding implications:

Not applicable.

Impact on / Overlap with Existing Services:

The BCF started in 2013 and the 2021-22 plan is a continuation of service provision and transformational initiatives that seeks to join up health and social care.

Main Report

Please see joint narrative plan and individual planning templates for each HWB.

Supporting Papers and Evidence:

N/A

Sign-off:

Workstream SRO: Charlotte Painter, Director Planned Care and Nina Griffith, Director Unplanned Care
London Borough of Hackney: Helen Woodland
City of London Corporation: Andrew Carter
City & Hackney CCG: Henry Black

City & Hackney Partnership

Better Care Fund
Narrative Plan
2021-22

Contents Page

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13. Equality and Health Inequalities
14. Summary

Stakeholder input into preparing the plan

- Discussions with senior officers at the Council, CCG and Homerton Hospital
- Discussions at Discharge Steering Group (includes service user reps, Healthwatch and Age UK East London)
- System operational command group (SOCG)
- Local and North East London (NEL) wide Homelessness meetings
- City HWB sign-off will be on 26/11/21
- Hackney HWB sign-off will be on 22/11/21

Background

Background

Like all partnerships, 2021-22 has been an extremely difficult and testing time. As winter approaches we are again planning for unprecedented pressure on the Health and Social Care System.

This year saw the continued implementation of the NHS Discharge Policy which has had a significant impact on all areas but particularly adult social care. Our partnership has been tremendously successful in reducing and maintaining low length of stays, with Homerton Hospital consistently being the Trust with the lowest length of stay within NEL and London generally.

Last year also saw Hackney Council subject to a major cyber attack in October 2020, with the effects still impacting adult social care systems, including our payment and performance management abilities. Work is ongoing to develop new modern systems to meet our future needs. This has meant that as well as managing the pandemic, staff have also had to deal with manual recording systems and have had to develop work arounds, which has also affected our ability to produce performance reports.

Governance

ICP Governance Arrangements

The following outlines how we have structured ourselves and our work:

- Historically, the commissioning and planning of services with partners was arranged under **care workstreams** structured around major areas of commissioning investment in health and care improvement.
- The pandemic has emphasised the importance of working in partnership on an operational basis to coordinate delivery of improvement work.
- Our future approach to system-level planning is organised around a single view of **population health outcomes** and improvement areas, broken down into broad thematic categories, rather than four or five separate plans reflecting the way that services are structurally organised.
- We have arrived at **five areas of focus for our improvement and transformation planning**, three which reflect broad thematic areas: “Children, Young People, Maternity and Families”, “Communities and Staying Well”, and ”Rehabilitation and Independence”; and two which represent areas which have distinct national and regional funding and oversight regimes: “Primary Care” and “Mental Health”.
- We have also mobilised a time-limited City and Hackney vaccination programme, given the importance of this agenda in 2021.

BCF Governance

As the following slides show, BCF schemes and priorities are integrated into the overall system governance, planning and priorities.

There is huge amount of joined up working and cooperation happening at the local level and BCF is part of these discussions.

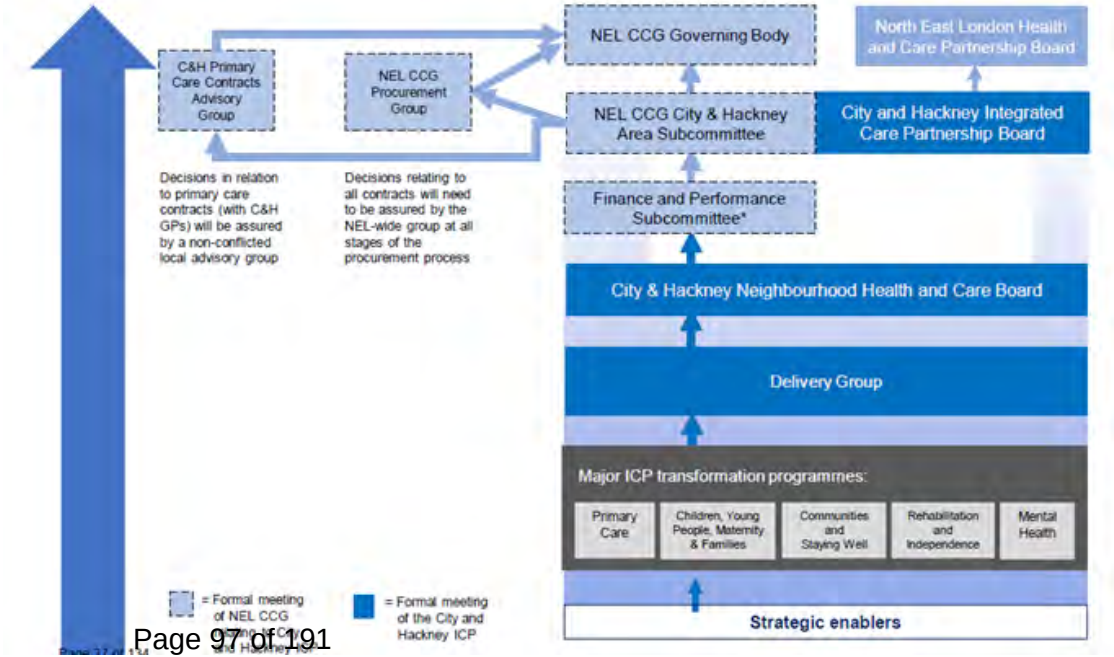
At a local level, LBH ASC Director, Finance and BCF Lead meet quarterly with two CCG Workstream Directors, Finance and BCF lead to monitor BCF schemes, performance and sign off returns. City of London Corporation staff also meet with CCG leads for monitoring and sign-off.

There is a also a monthly Hospital Discharge Group which is comprised of system partners, including service users, Healthwatch and Age UK. This group plans, challenges and reviews progress against the NHS Discharge Policy and related BCF Metrics.

Governance, Management and Reporting

Governance route for financial decisions between ICP and NEL CCG

This diagram shows the indicative route by which decisions would be assured in relation to major proposals, however the use of SFIs and the Scheme of Reservation and Delegation mean that many decisions will not require this full governance route.



Governance:

- The governance process to follow will be in-line with the NEL CCG Governing Body approved City & Hackney ICP structure (in addition to the approval by HWBs).

Management:

- Once the BCF budget is agreed between partners, it must be presented to the City & Hackney Finance and Performance Sub-Committee for approval prior to presenting to the Health & Wellbeing Boards.

Reporting:

- The existing reporting structure will continue in terms of financial data shared by LBH and CoL for invoicing purposes.

- Variance analysis and emerging risks will be highlighted to the FPSC to make recommendations to take action by the BCF commissioning leads.

City & Hackney ICP
Overall Approach to Integration

The 21/22 City and Hackney Integrated Care Partnership Priorities

The next slide sets out our key priorities for health and care partners in 2021/22, as established through the System Operational Command Group. This work will continue through the ICP Delivery Group. Two key themes run throughout the plan:

- **Addressing inequalities:** this has grown in significance, and we are taking a more systematic approach across all areas of our work. This should become core business, supported by a new Population Health enabler.
- **Covid recovery:** is a key focus for all parts of the system, including through the delivery of a vaccine programme, re-starting services, developing or adapting services to support people who are experiencing the ongoing impact from Covid-19 and being prepared to respond to future outbreaks / campaigns and resulting pressures on the health and care system.

Our local priorities also include delivery of the key 'must dos' for the health and care system defined in the NHS Operating Plan for 21/22.

Given the context of the ongoing pandemic the plan is predominantly focused on health care services, however, it does include a number of priorities that are focused on integration with social care, wider local authority and other partners.

Work is currently underway to develop the City and Hackney ICP that will bring together health and local authority partners to take joint responsibility for the health outcomes of the City and Hackney population. As this partnership is formed there will be a wider strategy development process, which will align to the development of the Health and Wellbeing Board(s) strategies over the next year.

The following plan presents the key deliverables for this year whilst we develop our longer term multi-year strategy.

City and Hackney Borough-based Partnership priorities 2021/22

High level one-page summary

Children, Young People, Families and Maternity

1. Mental health and wellbeing:

- Childhood Adversity, Trauma and Resilience support for system professionals working with families
- Prioritise earlier prevention and wellbeing through new Integrated Emotional Health and Wellbeing Action plan
- New pathways in place for CAMHS discharge and a T3.5 service with strengthened community approach to S&LT

2. Addressing inequalities in most vulnerable groups:

- Continue to Increase uptake of immunisations and vaccinations in childhood and pregnancy
- Continue to prioritise health and wellbeing needs of Looked After Children (LAC) and Unaccompanied Asylum Seeking Children (UASC) by tailoring services to specifically meet their needs.
- Continue multi agency early help for families who have complex medical needs, SEN and identified vulnerabilities.

3. Improving quality and integrating services:

- Continue to deliver maternity transformation in safety, address inequities and improve perinatal mental health
- Test approaches to social prescribing at PCN level for children and families, alongside NEL partners

Communities and Staying Well

1. **Integrated Urgent Care –** support people away from hospital and develop effective pathways from 111
2. **Discharge Pathways –** implement a sustainable single point of access, embed Home First and better involve patients in decisions about their discharge
3. **Neighbourhoods:**
   - Take a more proactive and joined up approach to support residents with rising needs
   - Continue to redesign services that will make up Neighbourhood blended teams and provide OD support to them
   - Increase resident involvement and integration of VCSE services in a Neighbourhoods
   - Arrangements to improve our knowledge of and act on health outcomes and inequalities
   - A Neighbourhoods approach to population health

Mental Health

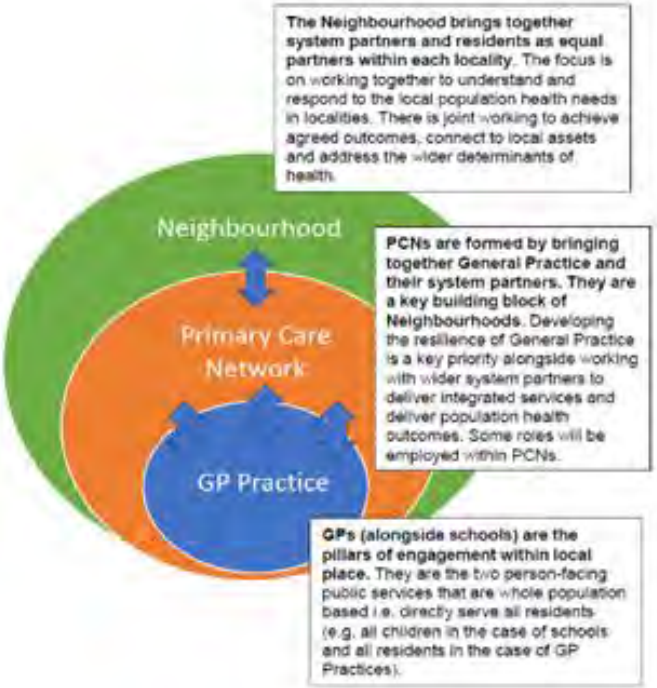
1. **Severe Mental Illness Digital Platform**
2. **Personal Health Budgets (PHBs)**
3. **Expand services that address Common Mental Health Problems** (Anxiety and Depression)
4. **Develop Staff wellbeing recovery plans**
5. **Dementia Service**

