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 11 November 2021, 10.00 – 10.40

By Microsoft Teams

No.	Time	Item	Page number	Lead
1.	10.00 (5 mins)	Welcome, introductions and apologies	Verbal	Chair
2.		Declarations of Interests	Paper 2a *Pages 3-11*	Chair
3.		Minutes of the Previous Meeting & Action Log	Papers 3a & 3b *Pages 12-26*	Chair
4.		Questions from the Public	Verbal	Chair
5.		ICP Chief Officer Report	Verbal	Tracey Fletcher
For Decision				
6.	10.05 (30 mins)	Neighbourhoods - Progress in 2021/22 and Future Plans: • Neighbourhoods programme proposal for 22/23; • -Neighbourhoods sustainability proposal for Community Pharmacy.	Papers 6a & 6b *Pages 27-79*	Nina Griffith

Hackney

CITY OF LONDON

NHS North East London Clinical Commissioning Group

7.	10.35 (5 mins)	Any Other Business	Verbal	Chair
For Information				
Monthly Financial Report			*Paper to follow*	N/A
Risk Register			*Paper to follow*	N/A
Integrated Commissioning Glossary			*Pages 80-85*	N/A
Date of next meeting: Thursday 9 December 2021 by Microsoft Teams				

City and Hackney Integrated Care Partnership Board

Register of Interests

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

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

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

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

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

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

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

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

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

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- 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 14 October 2021 by Microsoft Teams

Members:

Hackney Integrated Commissioning Board		
Hackney Integrated Commissioning Committee		
Deputy Mayor Anntoinette Bramble	Deputy Mayor & Cabinet Member for Education, Young People & Childrens' Social Care	London Borough of Hackney
Cllr Chris Kennedy	Cabinet Member for Health, Adult Social Care & Leisure	London Borough of Hackney
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
Siobhan Harper	Transition Director	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
Haren Patel	Clinical Director	Primary Care Network
Jenny Darkwah	Clinical Director	Primary Care Network
Honor Rhodes	Associate Lay Member	NE London CCG
Jon Williams	Executive Director	Healthwatch Hackney
Paul Calaminus	Chief Executive	East London NHS Foundation Trust
Paul Coles	General Manager	Healthwatch City of London
Dr Sandra Husbands	Director of Public Health	London Borough of Hackney
Dr Stephanie Coughlin	Neighbourhoods & Covid-19 Clinical Lead	NE London CCG / City & Hackney Integrated Care Partnership
Tony Wong	Chief Executive	Hackney Council for Voluntary Services
Eileen Taylor	Vice Chair	East London NHS Foundation Trust

Attendees

Alex Harris	Integrated Commissioning Governance Manager	NE London CCG / City & Hackney Integrated Care Partnership
Amy Wilkinson	Workstream Director: Children, Young People, Maternity & Families	NE London CCG / City & Hackney Integrated Care Partnership
Diana Divajeva	Public Health Analyst	London Borough of Hackney
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
Catherine Macadam	Associate Lay Member	NE London CCG / City & Hackney Integrated Care Partnership
Mary Fadairo	Governance & Assurance Officer	NE London CCG / City & Hackney Integrated Care Partnership
Ben Greenbury	Project Manager	NE London CCG / City & Hackney Integrated Care Partnership
Eugene Jones	Director of Service Transformation	East London NHS Foundation Trust
Waleed Fawzi	Consultant Psychiatrist	East London NHS Foundation Trust
Dan Burningham	Mental Health Programme Director	NE London CCG / City & Hackney Integrated Care Partnership

Apologies:

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
Ann Sanders	Lay member	NE London CCG
Ian Williams	Acting Chief Executive	London Borough of Hackney
Laura Sharpe	CEO	City & Hackney GP Confederation
Susan Masters	Co-Director: Health Transformation, Policy and Neighbourhoods	Hackney Council for Voluntary Services
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. RA welcomed Tony Wong (TW), the recently appointed Chief Executive of Hackney Council for Voluntary Services to his first meeting of the ICPB.