Rehabilitation and Independence

1. **Restoring Elective and Cancer Services –** working with NEL Cancer Alliance, wider partners and support services
2. **More integrated care for residents with ongoing health and care needs:**
   - Improve access to neighbourhood provision and integrating specialist skills in areas like: Diagnostics, First Contact Practitioner, LTCs (diabetes, heart and respiratory disease), Gynaecology; services for LD & autistic people
   - Develop new pathways and services for residents with long term rehabilitation needs after COVID-19
   - Improve specialist advice from consultants to GPs and patients and developing the model of advice and guidance
   - Better integrating the health and care offer to residents in care homes and residential settings
3. **Specific actions to address health inequalities**
   - Monitor and address the additional needs of particularly vulnerable people, and implement learning from the review of premature deaths of people with LD
   - Ensure that the 'in for good' approach taken to support homeless people and rough sleepers is built upon
   - Ensure that we improve end-of-life care within our health care system

Neighbourhoods approach to Integration: strengths-based & person-centred care

- Neighbourhoods is our major transformation programme for the redesign of community services locally. The programme is provider led.
- Neighbourhoods are critical to the delivery of integrated care and provide the geography around which we are aligning many of our health and care services. They are crucial in working together as system partners to address health inequalities.
- We are already bringing together these services, supporting multi-agency working and adopting a more strengths-based approach that focuses on what matters to residents.
- As a local system we want ‘place’ rather than ‘organisation’ and ‘conversation’ rather than ‘referral’ to be the currency of integrated service provision locally. We want to ensure that residents receive care and support that is closer to home, based on what matters to them and in a way which means they do not have to tell their story multiple times.



Key Changes Since Last BCF Plan

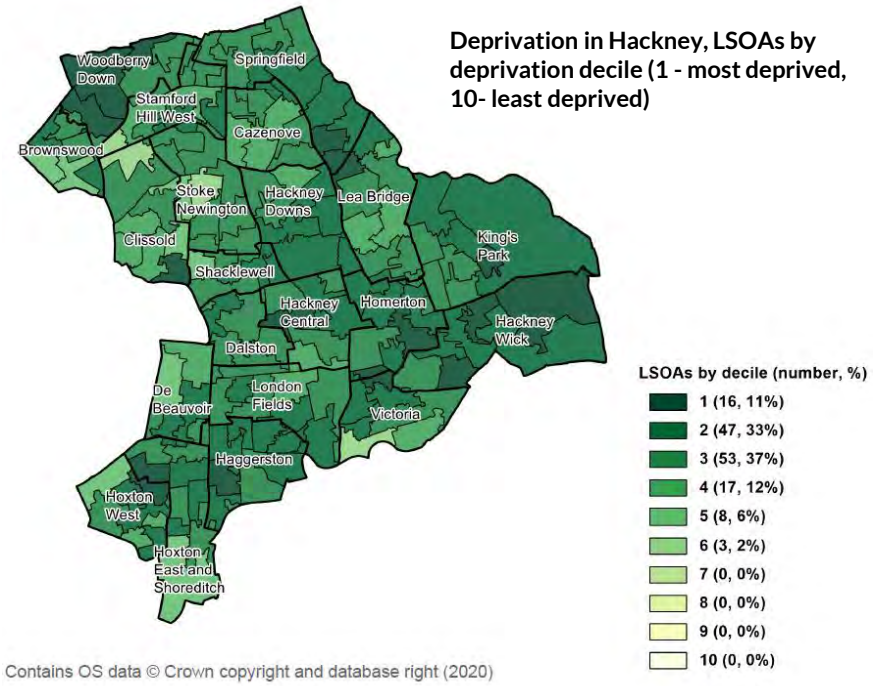
Funding remains in place for implementation of care act duties, carers services and reablement in addition to other core community services. The partnership has reviewed the schemes that formed the previous years return and it has been agreed that this year's plan should better reflect the partnership spend to reflect the investments which support the BCF metrics.

Schemes added this year:

- Pathway Homeless Hospital Discharge Team
- DES Supplementary Care Homes Service

The BCF plan also aligns with transformation and integration initiatives such as Ageing Well.

Hackney's Population



Sources: ONS, Population estimates. Ministry of Housing, Communities & Local Government, English Indices of deprivation 2019.

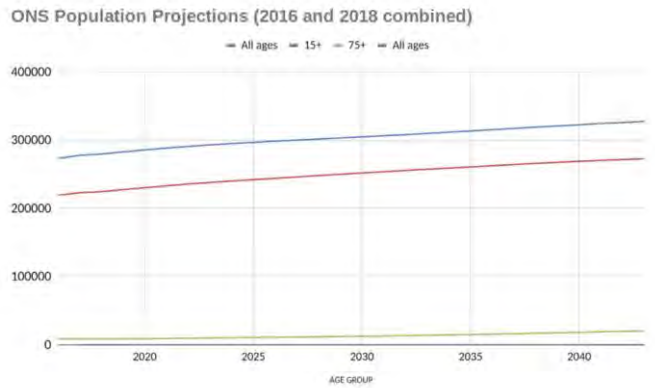
- Hackney has a population of just over 280,000 residents
- More than 20% are under 19 and under, 68% are aged 20-64 and c.10% are over 65 (gla figures)
- It is predicted that Hackney's population will grow to around 300,000 in 2030 and **the largest proportionate increase (around 33%) is predicted among residents aged 65+** (
- **Hackney is an ethnically and culturally diverse area** with around 40% of residents coming from a non-White background; the borough is home to large 'Other White', Black and Turkish/Kurdish communities, as well as a large and growing Charedi Jewish population
- **The borough is relatively deprived** although becoming less so on average; within-borough social inequalities are widening

Impact of COVID on Discharges in Hackney

Impact of Covid & Discharge Policy on Adult Social Care

- The number of hospital discharge clients has increased from 148 clients in 18/19 to **527** clients discharged in 20/21. Based on current trends there will be an estimated **670+** clients discharged in 21/22.
- The post covid homecare spend suggests an additional worst case scenario estimated pressure of **£6.8m** in 21/22
- The growth in all age population between 2016 and 2020 was on average 1.13% but the growth in the number of people receiving care was on average 6.14% in the same period.

ONS Populations figures



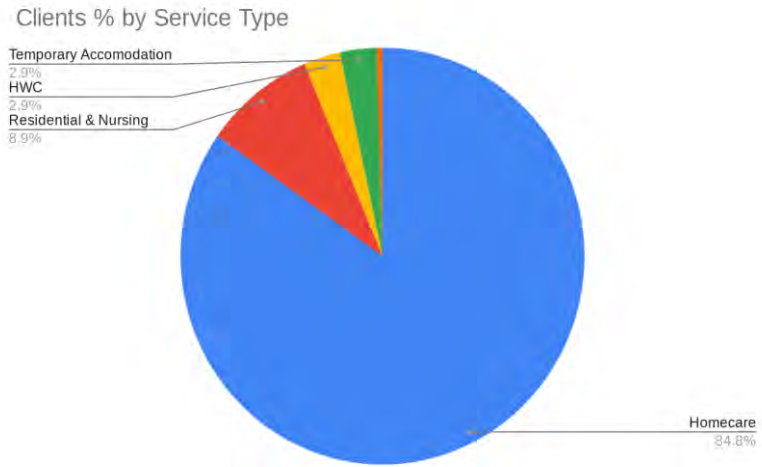
The predicted average annual growth in the Hackney population is 0.59%.

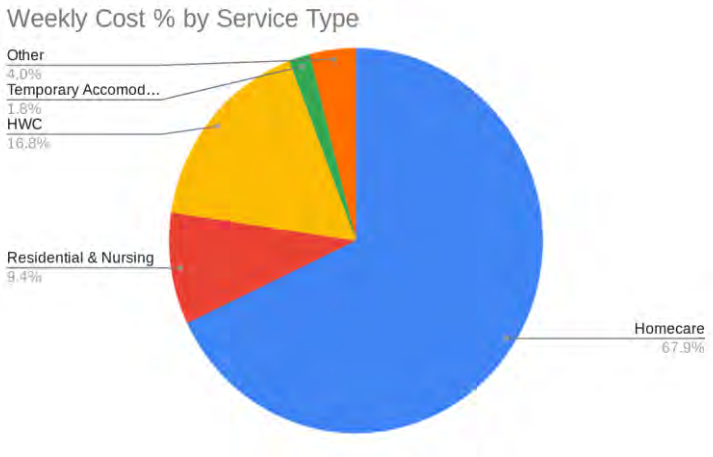
The predicted average annual growth of the population aged 75 or over is 3.42%.

The average annual growth in adult residents either accessing personal care or placed in a care home was on average 6.14% between 2016 and 2020.

The average annual growth in double handed care packages was 32% between 2017 and 2019.

Hospital Discharge - Client & Weekly Spend by Service Type

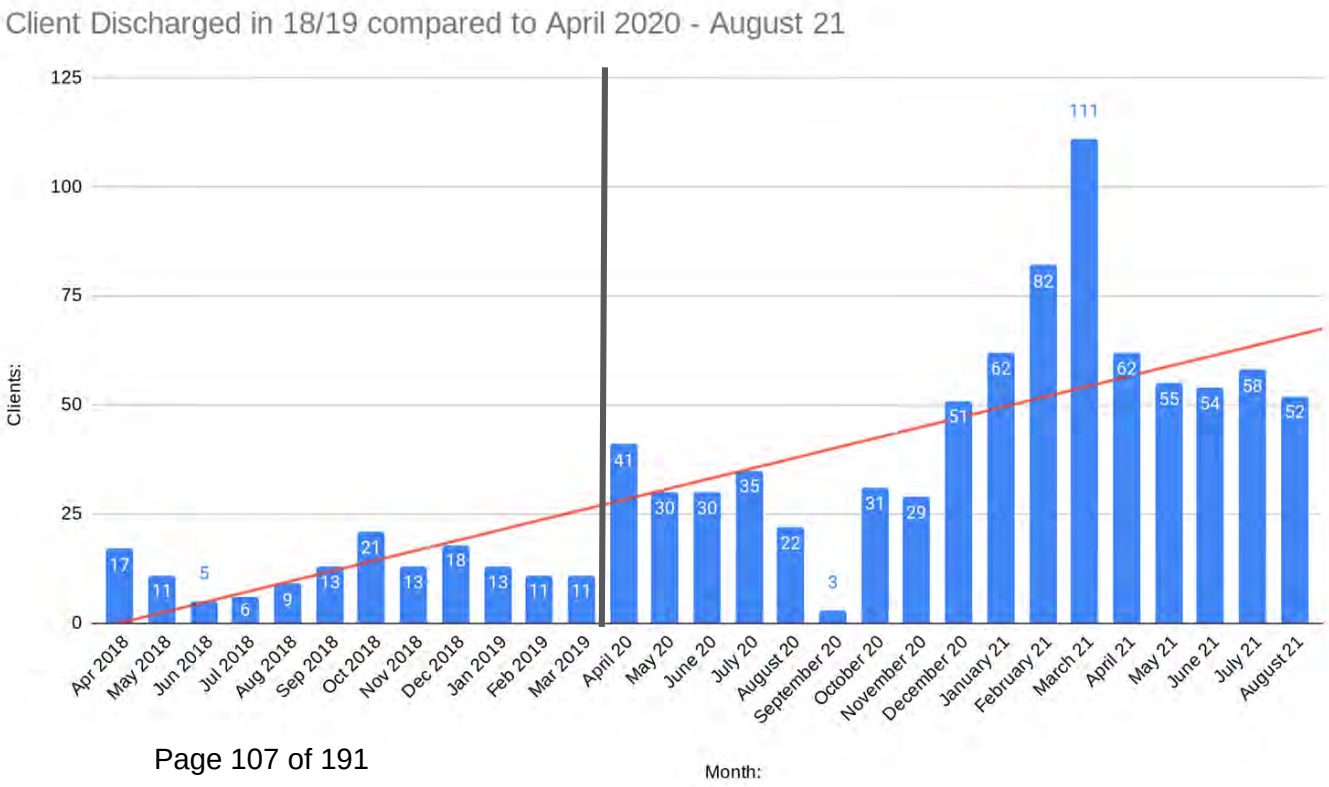




- In total there have been **808** clients discharged from April 20 to August 21
- **85%** of clients are discharged are into a homecare placement which equates to **687** clients
- **9%** of clients are discharged into a care home placement which equates to **73** clients

- **68%** of the costs of discharge directly relate to Homecare with an average Homecare package costing **£331** a week
- **9%** of the costs of discharge directly relate to Care Homes with an average Residential/Nursing package costing **£1,205** a week

Hospital Discharge - Clients Discharged between April 18 to August 21



18/19:

- There were a total of **148** clients discharged in 18/19

20/21:

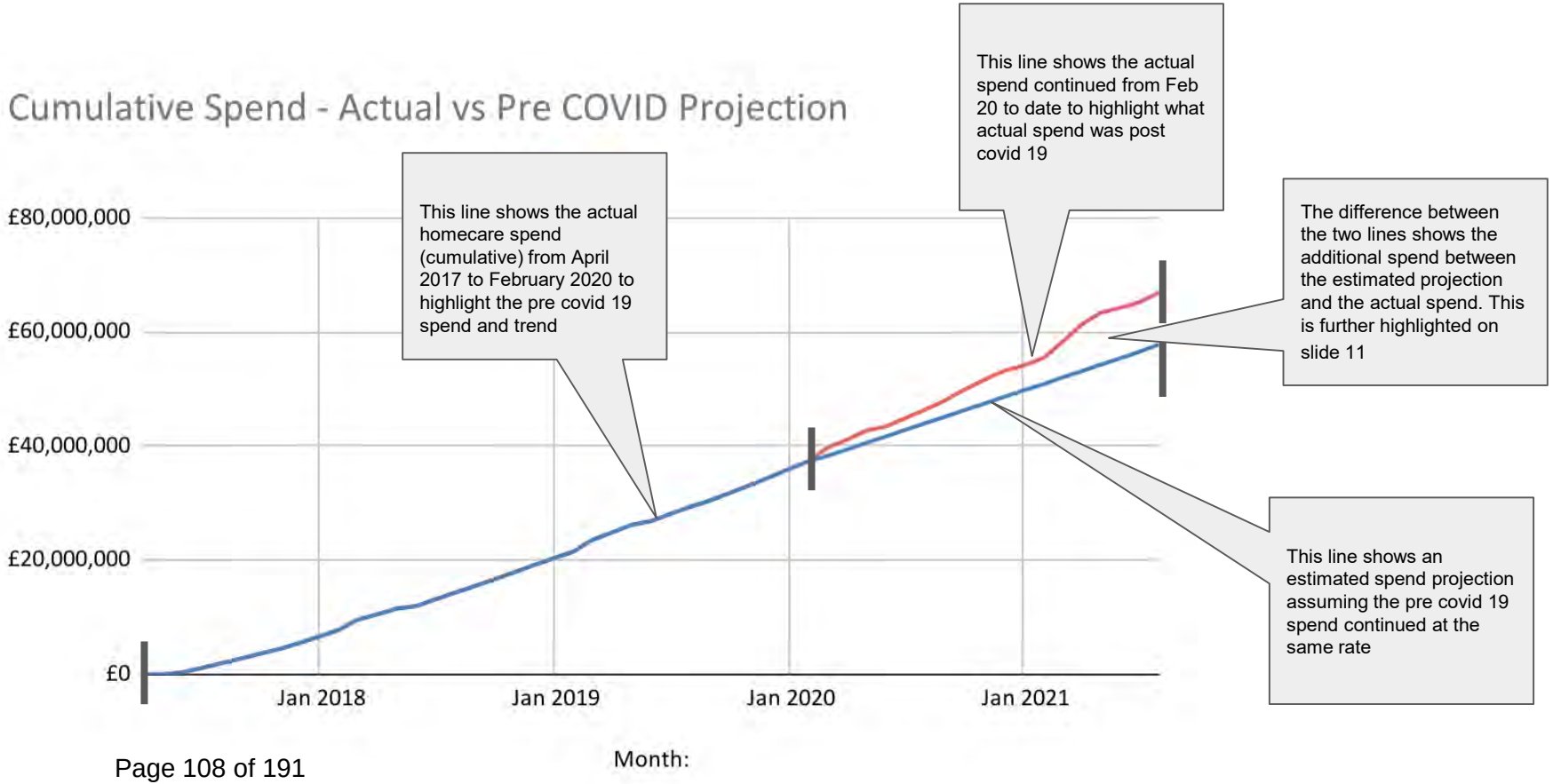
- In 20/21 there was **256%** increase in clients discharged compared to 18/19 (**527** clients discharged for 20/21)

21/22:

- There have been a total of **281** client discharged from April 21 to August 21
- Based on current 21/22 trends there is an estimated **670+**
- This would reflect an increase in clients of **353%** compared to 18/19 and **27%** compared to 20/21

**September 20 data skewed due to the Cyber Attack*
**Full data for 19/20 currently not available*

Monthly Cumulative Spend - Homecare April 17 to August 21

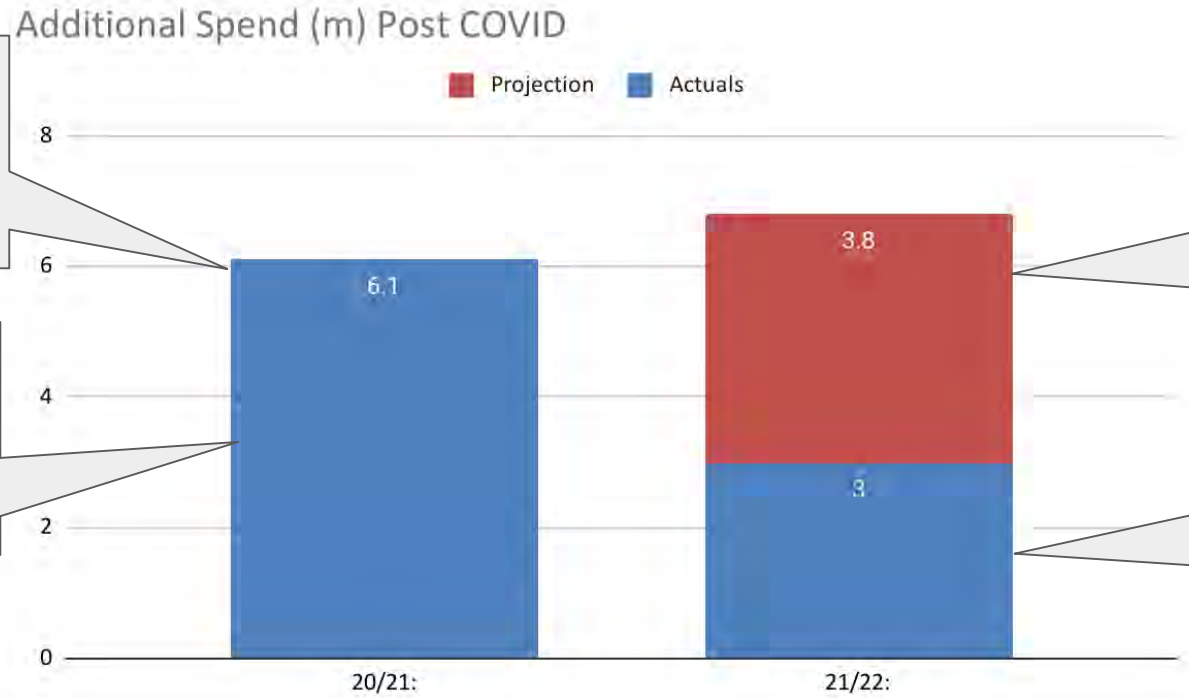


**** Data used is based on the actual monthly homecare cost (cumulative from April 2017)***

Additional Cumulative Homecare Spend Projections

This bar shows the difference between the actual homecare spend and the projected spend using pre COVID trend data as seen on slide 9.

The data suggest an estimated additional spend of £6.1m for 20/21



The remaining projection is based on an estimated trend using the post COVID actuals. The £3.8m therefore reflects the worst case scenario given current estimated trends continues

The data suggest an estimated additional spend of £3m from April 21 - August 21.

Table summary of Discharge pathways

Period	Numbers in Residential Homes	Numbers in Nursing Homes	Number in Homecare
2018-19	21	26	101
2019 - 20	n/a	n/a	n/a
2020 - 21	24	36	442
2021-22 (To date August)	13	16	244
2021-22 (Estimate)	30	36	563

Supporting Discharge (national condition four)

Supporting Discharge (national condition four)

To further improve outcomes for people being discharged from we have developed the following strands of work in 2021/22 - as described in the next four slides:

- New activities supporting the NHS Discharge Policy
- New Discharge support pathways
- Development work with the LGA and Social Marketing insights

Activities supporting the NHS Discharge Policy

Supporting Discharge	Action
Weekend working	Brokers extended hours (10 - 2 p.m.) Social Work (SW) discharge team increased capacity Weekend DSPA call re-established in Nov
Extend Bridging service for home care (Winter Plan Scheme)	Purchased block homecare hours to increase capacity to support same day discharge.
Out of Area	Discharge SW to continue to attend out of area calls where needed and Hackney clients OOA continue to be discussed at daily DSPA calls
Escalation plan	In place
Local weekly discharge meeting	Existing partnership meeting weekly to include updates on vacancies of discharge pathway facilities
NEL weekly discharge meeting	To escalate issues and offer mutual aid across three ICPs within NEL

Discharge Support - Interim Placements

Newly Commissioned Discharge settings	Facilities
Acorn Lodge	Block contract for 3 nursing hospital discharge beds
Goodmayes	2 accessible flats 4 rooms in shared house 1 Covid positive flat
LBH Assessment flats	6 flats plus 2 COVID
Housing with Care Flats	Housing with Care
Mary Seacole	7 Designated COVID+ Care Home beds
Manor Farm	Spot purchase beds
Homeless & no recourse to public funds	B&B Goodmayes (above) or Homeless hostel 6 Peabody step-down beds (aim January)
Charedi Community COVID-19 Post Discharge and Hospital Admission Avoidance Facility	Can be up to 9 beds
Homecare	Existing Framework
Mutual aid will be provided at other sites across NEL where available.	