2.	**Declarations of Interests** The City Integrated Commissioning Board **NOTED** the Register of Interests. The Hackney Integrated Commissioning Board **NOTED** the Register of Interests. The City and Hackney Area Committee **NOTED** the Register of Interests. RA briefed the ICPB that a new declarations of interest system was in the process of being implemented, which would allow members to self-manage their declarations. This was planned to become available in November.
3.	**Questions from the Public** No questions from the public were raised at the ICPB meeting.
4.	**Minutes of the Previous Meeting & Action Log** The City Integrated Care Partnership Board **APPROVED** the minutes of the previous meeting and **NOTED** the action log. The Hackney Integrated Care Partnership Board **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 the first, trial iteration of the report circulated with meeting papers from page 24 would be expanded on in the coming months. The report contained key updates from across the system and a proposal for a series of development sessions, starting with the need to establish a system team, with the third Neighbourhood Health and Care Board (NHCB) having met for the third time recently and its agreement that an Integrated Care Partnership (ICP) Delivery Lead should be appointed and Senior Responsible Owners (SROs) for Finance and Quality identified at the local system level. These SROs would join the existing ones for IT enablement and Workforce, which TF and Laura Sharpe (LS) held responsibility for respectively. Partnership representation and leadership from across the system would be vital to the success and this principle extended to clinical leadership, both practitioner and clinical leads across Trusts, Local Authorities and the CCG. TF confirmed that the ICP Delivery Lead post would be advertised in October 2021, would be jointly hosted between health and social care and, process permitting, an appointment would be able to be made within 4 to 6 six weeks. TF moved on to brief the ICPB that the CCG Finance and Performance Sub Committee (FPSC) and NHCB had agreed £600,000 of CCG resources to be made available for winter planning funds. These would need to be non-recurrent investments and may be used to either build on previously successful programmes of work or new initiatives to support system robustness through the winter months.

	TF confirmed that the appointment process for the NEL Integrated Care System (ICS) Chief Executive was underway, with several of those on the call having been involved in the recruitment process already. More news on this front should be available soon. An ICS development session had been held on 6 October 2021, attended by several ICPB members with a variety of views and ideas expressed across the region and the involved partners. This session was the start of this particular process, which would continue to engage, shape and take on feedback in the coming months in the run up to the ICS organisation going live in April 2022. Siobhan Harper (SH) announced that she had been appointed to the Transition Director role for the Tower Hamlets, Newham and Waltham Forest partnership and would be moving on from City and Hackney from the start of November 2021. SH continued that TF would be taking up more of a system wide role, and other work was underway to look at how the local teams and functions worked together locally. When these arrangements were confirmed, they would be shared publically and with ICPB members. SH thanked everyone for their support and experiences in working together in City and Hackney. RA thanked SH for her work in the local area, noting that SH's departure was a sign of the upcoming changes, even if to a neighbouring area. Chris Kennedy (CK) thanked SH for her support as well, adding that there was also an opportunity to look at the split of work, responsibilities and delegations between the local area and the NEL level in light of the upcoming changes towards the creation of an ICS organisation across the whole of NEL. CK added that examples of the upcoming changes were becoming apparent, with for instance, discussions on how safeguarding may work in the future already underway with proposals on the table. CK asked if ICPB members wanted to take the opportunity to agree a clear approach for the local area to these sorts of discussions, emphasising the need for early and appropriate consultation and discussion on any changes. CK thanked TF for the questions set out on page 25 of the circulated papers, adding that these formed a good starting point for discussion through local development sessions. CK flagged that one likely point of difference that would need discussion and shared understanding to be established would be around how local authorities and the NHS each managed finances and budgets, with approaches seeming to differ across the partners. RA supported CK's comments, adding that changes to safeguarding in particular needed to be discussed with local authority colleagues, especially considering their key, statutory roles in this important area of work. Honor Rhodes (HR) stated that a Safeguarding Assurance Group (SAG) had been held recently which had received the proposed changes to safeguarding arrangements and had fed back that local input and control remained vital to the success of this work at the local level. John Gieve (JG) asked whether any formal consultation process would be needed to address proposed changes to local safeguarding arrangements. JG continued to flag that the coverage of a possible scorecard in place to cover Neighbourhoods in one of the latter reports in the circulated papers. JG noted whether a similar scorecard process could be widened to cover both the transition programme, but also base services to support ICPB member's discussion and focus debate where it would be the most value. RA clarified that consultation on