Development Work with the LGA

The table below outlines work we are undertaking to review and improve our discharge work.

LGA Offer	Detail input
Review of joint working arrangements between social workers and therapists	Using the ethical Framework to reflect on practice and to identify the specific changes for social workers and therapists implementing the discharge policy and operating model. ● 1 session with social workers - 24 Nov ● 1 session with therapists - 24 Nov ● 1 joint session - 2 Dec
Review of the reablement Pathway	A Peer Consultant appointed by LGA will initiate a desktop review initially. ● Understanding of how other systems have maximized reablement offer ● Review of model and cost benefits analysis
Session to discuss how to manage out of area patients with other local authorities	● Lead a London-wide discussion - one off session
Data Support	● Initially share dashboard they have helped develop with another system

Social Marketing - Patient Information

Funded via a local BCF grant, we employed Claremont, a local Hackney-based social marketing company to use social marketing techniques to gain insight into the target population. These insights can be used to help design marketing messages and tools to reduce delays relating to patient and family choice, and better manage patient expectations around hospital stay and planned discharge home or to a residential placement.

To include: communicating the right message at the right time to ensure patients and their families are aware at admission to hospital of the home first approach and options available post discharge.

Phase 3 Feedback - Headline findings from public testing

Consistent and strong dislike of the term discharge – clear preference for 'leaving hospital'

When asked to rank the importance of different messages, the priority is around reassurance:
We won't send you home before you are ready

The second most important message was about being spoken to about what was happening:
Your team in the hospital will talk to you about getting you home again

The third most important message is regarding assessment:
Your specific needs for any ongoing support and care at home will be assessed and discussed with you, and the right package will be put together

11

Claremont
Communications for Behaviour Change

Phase 3 Feedback - Six key thematic areas for our report back

13

Claremont
Communications for Behaviour Change

The Disabled Facilities Grant

Disabled Facilities Grant (DFG) and wider services

- DFG is funded by the Department of Health and Social Care and is part of the BCF with priorities summarised as:
  - Care home costs saving
  - Prevention/Early intervention
  - Support timely hospital discharge
- The Local Authority engages with Housing Teams to use the fund to support disabled people to live more independently in their own home.
- Local policy was reviewed between Hackney's Housing and Adult Social Care in Feb 2021 to ensure a more focused approach to DRF to support the BCF priorities. Summary of recommendations and changes on next slides.

Summary of Recommendations - Hackney

1) **Dementia Grants (DG) -** improving lighting, sound proofing, changing the flooring, tonal contrasting tiling and sensors within St Peters, a housing with care accommodation.

2) **Hospital Discharge Grants (HDG) -** examples of works include: moving necessary furniture from upstairs to downstairs, clearing a room to make it safe, deep cleans or any other work needed to facilitate the discharge that cannot be provided by other means.

3) **Contribute to the cost of the council's occupational therapy team** - 3 OT posts to support timely assessments for adaptations- to prevent falls, admission, and reduce micro living environments.

4) **Partial waiver of up to £10,000 contribution for means testing**

5) **Smart Homes Kit** - A part of every DFG application. The Kit to incorporate voice activated technology to help with environmental controls and medication reminders. Building on the technology planned for the Hospital Assessments Flats.

6) **Discretionary Grant** - when the situation cannot be resolved with the mandatory costs of £30,000 (inclusive of fees), additional costs of maximum £10,000 can be available when this will support better care arrangements to enable the person to remain in their home for longer. A charge will be placed on the property.

Disabled Facilities Grant (DFG) Spend - Hackney

	Discretionary RRO (Regulatory Reform Order- Housing Assistance)	Estimate of numbers x costs	Total
1	**Dementia Grants (DG)**	10 x 2500	**£25,000**
2	**Hospital Discharge Grants (HDG) - Maximum is £2000**	60 x 400 = 2400 30 x 1000 = 30,000 5 x 2000 = 10,000	**£42,400**
3	**Contribute to the cost of the council's occupational therapy team**	DFG OTs @ £32 an hour umbrella rate + oncosts £1,336.97 x 46 = £61,501	**£184,503**
4	**Partial waiver of up to £5,000 contribution following means testing for first £7000**	6000 (approx contribution 2019-2020)	**£6,000**
5	**Smart Homes Kit**	10 x 3000	**£30,000**
			£287,903

City of London

City of London Context

- Latest estimate of population in City of London is 10,938 with predicted significant growth in the over 65 population in next decade. There is high life expectancy in the City of London - better than the rest of London for both males and females.These factors create potential for increased demand for health and social care services in the future.
- 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 and the Barbican.
- The City of London borders seven London boroughs and residents often have to access services that are delivered outside the square mile. The City of London has complex care pathways. 75 percent of City of London residents are registered with the one GP practice in the City, which is part of City and Hackney partnership. 16 percent of residents, on the east side of the City of London, are registered with GPs which are part of Tower Hamlets partnership.

City of London Context

- 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 the local partnership is Homerton University Hospital Foundation Trust (HUHFT). Community Health Services are also provided by HUHFT.
- There is no residential care or supported living provision within the City of London 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. Our homecare provision is currently being recommissioned and is set in the wider context of hospital discharge and reablement requirements.
- The City of London also commissions a number of preventative and support services from the voluntary sector. These include a Memory café, carers support, a wellbeing service and a universal advice service.

Changes to Services Commissioned

Area : City of London	Full Year Forecast
Mental Health Reablement Service (Decommissioned)	£0
Combined Hospital Discharge Scheme	£230,555

Area : CCG	Full Year Forecast
DES supplementary care homes services	£5,475
Pathway Homeless Discharge Team (5 months)	£4,913

Since the original BCF spending agreements, the steer from BCF became stronger in terms of hospital flow, delayed transfers of care and length of stay targets so partners have developed new services to support hospital discharges. Over the last few years, partners have also worked together to understand the issues homeless people face in accessing health services. We are building capacity into both discharge and community services to improve outcomes for this vulnerable population.

These services support implementation of the NHS Discharge Policy.

Impact of Covid on City of London Hospital Discharges

- There has been a more than 100% increase in the number of hospital discharges within City of London residents since April ‘20, with the medical stability of residents requiring more intensive packages of care.
- Compared with home care and reablement costs, Discharge to Assess hourly costs are 44% higher for single handed care and 54% higher for double handed care, as the service includes a premium to reflect the urgent nature and response required.
- With ‘home first’ a preferred pathway, we are seeing an increase in care requirements where perhaps a step down placement would be more appropriate. Once a resident is discharged home, a placement is often difficult to facilitate if a person wishes to remain in their own home. The cost of discharge to assess homecare support for complex cases are much higher than placement costs in some cases. 24hr sleep in costs £425 per day; 24 hr waking nights £695 per day. Double handed care packages are £58 per hour within this service.

Impact of Covid on City of London Hospital Discharges

- Our Rapid Response Service has increased in cost by 380% against budget allocation.
- A change in hospital discharge behaviour is not expected, meaning we will need to continue to support an assessment period until clients are more stable for ongoing care pathways.
- Hospital Prevention care and support is put in place via this service; both at home to avoid hospital admittance in the first instance, and to avoid hospital admittance due to medical stability fluctuation upon discharge.
- The City of London Corporation do not have a Hospital Discharge Team within a hospital setting. All discharges are ‘out of borough’ so 7-day working is in place within the current Adult Social Care Team. To ensure we are resilient in meeting winter and seasonal discharge activity, we will maintain weekend cover to support safe discharge and enhance our ability to maintain and support safe hospital discharge.
- With seasonal pressures from seasonal flu, covid fluctuations and winter impacts (poverty) a significant increase in demand and activity in discharge and discharge prevention is anticipated.

Supporting Discharge (national condition four)

New Consolidated Hospital Discharge Scheme

- Through the Better Care Fund, the City of London Corporation has funded a Rapid Response Service.
- During the pandemic, as hospital discharges increased, and policy changed, the Rapid Response Service became part of a wider approach to facilitating and supporting hospital discharges.
- Given that the mental health reablement service was decommissioned, this funding, in agreement with the local health partners, was shifted into hospital discharge work.

New Consolidated Hospital Discharge Scheme

The new consolidated service has three strands:

- The ***Hospital Admission Avoidance Service,*** providing home-based support for up to 72-hours for those most at risk of acute admission to hospital. It includes intensive home care support (e.g. live in or double up support) with an assessment of ongoing care needs.
- ***Supported Hospital Discharge Service (***Discharge to Assess), providing intensive home care support to accompany a person home from hospital, a care assessment in the home and installations of minor aids and adaptations. The Discharge to Assess model has varying timescales of delivery. It is expected that a period of up to 72-hours will provide sufficient assessment of need and care support, however, there is an increase in discharge of residents who require a higher package of care and support, who pre-pandemic, would have remained in hospital longer. The assessment of need during this time can vary due to a residents medical stability. In such cases, the discharge to assess care service will remain in place.
- ***7-day Hospital Discharge*** (post 30th September 2021) will continue to provide additional resource to the City of London Corporation Hospital Discharge Service in support of 7 day working. We preempt that the hospital discharge activity will not change in the immediate future, with complexity of cases and assessment still requiring 2-hour response times.

Disabled Facilities Grant (DFG)

- DFG is funded by the Department of Health and Social Care and is part of the BCF with priorities summarised as:
  - Care home costs saving
  - Prevention/Early intervention
  - Support timely hospital discharge
- In the City of London, DFGs are primarily used for prevention and early intervention. They have supported people to maintain independence safely at home.
- There have been low levels of DFG applications in recent years although these are starting to increase and as part of our review, we will be considering how awareness and applications can be raised.
- There are plans during 2022 / 23 to undertake a review of DFGs in the City of London and develop a Housing Assistance Policy to use DFGs more flexibly and innovatively.

Equality & Health Inequalities

Equality and health inequalities at a System Level

- The direct health impacts of COVID-19 have disproportionately affected some minority ethnic groups, older people, men, people with underlying health conditions (esp multi-morbidity), care home residents and staff, those working in other public facing occupations, as well as individuals and families living in socially deprived circumstances.
- Whilst the pandemic has exposed inequalities in service access, our response has also provided opportunities to adapt and improve service delivery.
- The City and Hackney borough-based partnership priorities outlines a plan to tackle health inequalities through a population health framework.
- These actions and initiatives will enable better understanding of how equitable our BCF schemes are.

Tackling Health Inequalities through Population Health Framework

- Establish Population Health Hub as a system wide resource to support with the embedding of a population health approach
- Draft Health and Wellbeing Strategies, using the Kings Fund Population Health approach
- Improve routine collection and analysis of equalities data and insight, and its use to inform planning and action
- Develop and embed tools and resources to support routine consideration of health equity in decision making and planning
- Adopt a partnership position and action plan to tackle structural racism and wider discrimination with local institutions
- Build trust and adopt flexible models of engagement to work in partnership with residents
- Align with NEL work on anchor institutions
- Collectively develop plans for Prevention and Investment Standard
- Embed strengths-based, preventative based approaches (including MECC)
- Build on Covid19 risk assessments to provide ongoing support for wider staff wellbeing needs.

10 Cross-Cutting Areas for Action to Reduce Health Inequalities

1. **Equalities data & insights**: Routine collection and analysis of service equalities data & insight to inform actions
2. **Tools & resources**: Develop, and enable system-wide adoption of, tools to embed routine consideration of health equity in decision-making
3. **Tackling structural racism & systemic discrimination**: adopt a partnership position and action plan to tackle racism and wider discrimination with local institutions
4. **Community engagement, involvement and empowerment**: build trust and adopt flexible models of engagement to work in partnership with residents to improve population health
5. **Health in all policies**: ensure wider policies and strategies explicitly consider and address health inequalities
6. **Anchor networks**: local anchor institutions collectively use their local economic power to lead action on reducing social inequalities
7. **Strengths-based, preventative approach to service provision**: 'no wrong door' access to support for residents to address wider health and wellbeing needs
8. **Staff health and wellbeing**: build on Covid-19 risk assessments to provide ongoing support for wider staff wellbeing needs
9. **Digital inclusion**: pool system resources to x3 dimensions of exclusion: skills, connectivity, accessibility
10. **Tailored, accessible information about services and wider wellbeing support**: produce information in community languages that is culturally appropriate and responsive to local diverse needs

Source: City & Hackney Health Inequalities Steering Group (April 2021)

Equality and health inequalities at a BCF Level

Specific BCF projects which help to address health inequalities:

- Mobilise the Pathway Homeless Hospital Discharge team and step-down accommodation to support homeless people through their hospital stay, to support a safe discharge and ensure referral into the right onward services (new scheme)
- Development of patient information leaflets for hospital discharge that are accessible (new scheme)
- Implementation of the DES Supplementary Care Homes Service for older adults care homes (new scheme)
- Develop a neighbourhood approach to population health that addresses the variation seen between populations at the 30-50,000 level
- Integrating the Voluntary, Community, and Social Enterprises (VCSE) into neighbourhoods, to help reach wider communities and to address the wider determinants of health
- Ensure that we improve end-of-life care within our healthcare system working with all partners, including St Joseph’s Hospice.

Summary

- The system is working well and the pandemic has helped bring us together but also brought new challenges which we are gearing up to meet.
- We've seen increased exposure of inequalities which has renewed system focus on this across all services. Through BCF schemes in particular we are supporting vulnerable people at home, care home residents and homeless populations.
- In working together to expedite hospital discharge we have increased demand in homecare, especially evident with the high level of need at discharge and increase in double handed care packages.
- While a home first approach is appropriate, we need to be aware of and acknowledge people's concerns and anxieties about returning home to safe settings and not being discharged too quickly or in a way that is not safe.
- Our independent sector providers (e.g. care homes, homecare, hostels, B&B's) are critical partners.
- The role of digital solutions (e.g. virtual assessments, remote monitoring, Assistive, Technology) enable a more flexible, patient-centred approach to health and care interventions.
- Prevention remains important and the development of the Population Health Hub as a system wide resource will support with the embedding of a population health approach.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Hackney
Completed by:	Mark Watson & Cindy Fischer
E-mail:	mark.watson@hackney.gov.uk
Contact number:	7595288950

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Mayor
Name:	Philip Glanville

Has this plan been signed off by the HWB at the time of submission?	No
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 22/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Mayor	Philip	Glanville	"Philip Glanville (Mayor)" <philip.glanville@hackney.
	Clinical Commissioning Group Accountable Officer (Lead)	Mr	Henry	Black	henryblack@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Ms	Nina	Griffith	nina.griffith@nhs.net
	Local Authority Chief Executive	Mr	Mark	Carroll	mark.carroll@hackney.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Helen	Woodland	helen.woodland@hackney.gov.uk
	Better Care Fund Lead Official	Mr	Mark	Watson	mark.watson@hackney.gov.uk
	LA Section 151 Officer	Mr	Ian	Williams	ian.williams@hackney.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Hackney

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,730,686	£1,730,686	£0
Minimum CCG Contribution	£23,100,819	£23,100,819	£0
iBCF	£16,147,569	£16,147,569	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£40,979,074**	**£40,979,074**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£6,579,962
Planned spend	£11,524,102

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,408,779
Planned spend	£6,805,444

Scheme Types

Assistive Technologies and Equipment	£1,384,197	(3.4%)
Care Act Implementation Related Duties	£19,975,455	(48.7%)
Carers Services	£741,176	(1.8%)
Community Based Schemes	£3,709,410	(9.1%)
DFG Related Schemes	£1,730,686	(4.2%)
Enablers for Integration	£1,193,304	(2.9%)
High Impact Change Model for Managing Transfer of	£499,635	(1.2%)
Home Care or Domiciliary Care	£0	(0.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£3,994,113	(9.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£6,518,199	(15.9%)
Prevention / Early Intervention	£830,829	(2.0%)
Residential Placements	£369,532	(0.9%)
Other	£32,538	(0.1%)
Total	**£40,979,074**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	241.0	232.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	8.9%	9.6%
	LOS 21+	4.6%	5.5%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	94.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	0	353

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.7%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Hackney

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Hackney	£1,730,686
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,730,686**

iBCF Contribution	Contribution
Hackney	£16,147,569
Total iBCF Contribution	**£16,147,569**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS City and Hackney CCG	£23,100,819
Total Minimum CCG Contribution	**£23,100,819**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£23,100,819**	

	2021-22
Total BCF Pooled Budget	**£40,979,074**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Hackney

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,730,686	£1,730,686	£0
Minimum CCG Contribution	£23,100,819	£23,100,819	£0
iBCF	£16,147,569	£16,147,569	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£40,979,074**	**£40,979,074**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£6,579,962	£11,524,102	£0
Adult Social Care services spend from the minimum CCG allocations	£6,408,779	£6,805,444	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Services to support Carers	Carers services	Carers Services	Other	Carer advice, support and respite	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£741,176	Existing
2	Community equipment and adaptations	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum CCG Contribution	£1,098,039	Existing
3	Maintaining eligibility criteria	Packages of care	Care Act Implementation Related Duties	Other	Packages of care	Social Care		LA			Local Authority	Minimum CCG Contribution	£3,827,886	Existing
4	Targeted preventative services	Housing related floating support, health and wellbeing activities,	Prevention / Early Intervention	Other	Housing related floating support, health and	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£409,653	Existing
5	Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Telecare		Social Care		LA			Private Sector	Minimum CCG Contribution	£286,158	Existing
6	Interim beds	Residential placements and step down accomodation	Residential Placements	Nursing home		Social Care		LA			Private Sector	Minimum CCG Contribution	£369,532	Existing
7	Management Officer Post	BCF Officer to support overall development and implementatio of BCF	Enablers for Integration	Programme management		Social Care		LA			Local Authority	Minimum CCG Contribution	£73,000	Existing

8	Integrated Independence Team	Intermediate care service - rapid response, home treatment &	Reablement in a persons own home	Reablement service accepting community and		Community Health		LA			NHS Community Provider	Minimum CCG Contribution	£3,994,113	Existing
9	Neighbourhoods Programme	Neighbourhoods is our major transformation programme for the	Enablers for Integration	Integrated models of provision		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,120,304	Existing
10	Adult Cardiorespiratory Enhanced +	ACERS Respiratory Service is a 7 day service, that provides care and	Community Based Schemes	Multidisciplinary teams that are supporting		Other	Works across Primary and Secondary Care	CCG			NHS Acute Provider	Minimum CCG Contribution	£701,746	Existing
11	Bryning Day unit/Falls Prevention	The Bryning Unit is a multidisciplinary team running a weekly	Prevention / Early Intervention	Other	Physical health and wellbeing	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£421,176	Existing
12	Asthma	Supports those living with Asthma, who are either admitted with an	Other		Complex case management of frequent A&E	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£32,538	Existing
13	St Joseph's Hospice	Inpatient and community-based palliative care services	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£2,614,128	Existing
14	Paradoc	The service provides an urgent GP and paramedic response	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			NHS Acute Provider	Minimum CCG Contribution	£885,075	Existing
15	Adult Community Rehabilitation Team	To provide specialist inter-disciplinary and uni-disciplinary	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,007,664	Existing
16	Adult Community Nursing	To provide an integrated, case management service to	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,519,139	Existing
17	Age UK - Take Home and Settle	Discharge support to isolated, vulnerable people.	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Other	Charity	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£176,189	Existing
18	Discharge Coordinators	Discharge Coordinators work within our Integrated Discharge	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£164,581	New
19	GP Out of Hours Home Visiting Service	Primary Care out of hours for patients requiring home visits.	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£388,713	Existing
20	Pathway Homeless Hospital Discharge Team	Multidisciplinary hospital discharge team for homeless individuals.	High Impact Change Model for Managing Transfer	Early Discharge Planning		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£158,865	New
21	DES supplementary care homes	GP enhanced services within older adults care homes.	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£111,144	New
22	Disabilities Facilities Grant	To support disabled people to live more independently in their	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£1,730,686	Existing
23	IBCF meeting adult social care need	ICBF Includes Meeting ASC Need, Reducing Pressure on NHS &	Care Act Implementation Related Duties	Other	Adult Social Care Support	Social Care		LA			Local Authority	iBCF	£16,147,569	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.