	the safeguarding arrangements was probably not appropriate, as while there were not substantive changes to the safeguarding processes, the level at which these processes were held and implemented was possibly changing. RA added that feedback would still be gathered and passed on. Jonathan McShane (JMS) thanked TF for the report, noting that he was taking forward the proposals for a series of ICPB development sessions and that if any members wanted to feed in to this process, they could contact him directly. JMS continued that based on discussions in the meeting so far, that a session on delegation arrangements and the role of the place based partnership seemed to be something of a priority, along with exploring the decision making process across NEL and place involvement in those decisions. JMS asked for feedback on holding the facilitated proposed development sessions in November 2021 and January 2022, with the ICPB extended by around an hour to enable members to meet in private to hold these discussions. JMS added that the team would also be looking at running at least one of these sessions physically – and safely – together in a room, if this was something that members could reach agreement on. **ACTION:** ICPB members to hold time in diaries to extend the ICPB's on Thursday 11 November 2021 and Thursday 13 January 2022 by one hour to end at 1300 if at all possible. RA raised that the November 2021 session would be challenging to hold physically, as the Court of Common Council would be meeting in the City of London on the same day, but that an in person session in January 2022 would be welcomed. Mark Rickets (MR) expressed support for the development session arrangements, flagging that the members may also want to use some of the session time to explore how they might approach difficult conversations and disagreement as a group in terms of strengths of relationships and working together. MR suggested that using case studies or scenarios to test these kinds of situations may be helpful. Helen Fentimen (HF) flagged that the system as a whole was undergoing significant change, both in terms of structure and people and that colleagues across all the partner organisations needed to be supported through the transition process. HF continued that clarity on responsibilities was vital to the success of the future system and that exploring this in the development sessions could be very useful, and that these discussions could inform fuller schemes of delegation that could be consulted on and agreed. HF added that approaching this work with a view to resolving differences of opinion would be vital, and securing clarity on what freedoms City and Hackney as a place would hold, in the context of the wider work and responsibilities across NEL. Catherine Macadam (CM) noted that the August ICPB had discussed development work underway on how members worked together to promote a shared culture and values and asked if this areas would be addressed through these upcoming sessions. JG noted that securing availability from NEL CCG leadership team members would be important to the success of the development sessions, both in terms of providing feedback but also to ensure that the latest information is available to all

	members. RA responded that perhaps the ICPB members may benefit from holding the first session amongst themselves to reach a consensus on as many points as possible, before involving future ICS leadership colleagues in the second session. RA added that this timetable would probably ensure that the new ICS Chief Executive could join the session in January 2022. SH flagged that the place and ICPB would be part of the future ICS system, with more representation for local authority colleagues across and at the NEL wide level of decision making and that any decision making on local and NEL wide services would need to be shared across partners. JG noted that City and Hackney benefited from long established working relationships as an ICB and now ICPB, and that efforts to raise and share examples of partnership working and processes across NEL from local colleagues should be promoted. RA agreed, adding that many other parts of NEL were now starting to arrange their processes and ways of working together. TF flagged that City and Hackney colleagues needed to keep in mind that many colleagues at the NEL were going through transition and change and that while many people may find the uncertainty challenging, all those involved, including ICPB members were part of the same team and the same future organisation. TF continued that local members needed to promote and defend the needs and interests of local people where this was needed, for instance in debating the safeguarding and quality changes. MR agreed with the assessment that City and Hackney colleagues held significant experience of partnership working that could be valuably shared with colleagues across NEL and help shape future working arrangements in terms of place based working and delegations. MR added that he wanted his public appreciation of SH's work and support recorded in recent times.
6.	**NHSE Ageing Well Programme: 2021/22** RA welcomed Nina Griffith (NG) to the meeting to support discussion on this agenda item. NG drew the ICPB's attention to the circulated paper, outlining the background and context around the NHS England Aging Well programme, as well as making proposals for agreement around the use of this funding. NG set out the three key national priorities present in this work – promoting enhanced health in care homes, supporting a 2 hour community response and providing anticipatory care and confirmed the funding arrangements to support this work, including programme funding at the NEL wide level, primary care funding through Primary Care Network (PCN) contracts and a community services development fund operating across the NEL system. NG noted that the development fund monies were non-recurrent, but that a multi-year proposal was being made through to 2024, with £9.4 million committed across NEL in 2021/22 and a similar level of funding expected in the next two years. NG confirmed that discussions at the NEL level had resulted in agreement that the funds would be distributed to the local level on a population and population needs basis, resulting in an allocation of £1.1 million for City and Hackney in 2021/22. NG set out how the use of the funds locally had been discussed and developed locally so far, with a stock take of relevant local provision through other services undertaken, a data review and benchmarking of current performance and a

	structured engagement process with community leads and partners undertaken. NG continued that existing strategic priorities were also considered and the resulting proposals aligned with the Neighbourhoods programme and existing strategies, like the Hackney Aging Well strategy. NG added that the local team were waiting on the final service model for the anticipatory care service from NHS England and Improvement (NHSEI), and so a proposal was being put forward to hold back £500,000 of the available funding to address this service when more information became available in the coming months, although £50,000 was proposed for investment in a focussed pilot and case notes review to inform the next phase of this work. In the mean time, efforts had been focussed on proposals to address the two hour response and enhanced health in care homes, with details of proposals covered in the circulated paper and including: • Proactive therapies and mental health support to care homes • Self-referral into Integrated Independence Team (IIT) rapid response • Paramedic training • Improving delivery of discharge to assess and post discharge assessments • Home Treatment & Reablement NG briefed the ICPB that efforts had been made to broaden the scope and support partnership working through these proposals and that local authority partners in particular had fed back that promoting the reduction of social isolation through this work could be beneficial for all involved. NG added that this had been added to the evaluation measures for the proposals. RA thanked NG for the proposals and briefing, noting that the 2 hour response initiative appeared to be challenging, although a very positive effort. RA asked if the inclusion of discharge in this work was appropriate and asked for context behind this decision. NG responded that the local system already operated a 2 hour discharge provision, involving both the ParaDoc service and the IIT re-enablement team. Additionally, the community nursing team had an urgent care team who also fed into this work, although they didn't work to a 2 hour response in all situations. NG continued that when looking at a 2 hour 'target', local services already performed very well, with more capacity in these services to take on more referrals if needed. This programme of work would therefore focus on promoting the use of these services where possible, partnership working and self-referral for patients to access the offer directly. HF welcomed the inclusion of anticipatory care in this proposal, noting that this was an area of work that had been discussed for many years and adding that it would be important to set a clear understanding of what this anticipatory care proposal comprised to enable shared understanding. HF continued that most of the proposals before the ICPB contained elements of addressing anticipatory care and that drawing out and concentrating on these elements, an integrated and consistent set of services could flourish. NG agreed, setting out the approach to the current anticipatory care pilot, which involved individually reviewing a cohort of moderately frail over 55's to assess risks of potential crisis, outreach needs and ongoing needs from a multi-disciplinary team operating at the neighbourhood level to assess what input may be needed. NG continued that this process concentrated on ensuring that the individual is reviewed from a variety of different care viewpoints and needs thoroughly explored to produce a joint, holistic plan. NG noted that there probably was a consistent, if multi-