16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Hackney

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	241.0	232.0	We have set the plan using the 2-year trend data. The fact that Covid continues to be a challenge impacting on primary care and community services could negatively impact on avoidable admissions this year. The following services funded are by the BCF and aim to	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.9%	9.6%	Homerton is one of the best performing acute providers within London on length of stay longer than 14 days. There is a Medical Productivity Project within the Homertonand an Improving Emergency Care Project and Operational Manager who is the key post enabling effective working between wards and the Discharge Team and Discharge SPA (Transfer of Care Hub). There is a good flow of patients through the hospital and discharge	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	4.6%	5.5%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.0%	One of the key focuses of the Discharge Group has been to ensure discharge to assess is implemented and monitored. We have a limited number of care homes and no intermediate care beds which has strenthened our Home First approach.	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	401	304	0	353	Due to the Cyber attack in 2020 we do not have actual data for 20-21.
	Numerator	86	66	0	82	Figure stated is medium estimate based upon high and low estimates from Performance Framework YTD Aug 2020/21 & Finance 2021/22 Estimates.
	Denominator	21,432	21,692	22,316	23,229	However this should be caveated due to impact of Covid

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	91.3%	92.3%	80.7%	Due to the Cyber attack in 2020 we do not have actual data for 20-21.
	Numerator	315	311	322	We used Projected "Target This Year" from Performance Framework Report YTD Aug 2020/21.
	Denominator	345	337	399	However this should be caveated due to impact of Covid and the longer term effects this may have, and the

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Hackney

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Slide 3 of narrative identifies stakeholder meetings where issues/priorites have been discussed which contributed to the plan. The narrative submitted is for both the London Borough of Hackney and City of London		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	Slide 10-12 provide the Integrated Care Partnerships agreed priorities. 42-45 identify plan to reduce health inequalities and some key BCF projects.		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Slides 29-32		
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	Slides 23-28 detail support for discharge which has been agreed to at our Discharge Steering Group that involves system partners, including the Hospital Trusts.		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	Slide 14.		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	City of London
Completed by:	Ellie Ward
E-mail:	ellie.ward@cityoflondon.gov.uk
Contact number:	020 7332 1535

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chairman of HWB
Name:	Marianne Fredericks

Has this plan been signed off by the HWB at the time of submission?	No
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Fri 26/11/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Marianne	Fredericks	marianne.fredericks@cityoflondon.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Henry	Black	henryblack@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Nina	Griffith	nina.griffith@nhs.net
	Local Authority Chief Executive		John	Baradell	john.baradell@cityoflondon.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Andrew	Carter	andrew.carter@cityoflondon.gov.uk
	Better Care Fund Lead Official		Ellie	Ward	ellie.ward@cityoflondon.gov.uk
	LA Section 151 Officer		Mark	Jarvis	mark.jarvis@cityoflondon.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: City of London

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£37,091	£37,091	£0
Minimum CCG Contribution	£799,980	£799,980	£0
iBCF	£314,144	£314,144	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£1,151,215**	**£1,151,215**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£209,682
Planned spend	£468,846

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£146,460
Planned spend	£311,354

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£314,144	(27.3%)
Carers Services	£12,855	(1.1%)
Community Based Schemes	£108,119	(9.4%)
DFG Related Schemes	£37,091	(3.2%)
Enablers for Integration	£28,897	(2.5%)
High Impact Change Model for Managing Transfer of	£4,913	(0.4%)
Home Care or Domiciliary Care	£230,555	(20.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£67,944	(5.9%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£0	(0.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£331,830	(28.8%)
Prevention / Early Intervention	£13,527	(1.2%)
Residential Placements	£0	(0.0%)
Other	£1,340	(0.1%)
Total	**£1,151,215**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	177.0	299.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	10.3%	11.7%
	LOS 21+	4.9%	7.4%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	94.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	578	730

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: City of London

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
City of London	£37,091
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£37,091**

iBCF Contribution	Contribution
City of London	£314,144
Total iBCF Contribution	**£314,144**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS City and Hackney CCG	£799,980
Total Minimum CCG Contribution	**£799,980**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£799,980**	

	2021-22
Total BCF Pooled Budget	**£1,151,215**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: City of London

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£37,091	£37,091	£0
Minimum CCG Contribution	£799,980	£799,980	£0
iBCF	£314,144	£314,144	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£1,151,215**	**£1,151,215**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£209,682	£468,846	£0
Adult Social Care services spend from the minimum CCG allocations	£146,460	£311,354	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Care Navigator	To ensure safe hospital discharge for City of London residents	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£67,944	Existing
2	Discharge Scheme	To prevent hospital admissions, facilitate safe hospital discharge and to provide an intensive Discharge to Assess offer.	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		Social Care		LA			Private Sector	Minimum CCG Contribution	£230,555	New
3	Carers Support	To provide specialist independent support, information and advice for adult carers living in the City of London to support them in their caring role and promote their health and wellbeing	Carers Services	Other	provides specialist independent help, advice and support for informal carers in the community.	Social Care		LA			Private Sector	Minimum CCG Contribution	£12,855	Existing

4	Disabled Facilities Grant	To support disabled people to live more independently in their own home	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£37,091	Existing
5	IBCF	• meeting adult social care needs • reducing pressures on the NHS, including seasonal winter pressures • supporting more people to be discharged from hospital when they are ready	Care Act Implementation Related Duties	Other	Adult Social Care Support	Social Care		LA			Local Authority	iBCF	£314,144	Existing
6	Adult Cardiorespiratory Enhanced +	ACERS Respiratory Service is a 7 day service, that provides care and	Community Based Schemes	Multidisciplinary teams that are supporting		Other	Works across Primary and Secondary Care	CCG			NHS Acute Provider	Minimum CCG Contribution	£21,703	Existing
7	Asthma	Supports those living with Asthma, who are either admitted with an	Other		Complex case management of frequent A&E	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£1,340	Existing
8	Bryning Unit/Falls Prevention	The Bryning Unit is a multidisciplinary team running a weekly	Prevention / Early Intervention	Other	Physical health and wellbeing	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£13,527	Existing
9	Paradoc Service	The service provides an urgent GP and paramedic response	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			NHS Acute Provider	Minimum CCG Contribution	£19,998	Existing
10	Adult Community Rehabilitation Team	To provide specialist inter-disciplinary and uni-disciplinary	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£86,416	Existing
11	Adult Community Nursing	To provide an integrated, case management service to	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£213,486	Existing
12	St Joseph's Hospice	Inpatient and community-based palliative care services	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£80,849	Existing
13	Neighbourhoods Programme	Neighbourhoods is our major transformation programme for the	Enablers for Integration	Integrated models of provision		Community Health	All system partners are involved:	CCG			NHS Community Provider	Minimum CCG Contribution	£28,897	Existing
14	GP Out of Hours Home Visiting Service	Primary Care out of hours for patients requiring home visits.	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£12,022	Existing
15	Pathway Homeless Hospital Discharge Team	Multidisciplinary hospital discharge team for homeless individuals.	High Impact Change Model for Managing Transfer	Early Discharge Planning		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£4,913	New
16	DES Supplementary Care Home Service	GP enhanced services within older adults care homes.	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£5,475	New

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: City of London

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	177.0	299.0	It's challenging to set figures without robust data from 2020-21 and the data in 2018/19 doesn't have a consistent pattern and seems very high for the City. The fact that Covid continues to be a challenge impacting on primary care and community services could negatively impact on avoidable admissions this year.	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	10.3%	11.7%	The City of London do not have any hospitals within it's boundaries so are not formally part of a Hospital Discharge Team. All discharges are 'out of borough'; however, 7-day working is in place within the Adult Social Care Team. The Care Navigator and the Discharge Scheme which are funded by the BCF ensure patients are discharged once they no longer meets the criteria to reside. With the teams able to provide a timely response, City residents do	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	4.9%	7.4%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.0%	There are no local care homes and home first is the embedded local approach following expectations within the BCF and the Discharge Policy. The Care Navigator and Discharge Scheme are in place to enable discharge home once a patient no longer meets the criteria to reside.	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	674	61	578	730	There is an error for 19/20 actual - it was 10. The ASC approach means that we are able to support people's independence at home for a long time. Those entering residential or nursing care are generally much older and live there for more shorter periods. However, our older population is increasing. A new asset based approach
	Numerator	10	1	10	12	
	Denominator	1,484	1,642	1,731	1,643	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%	66.7%	85.0%	Our reablement service is being remodelled and will continue to be an integral part of our overall approach to hospital discharges.
	Numerator	9	2	9	
	Denominator	10	3	10	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: City of London

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Slide 3 of narrative identifies stakeholder meetings where issues/priorites have been discussed which contributed to the plan. The narrative submitted is for both the London Borough of Hackney and City of London		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	Slide 10-12 provide the Integrated Care Partnerships agreed priorities. 42-45 identify plan to reduce health inequalities and some key BCF projects.		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Slide 30		
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	Slides 39-41		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	Slide 14		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Title of report:	Hackney Joint Health and Wellbeing Strategy 2022-26
Date of meeting:	9th December 2021
Lead Officer:	Chris Lovitt, Deputy Director of Public Health
Author:	Sara Bainbridge, Public Health Registrar
Committee(s):	Hackney Health and Wellbeing Board (10th November 2021) Mental Health Coordination Committee (29th November 2021) SOC-G (2nd December 2021) Health in Hackney Scrutiny commission (9th December 2021)
Public / Non-public	Public

Executive Summary:

This paper provides an update on the development of Hackney's Joint Health and Wellbeing Strategy (HWBS), a statutory requirement of Hackney's Health and Wellbeing Board.

The strategy for 2022-26 is currently open for a 12-week consultation, closing on 17th February 2022. The aim is for a finalised strategy to be approved by the Hackney Health and Wellbeing Board in March 2022, and an action plan and launch to follow in 2022.

The ICB is asked to:

1. Note the HWBS priorities and next steps for consultation and action planning.
2. Suggest groups or others to consult during the 12 week consultation, and promote the consultation.
3. Ensure relevant ICB members are part of the Task and Finish Group (meeting in January and February 2022) to establish measurable ambitions and an action plan, and that action planning aligns with plans that fall under the ICB's remit.

Recommendations:

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

- To **NOTE** the HWBS priorities and next steps for consultation and action planning
- To **CONSIDER** the consultation plans, promote the consultation and suggest any other groups or stakeholders to consult during the 12 week consultation.
- To **APPROVE** the action planning proposals and ensure that the Board is satisfied with alignment between the HWBS action plan and planning of services that fall under their responsibility.

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

Deliver a shift in resource and focus to prevention to improve the long term	x	The Health and Wellbeing Board intends for this strategy to reduce health inequalities in Hackney.

health and wellbeing of local people and address health inequalities		
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	x	One of the proposed priorities of the strategy is to improve mental health and reduce mental ill-health in Hackney.
Empower patients and residents	x	The strategy aims to take a community-centred approach.

Specific implications for City

This strategy has been developed specifically for Hackney, but we intend to continue working alongside the City of London Health and Wellbeing Strategy development to ensure there is alignment where appropriate.

Specific implications for Hackney

This strategy sets out the Health and Wellbeing Board's strategic focus from 2022-2026, and aims to reduce health inequalities. These specifically relate to mental health, social connection and financial security.

Patient and Public Involvement and Impact:

Residents took part in engagement over the summer of 2021, by completing surveys and joining engagement workshops. Over 400 responses were collected and analysed. Residents will also be invited to submit their views as part of the consultation, which is open until February 17th 2022.

Clinical/practitioner input and engagement:

Healthcare professionals were engaged as part of meetings and workshops in summer 2021. They are also going to be invited to submit their views as part of the consultation, and some follow-up meetings arranged.

Communications and engagement:

Yes - Hackney Council colleagues have drafted a communication plan for the consultation phase of the strategy development (running from November to February 2022).

Comms Sign-off

Not applicable as responsibility has sat with local authority colleagues.