	disciplinary approach to this work, even across the different cohorts of patients involved. NG confirmed that the findings from the pilot would be shared and discussed with ICPB members in the coming months. CM flagged that the local area was home to a disproportionately low number of care homes, with older people more likely to end up being cared for out of the area. CM asked if these programmes under discussion at the ICPB extended to cover those patients out of the area, but originally from the City or Hackney. NG responded that there was a consistent health in care homes direct enhanced service (DES) in place across NEL which applied to all Care Quality Commission (CQC) registered homes, although the local area did go a little further in a few key areas in terms of primary care support, leadership and quality. There was a baseline offer in place across NEL, much of which was drawn from the NHSEI offer. Jon Williams (JW) asked what patient involvement processes had been followed in drawing up these plans, and what steps were planned to involve patients in planning their care, potentially with advocacy support. JW also raised that recruitment to the roles that these proposals appeared to be setting up may be challenging in the current national workforce climate. NG responded that aspects of this work were still in a development phase, but that patients were engaged in this development work. With regards to workforce, there were risks present that would be monitored. CK asked whether this health in care homes proposal covered housing with care. NG responded that it wouldn't and that initially at least, it would only cover CQC registered settings. Work was planned to look at other settings the offer could be extended to cover, and anticipatory care would cover those in these community settings. CK thanked NG and noted that working with community and voluntary organisations could be very valuable when planning elements of this work. Stephanie Coughlin (SC) thanked NG for the proposals, noting that this pivot to considering patient needs in a proactive and partnership focussed approach was both exciting and likely to better meet the individual patient needs. SC asked what was being planned to support and encourage this change in thinking amongst local clinicians, noting that much was being asked of front line colleagues at the moment. SC continued to flag that this work should also consider that, if proactive care is a success, it is likely to reveal unmet care needs that will impact on activity across the wider health and care system and that the workforce and other impacts may need to be considered. Tony Wong (TW) noted that HCVS had been working on social isolation recently that may be useful for this work in terms of evaluation and impact. Paul Calaminus (PC) welcomed the proposals, flagging that it would be important to measure and record the benefits returned through this work, wherever they may materialise – benefits for the patient and their carers, for partner organisations or for the system as a whole. **DECISION:** The LBH Committee, COLC Committee and CCG Area Committee comprising the ICPB approved the proposals for use of the Community Services Development fund to support the NHSE Ageing Well Agenda, investing £641,200 across five programmes of work. A further £500,000 was agreed to be held

	pending the release of the national service model and results of the local pilot service.
7.	**A proposal to permanently locate the inpatient dementia assessment services at East Ham Care Centre** RA welcomed Eugene Jones (EJ), Waleed Fawzi (WF) and Dan Burningham (DB) to support discussion on this agenda item and the proposal. EJ drew the ICPB's attention to the circulated papers and noted that many members may be familiar with the history of this work, which had been extensively discussed across the area in the previous years. EJ stated that the proposal under discussion was to make the movement of the inpatient dementia assessment service to the East Ham Care Centre from Columbia Ward in Mile End permanent, where it has been located for the last 12 months. EJ noted that positive patient, carer and family member feedback and the green zone covid-19 arrangements still in place, along with ELFT's wider strategic work all pointed towards this being a positive step, and that at this time, feedback was being sought to inform a formal, final proposal on which a decision would be needed in the coming months. While the movement had initially been made in August 2020 on a temporary basis to ensure Covid-19 free, 'green zone' treatment, the move had produced other benefits from the more modern, better suited facilities in East Ham, with ensuite bedrooms available, more natural light, access to outdoor space, plus a on site restaurant and free visitor parking. Additionally, there are other wards on the East Ham site, allowing cross cover and extension of services to be offered and benefits from co-location. EJ continued that the average length of stay in East Ham had reduced to 82 days from the 98 days in Mile End, a difference of 16 days with no issues around re-admissions recorded. WF added that with more integration and partnership working with local authority colleagues, it was hoped that this length of stay could come down even further. WF added that the benefits of co-locating at East Ham were being realised through a more experience workforce and the ability to move patients from ward to ward easily, as their needs changed, resulting in better care. EJ flagged that patient, carer and family feedback was also overwhelmingly positive with over 95% positive responses to the friends and family test and an increase in the number of respondents. EJ recognised that there were concerns present around transport and access for local people to visit friends and family in East Ham and in response, an offer had been put in place to provide the booking of taxi's door to door or other supportive measures, including free visitor parking. East London Foundation NHS Trust (ELFT) were working with HealthWatch, the People and Place Group (PPG) and local patient groups to produce a protocol covering easy access to travel arrangements and communications and information around travel. EJ confirmed that ELFT would be launching a public consultation, as requested by the Hackney Health Overview and Scrutiny Committee (HOSC) back in July 2020, when the temporary move was first considered. This will launch in December 2021 and comprise three questions, including one on satisfactory and robust travel arrangements.

	DB thanked EJ for the briefing, noting that the ward in question was moving from Tower Hamlets to East Ham and was a short stay ward, with more consolidation of dementia experience and workforce at the new facility. The movement was thought to be connected to a better quality of care, but there were concerns present around travel distance and arrangements, as EJ had flagged. EJ stated that journeys from a set of locations across the City and Hackney had been mapped by public and private transport to the East Ham facility, and were generally upwards of one hour on public transport. Paul Coles (PC) asked that these public transport options be mapped out for simplicity in terms of changes as well as by total travel time, as well as any walking distances, which may be challenging for frail family members. EJ responded that the East Ham ward benefited from a bus stop outside the building, but that most bus journeys required connections to East Ham. EJ noted the majority of visitors to the East Ham ward tended to be elderly themselves, and were offered a taxi service door to door. WF flagged that ELFT had been undertaking a programme of consolidation recently and the need to increase taxi usage had become apparent early in that work and was now well embedded across local services. EJ noted that a survey of carer and visitor experience was currently underway and that the results of this work would be used to inform the ELFT offer and final proposal in this area of work. EJ set out that the consultation will close and a report on responses produced in March 2022 after a twelve consultation starting December 2021, with an update to this ICPB following shortly afterwards. CM asked whether the questions indicated in the circulated report were final, noting that an additional question had been posed in feedback from the People and Place Group on travel. EJ responded that it was likely that this question would be added.
8.	**Neighbourhoods: Progress in 2021/22 and Future Plans** NG briefed the ICPB on progress within the Neighbourhoods programme of work along with an update on proposals for the programme in the upcoming year and onwards to a sustainable footing. NG noted that the circulated papers provided updates on progress against the six previously agreed priorities, including that the community nursing Neighbourhood model was now in place, as were the adult social care teams. Local models of care were now being designed around the Neighbourhood delivery model, for instance with multi-disciplinary teams now operational to focus on those local people with the most complex needs in need of a multi-agency approach. The anticipatory care pilot would be based on the neighbourhood model, as discussed earlier in the meeting. Work continued to develop community navigation – the linking of Neighbourhood models of care into communities, partners and other services to meet broader needs. NG updated the ICPB that work was progressing on developing an outcomes framework to ensure the success of the Neighbourhoods programme, supported by Cordis Bright, who had produced an initial stocktake report of the project which will be able to be shared in the coming months. This work will continue to