Equalities implications and impact on priority groups:

The strategy aims to reduce health inequalities and will focus action on several parts of the community who currently experience inequity. It is taking an anti-racist approach. The action plan will include consideration of protected characteristics and socio-economic inequalities.

Safeguarding implications:

There are no safeguarding implications.

Impact on / Overlap with Existing Services:

There are existing strategies and plans which include work relevant to the priorities of the health and wellbeing strategy which must be taken into account to avoid duplication or confusion.

Main Report

BACKGROUND

Hackney Health and Wellbeing Board have been developing the Joint Health and Wellbeing Strategy since November 2020. Every local Health and Wellbeing Board has a duty to produce a Health and Wellbeing Strategy. A Health and Wellbeing Strategy outlines key health and wellbeing priority areas for each local authority area. This means this strategy is *just* for Hackney, but we are working closely with others (e.g. City of London, other members of the ICS).

Hackney Health and Wellbeing Board have agreed that this strategy will aim to reduce health inequalities. Work to develop and refine priorities for action have therefore been driven by that aim.

At the November 2021 meeting, the Health and Wellbeing Board agreed to:

- The draft strategy, which had 3 priorities (mental health, social connection, financial security), as well as suggestions for ways of working.
- Publish the draft strategy for a 12-week consultation (running from November to February). This is so the strategy can be approved at the March 2022 meeting (before the pre-election period), with a detailed action plan to follow in summer 2022.

PROCESS SO FAR

- Engagement with residents and stakeholders took place between July and mid-September 2021. A summary report of engagement insight was produced and circulated to members of the HWB at the end of September. It informed discussion at a prioritisation workshop which was held on 1st October 2021.

- **Prioritisation**

Potential priority issues were identified by analysing the responses to surveys with residents (both conducted online, or face to face, by peer researchers) and identifying what issues had been raised most often, or themes that seemed to be commonly raised in response to the questions asked.

Wider stakeholder input - via workshops and meetings - had been captured in notes, and their contents were analysed for commonly raised themes. By combining the issues that had come up most frequently from residents and wider stakeholders, 12 issues were shortlisted.

The prioritisation criteria listed below were used to help attendees at the prioritisation workshop narrow down potential areas of focus in the strategy.
Prioritisation criteria:

a. The extent of the need (considering breadth, depth, and trajectory)
b. Our ability to change the situation(what is 'influenceable')
c. The potential for making the most impact on people's health and wellbeing (when considered in terms of both costs and benefits)
d. The need for a partnership and system-wide approach to the issue, via the HWB strategy, add value and/or bring a unique perspective
e. Alignment with our collective values

Invitations to the prioritisation workshop were sent to Health and Wellbeing Board members and members of the City and Hackney Health Inequalities Steering Group.

Before and during the workshop, attendees were able to highlight and discuss priorities to include in the strategy. During the meeting, an online voting tool was used, which resulted in 'mental health', 'social inclusion' and 'financial security' being chosen most frequently.

STRATEGY DEVELOPMENT

Using the input from the prioritisation workshop, the review of population health needs, engagement insight and discussions with colleagues working on these draft priority topics, further information was gathered on the three priority issues:

- Mental health
- Social connection
- Financial security

The strategy recognises that these priorities can be interrelated. It also notes that other issues raised during engagement and development of the strategy may also benefit from the action taken in relation to these priorities.

To ensure that the focus of the strategy would reduce health inequalities, a framework from the 2010 Marmot Review 'Fair Society, Healthy Lives' was suggested by Dr Sandra Husbands, director of public health. Using this framework pinpoints areas for collective action. The framework was originally developed using systematic reviews of evidence that showed what actions and areas of focus can make the most difference to reduce health inequalities.

A draft strategy has been developed, reflecting these priorities and potential areas for action. It also suggests taking a 'community centred' approach to the work, as this reflects feedback

from stakeholders and residents during engagement. This approach includes co-production and working at a neighbourhood level.

A more detailed action plan will be developed - the intention is that this will reflect ambition, ongoing actions and the added value a partnership approach from the HWB could bring.

CONSULTATION APPROACH

Following approval of the draft by the Health and Wellbeing Board, the draft strategy is now open for public consultation for 12 weeks.

In order to ensure widespread engagement with the strategy, the consultation will be promoted using online and offline methods. A continued partnership with Volunteer Centre Hackney is currently being discussed, building on the successful engagement phase, which involved volunteer peer researchers. We also intend to meet with stakeholders over the 12 weeks. A communication plan is included as a background paper.

ACTION PLANNING - TASK AND FINISH GROUPS

In addition to consultation on the priorities, there is a need for the HWB strategy to align with ongoing, relevant work on each priority and capture this into an action plan, as well as establish ambitions and any added work of the partnership.

An existing working group will audit relevant ongoing work across the system that will need to be recognised in the action plans. We propose additional members can then join two task and finish group meetings in January and February 2022, to identify and suggest any further actions that should be included in the action plan (the 'added value' from partnership approach) and to agree ambitions of the strategy and sense check metrics.

Options

Action planning for the Health and Wellbeing Strategy will need to ensure that it is not just compiling existing work but also identifying any gaps or opportunities to reduce health inequalities relating to the three priorities of mental health, social connection and financial security, as well as its 'ways of working' which includes taking a community centred approach. It will also need to take into account current work to ensure it is not duplicating or disrupting ongoing efforts.

If action planning identifies opportunities or asks for ICB resource, this will need to be discussed by the ICB as one partner organisation of the Health and Wellbeing Board.

Lack of engagement with the Health and Wellbeing Strategy and its ambitions may miss an opportunity to go further in reducing health inequalities in Hackney.

Proposals

- To promote the consultation and suggest any additional stakeholders to engage with before February 2022.
- To ensure that there is alignment between action planning for the Hackney Health and Wellbeing Strategy and ICB plans.

Conclusion

The ICB is asked to support the next steps for the Hackney Health and Wellbeing Strategy, to ensure that it will lead to reduced health inequalities by the end of its duration.

Supporting Papers and Evidence:

Draft Hackney Health and Wellbeing Strategy, 2022-26 Engagement insight report Consultation Communications Plan (attached)

Sign-off:

TBC: Chris Lovitt, Deputy Director of Public Health, Hackney and City of London Public Health Team

Hackney Health and Wellbeing Board Strategy Consultation: Communications Plan

Issue: Hackney's Health and Wellbeing Board (HWB) is a partnership that works together to improve the health and wellbeing of people in Hackney and also helps to reduce health inequalities. The HWB has completed an engagement phase during Summer 2021 to identify key priorities for the Strategy, and are now consulting to find out if people who live and work in the borough support the strategy's priorities, and for people to suggest actions and ambitions for each of the three priority areas (mental health, financial inclusion and social connection) between 2022 and 2026.

Objective: The aim is to gather feedback from residents and wider stakeholders on the draft Health and Wellbeing Strategy. The overall aim is to have a strategy signed off in March 2022 that has widespread support from stakeholders across Hackney, including residents.

In order to achieve this the feedback gained must be from a diverse demographic, including members of typically seldom heard audiences and those who may not be online. Therefore it will be important that the survey is well promoted and easy to access for all residents, to ensure the success of the overall strategy.

This strategy will form part of our work taking collective action to prevent and reduce health inequalities - the avoidable and unfair differences in health between different groups and communities.

The survey will be live from Mid November- Feb 2022 over a 12 week period.

Measurable objectives:

- To ensure that a diverse range of audiences respond to the survey
- Get more than 333 responses
- The survey is well promoted and visible in community centres and public spaces
- Click through numbers on social media.

Draft Strategy
Can be found here

Consultation Survey Questions

Can be found here

Survey
Hosted on Citizen Space and HWB Board website will link to the consultation
Hard copies of a summary and the consultation questions will be printed and made available
Will be published w/c 22nd Nov 21

Communications strategy: The aim is to achieve at least 3 points of high activity, at the start in November, over the new year period (first week of January) and the last 2 weeks of consultation. The communication strategy is to promote the survey to residents through both traditional and digital channels. In terms of online, social media both free and promotional content will be used. For this we will need to work with design to create eye-catching assets that can be used on Twitter, Facebook and Instagram. Traditional methods will include a poster distribution across estates, community centres, businesses, children's centres and libraries. There will also be an easy-read leaflet, paper surveys and alternative ways for residents and stakeholders to feed back, and we will make reasonable adjustments where required to ensure that people can feedback in a way that suits their needs. We will ensure that we are reviewing who is taking part in the consultation on a weekly basis to ensure that we are reaching a diverse representation of Hackney's population.

A range of newsletters will be used for regular promotion over the 12 week period, these newsletters include:

- HCVS newsletter
- Members bulletin
- VCH volunteer newsletter
- Healthwatch newsletter
- School bulletin
- Kings Park Moving Together
- Council newsletter
- Community champions
- Housing newsletter
- Hackney newsletter
- MPs and GLA member
- VCH volunteer newsletter
- Healthwatch newsletter
- Digital inclusion network

Proposed text for newsletter

The Hackney Health and Wellbeing Strategy consultation is now open.

The Hackney Health and Wellbeing Board has drafted a Health and Wellbeing Strategy for 2022-2026. This has three key things we want to work on together, to improve health and reduce inequalities. We want to find out if you agree with these priorities and if you have any suggestions.

Your views matter, and we would like you to take part in this short survey which should take around 10 minutes to complete. You will find it helpful to take a look at the draft strategy here before completing this. Please get in touch with Sara Bainbridge (sara.bainbridge@hackney.gov.uk) if you would like a paper copy or in another format or language.

Fill out the survey before 17th February 2022 here:

https://consultation.hackney.gov.uk/health-and-wellbeing/health-and-wellbeing-strategy/consultation/intro/

Channels: A mix of online and offline channels.

Information to be shared on partner websites and newsletters:

- Older People Reference Group
- Place Based Network
- Healthwatch patient reps (sending to Jon Williams)
- Youth Parliament
- Young Hackney channels
- Through CCG
- Through ELFT
- Through Homerton Hospital (and their membership)

- Through GP Confederation
- HWB Website page
- CCG website
- Kings Park Moving Together
- Through COVID-19 Grant Holders Forum
- Hackney Education

Posters sent to estates, pharmacies, parks, mobile libraries and community centres**:**

- GP practices
- Pharmacies
- Vaccine pop up clinics
- Libraries
- Hackney Council staff who might work with specific groups (e.g. traveller and boater communities)
- MPs and GLA member surgeries
- Faith and Ethnicity based community centres (Mosques, Synagogues, Temples, Hackney Chinese Centre)
- Citizens Advice Bureau
- Foodbanks
- Parks
- Bus stop ads (JCDecaux)
- Schools

<u>Proposed text for the posters and leaflet:</u>

Hackney Health and Wellbeing survey 2022-2026

Your health needs you.

Take part in the survey before 17 February 2022.

www.hackney.gov.uk/HWBsurvey

Council's social media channels, including Facebook, Twitter, Instagram and LinkedIn**:**

- Social media channels
- Paid ad- social media

Proposed social media text:

- *We want to find out what matters to you about health and wellbeing in Hackney. Your views will help shape our next Health and Wellbeing Strategy, have your say here:*

- *Residents are being invited to take part in a survey on health and wellbeing priorities for the next four years. Complete the survey here:*

- *Have your say on our Health and Wellbeing Strategy 2022-2026. We want to hear your views about the proposed priorities for the strategy to ensure it meets the borough's needs. Read the strategy and complete the survey here:*

- *Have your say on creating a healthier borough. Click below to read more about the proposed Hackney Health and Wellbeing Strategy. Click here:*

Press release:

Hackney's Health and Wellbeing Board will be carrying out a survey with residents and wider stakeholders across the borough between November and February, to find out if they support a new strategy.

The survey which will be available online and through the post will ask residents questions about how we can support residents with their mental health, their connections with other people in the borough and beyond, and help reduce poverty

The survey will help form a strategy that will seek to prevent and reduce health inequalities - the avoidable and unfair differences in health between different groups and communities.

To achieve this, the board has identified three priority areas for action- improving mental health, increasing social connection and supporting greater financial security.

Cabinet Member for Health, adult social care, voluntary sector and leisure, Cllr Chris Kennedy said: “The new Health and Wellbeing strategy is a great opportunity to focus on three things that could make a huge difference to people and their health in Hackney - mental health, social connection and financial security. .

“We want everyone in Hackney to be able to be as happy and healthy as possible. We look forward to shaping our health and wellbeing strategy and ensuring it makes positive changes to the lives of our residents. I would encourage as many people as possible to participate.”

You can access the survey here before February 2022.

Outreach

Peer researchers
Peer researchers will promote the consultation to residents in Hackney, and will have paper copies available for residents to complete during this time. Peer researchers will also attend events during the consultation period to increase awareness and update of the survey.

The team will ensure that outreach is conducted in order to capture residents views on the consultation, these could include attendance at:

- Vaccine pop up clinics
- Libraries
- Market days
- Britannia outreach day
- Adventure playgrounds and Play Streets
- Parks
- Attendance at classes commissioned by Public Health and others.

Wider Stakeholders
Alongside general consultation communication, the team will attend meetings with stakeholders during the 12 week period to update stakeholders on the Strategy progress, and encourage them to take part in the consultation. This will include attendance at Hackney Council internal meetings, VCS meetings, neighbourhood meetings, community champion meetings and health and care meetings.

We also have a list of 500+ stakeholders and residents who have asked to be kept engaged in the Strategy's progress. We will be writing to all of these contacts to share our insight report, how we developed this insight into priorities, and what we would like their feedback on during the consultation period.

A smaller number of key stakeholders and residents will also be invited to develop priority actions and ambitions across the three priorities and ways of working.

Timeline

November:

- Finalise budget
- Send DOF to design
- Distribution to newsletters
- Upload press release and send to local press
- Distribute posters to stakeholders

December

- Launch social media campaign (depending on assets)
- Mid December launch paid for campaign

January

- Continue social media push

February/ March

- Amendments to strategy and actions plans drafted
- March: Health and Wellbeing Board approval of final strategy
- Evaluation

Integrated Commissioning Glossary

ACEs	Adverse Childhood Experiences	
ACERS	Adult Cardiorespiratory Enhanced and Responsive Service	
AOG	Accountable Officers Group	A meeting of system leaders from City & Hackney CCG, London Borough of Hackney, City of London Corporation and provider colleagues.
CPA	Care Programme Approach	A package of care for people with mental health problems.
CYP	Children and Young People's Service	
	City, The	City of London geographical area.
CoLC	City of London Corporation	City of London municipal governing body (formerly Corporation of London).
	City and Hackney System	City and Hackney Clinical Commissioning Group, London Borough of Hackney, City of London Corporation, Homerton University Hospital NHS FT, East London NHS FT, City & Hackney GP Confederation.
CCG	Clinical Commissioning Group	Clinical Commissioning Groups are groups of GPs that are responsible for buying health and care services. All GP practices are part of a CCG.
	Commissioners	City and Hackney Clinical Commissioning Group, London Borough of Hackney, City of London Corporation
CHS	Community Health Services	Community health services provide care for people with a wide range of conditions, often delivering health care in people's homes. This care can be multidisciplinary, involving teams of nurses and therapists working together with GPs and social care. Community health services also focus on prevention and health improvement, working in partnership with local government and voluntary and community sector enterprises.
COPD	Chronic Obstructive Pulmonary Disease	
CS2020	Community Services 2020	The programme of work to deliver a new community services contract from 2020.
DES	Directed Enhanced Services	
DToC	Delayed Transfer of Care	A delayed transfer of care is when a person is ready to be discharged from hospital to a home or care setting, but this must be delayed. This can be

		for a number of reasons, for example, because there is not a bed available in an intermediate care home.
ELHCP	East London Health and Care Partnership	The East London Health & care Partnership brings together the area's eight Councils (Barking, Havering & Redbridge, City of London, Hackney, Newham, Tower Hamlets and Waltham Forest), 7 Clinical Commissioning Groups and 12 NHS organisations. While East London as a whole faces some common problems, the local make up of and characteristics of the area vary considerably. Work is therefore shaped around three localized areas, bringing the Councils and NHS organisations within them together as local care partnerships to ensure the people living there get the right services for their specific needs.
FYFV	NHS Five Year Forward View	The NHS Five Year Forward View strategy was published in October 2014 in response to financial challenges, health inequalities and poor quality of care. It sets out a shared vision for the future of the NHS based around more integrated, person centred care.
IAPT	Improving Access to Psychological Therapy	Programme to improve access to mental health, particularly around the treatment of adult anxiety disorders and depression.
IC	Integrated Commissioning	Integrated contracting and commissioning takes place across a system (for example, City & Hackney) and is population based. A population based approach refers to the high, macro, level programmes and interventions across a range of different services and sectors. Key features include: population-level data (to understand need across populations and track health outcomes) and population-based budgets (either real or virtual) to align financial incentives with improving population health.
ICB	Integrated Commissioning Board	The Integrated Care Board has delegated decision making for the pooled budget. Each local authority agrees an annual budget and delegation scheme for its respective ICB (Hackney ICB and City ICB). Each ICB makes recommendations to its respective local authority on aligned fund services. Each ICB will receive financial reports from its local authority. The ICB's meet in common to ensure alignment.

ICS	Integrated Care System	An Integrated Care System is the name now given to Accountable Care Systems (ACSs). It is an 'evolved' version of a Sustainability and Transformation Partnership that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide joined up, better coordinated care. In return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners.
IPC	Integrated Personal Commissioning	
ISAP	Integrated Support and Assurance Process	The ISAP refers to a set of activities that begin when a CCG or a commissioning function of NHS England (collectively referred to as commissioners) starts to develop a strategy involving the procurement of a complex contract. It also covers the subsequent contract award and mobilisation of services under the contract. The intention is that NHS England and NHS Improvement provide a 'system view' of the proposals, focusing on what is required to support the successful delivery of complex contracts. Applying the ISAP will help mitigate but not eliminate the risk that is inevitable if a complex contract is to be utilised. It is not about creating barriers to implementation.
LAC	Looked After Children	Term used to refer to a child that has been in the care of a local authority for more than 24 hours.
LARC	Long Acting Reversible Contraception	
LBH	London Borough of Hackney	Local authority for the Hackney region
LD	Learning Difficulties	
LTC	Long Term Condition	
MDT	Multidisciplinary team	Multidisciplinary teams bring together staff from different professional backgrounds (e.g. social worker, community nurse, occupational therapist, GP and any specialist staff) to support the needs of a person who requires more than one type of support or service. Multidisciplinary teams are often discussed in the same context as joint working, interagency work and partnership working.

MECC	Making Every Contact Count	A programme across City & Hackney to improve peoples' experience of the service by ensuring all contacts with staff are geared towards their needs.
MI	Myocardial Infarction	Technical name for a heart attack.
	Neighbourhood Programme (across City and Hackney)	The neighbourhood model will build localised integrated care services across a population of 30,000-50,000 residents. This will include focusing on prevention, as well as the wider social and economic determinants of health. The neighbourhood model will organise City and Hackney health and care services around the patient.
NEL	North East London (NEL) Commissioning Alliance	This is the commissioning arm of the East London Health and Care Partnership comprising 7 clinical commissioning groups in North East London. The 7 CCGs are City and Hackney, Havering, Redbridge, Waltham Forest, Barking and Dagenham, Newham and Tower Hamlets.
NHSE	NHS England	Executive body of the Department of Health and Social Care. Responsible for the budget, planning, delivery and operational sides of NHS Commissioning.
NHSI	NHS Improvement	Oversight body responsible for quality and safety standards.
	Primary Care	Primary care services are the first step to ensure that people are seen by the professional best suited to deliver the right care and in the most appropriate setting. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
PD	Personality Disorder	
PIN	Prior Information Notice	A method for providing the market place with early notification of intent to award a contract/framework and can lead to early supplier discussions which may help inform the development of the specification.
QIPP	Quality, Innovation, Productivity and Prevention	QIPP is a programme designed to deliver savings within the NHS, predominately through driving up efficiency while also improving the quality of care.
QOF	Quality Outcomes Framework	
	Risk Sharing	Risk sharing is a management method of sharing risks and rewards between health and social care organisations by distributing gains and losses on an agreed basis. Financial gains are calculated as the difference between the expected cost of

		delivering care to a defined population and the actual cost.
	Secondary care	Secondary care services are usually based in a hospital or clinic and are a referral from primary care. rather than the community. Sometimes 'secondary care' is used to mean 'hospital care'.
	Step Down	Step down services are the provision of health and social care outside the acute (hospital) care setting for people who need an intensive period of care or further support to make them well enough to return home.
SOCG	System Operational Command Group	An operational meeting consisting of system leaders from across the City & Hackney health, social care and voluntary sector. Chaired by the Chief Executive of the Homerton Hospital. Set up to deal with the immediate crisis response to the Covid-19 pandemic.
SMI	Severe Mental Illness	
STP	Sustainability and Transformation Partnership	Sustainability and transformation plans were announced in NHS planning guidance published in December 2015. Forty-four areas have been identified as the geographical 'footprints' on which the plans are based, with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). A named individual has led the development of each Sustainability and Transformation Partnership. Most Sustainability and Transformation Partnership leaders come from clinical commissioning groups and NHS trusts or foundation trusts, but a small number come from local government. Each partnership developed a 'place-based plans' for the future of health and care services in their area. Draft plans were produced by June 2016 and 'final' plans were submitted in October 2016.
	Tertiary care	Care for people needing specialist treatments. People may be referred for tertiary care (for example, a specialist stroke unit) from either primary care or secondary care.
	Vanguard	A vanguard is the term for an innovative programme of care based on one of the new care models described in the NHS Five Year Forward View. There are five types of vanguard, and each address a different way of joining up or providing more coordinated services for people. Fifty

		vanguard sites were established and allocated funding to improve care for people in their areas.
VCSE	Voluntary Community and Social Enterprise	

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