	develop a theory of change and an evaluation framework for the programme and new models of care being put in place. NG set out the work underway to improve communications around the Neighbourhood programme, aimed at both the local workforce who might be working with parts of the programme and also local people, who might be using services within the programme. This work included a new website, newsletter and explanatory video to keep people engaged and involved wherever possible. NG noted that the team would be returning to the November 2021 ICPB to set out a proposal for 2022/23 and beyond, including an ask for resources to continue the programme work, which will be a smaller sum than in the past and proposals for specific Neighbourhood models which have been tested and piloted at a smaller scale and may now be ready for launch at the Neighbourhood level as sustainable, business as usual services. These proposals included adult social care, voluntary sector involvement, community and resident engagement and a model for how community pharmacy will work across the Neighbourhood footprint. RA noted that the discussion in November would require substantive discussion, which would need to be balanced with the previously discussed ICPB development session. JG asked whether each service was preparing its own evaluation framework, as covered in the circulated paper, and if so, whether a programme wide evaluation was also planned to bring some consistency to this process. NG responded that this was the focus of work Cordis Bright were engaged in, to take a view at the programme and system level, rather than the individual service level. CK asked how some of the very basic services interfaced with and potentially received funding from the Neighbourhoods programme, for instance, a meal service currently funded from a grant and received referrals for a community meal from health and care services. CK asked how that meal might be funded under the future system and be supported. NG responded that while the funding under discussion at the ICPB was unlikely to directly fund such a service, the HCVS model that was under development would set out how community and voluntary sector organisations interface and work within the Neighbourhoods model. NG continued that grant funding may also follow such a model and additionally, the community navigation work would provide increased visibility for the wider community and voluntary sector. HR supported the current direction of travel, noting that the next month's discussions on specific proposals would be vital to ensure successful, highly localised Neighbourhood delivery and involvement for services from the smallest, like a community meal service to well established NHS or local authority partners. RA agreed with this assessment, noting that care must be taken to ensure that large, well established and experienced organisations didn't crowd out grassroots and community respected vital services. Caroline Millar (CM) noted that there was possibly some anxiousness amongst community organisations around this work already and increasing demands placed on them in terms of activity and how they work with larger, statutory organisations without an indication that they would be resourced for this. ICPB members needed to keep these impacts in mind when discussing this work.

9.	**Monthly Financial Report** Sunil Thakker (ST) briefed the ICPB that just before the meeting, NHSEI had made £250 million available for the winter access fund, covering November 2021 to March 2022. This funding was directed to be used to ensure access to same day primary care services and supporting access to general practice and criteria would be attached to draw down and use this funding, with a deadline for submission of plans from CCGs at the end of October 2021. ST added that the ICPB would be kept updated on this work and use of funding. ST drew the ICPB's attention to the circulated financial report, with the integrated, consolidated basis across the three partner organisations returning a £3.9 to 4 million overspend on a full year basis. Looking at individual organisational details, the ICP was declaring a breakeven position against the £267 million budget six month budget that had been allocated to it, with costs pressures recognised in primary care and independent sector care. These were being managed through reserves available to the ICP. ST drew the member's attention to page 129 which set out risks, opportunities and mitigations in place and which supported the manageable risk portfolio associated with the ICPs work. ST continued to brief the ICPB that NEL CCG was also declaring a breakeven position, while also recognising risks associated with independent sector acute organisations, prescribing costs and continuing health care. ST noted that discharge costs associated with Covid-19 care are being retrospectively charged at the moment and this may result in a cost pressure in the coming months. ST noted that a planning exercise to look at the second half of 2021/22 had just commenced and that the ICPB would be kept updated on this work. ST briefed the ICPB that the London Borough of Hackney (LBH) position was covered in the circulated papers on page 131, indicating a £3.7 million overspend, driven by Covid-19 expenditure, adult social care and residual costs relating to the cyber-attack experienced earlier in the year. ST continued that page 133 set out the City of London Corporation (COLC) position, with a small overspend of £200,000 illustrated. CK highlighted that LBH had just agreed an exceptional single care package that came in at £500,000 demonstrating the potential impacts a single, complicated package of care could have on the organisations total budget. Costs in this area were tending towards higher total sums as needs became more complex, and more options became available to help support those complex needs. CK noted that with the increase in total volume of care packages, LBH was no longer funded at the level to address this area of work.
10.	**ICPB Register of Risks** Matthew Knell (MK) drew the ICPBs attention to page 134, where the risk register papers started which included 11 red rated risks, along with 1 risk that had decreased in score from a red to an amber and would not feature on the following months report. Another risk, regarding levels of childhood immunisation had risen from an amber to a red and was now included on the register. MK noted that there were currently 17 amber rated risks at the highest score point before they

	may rise into red rated status, none of which had changed in score in the previous month. RA raised that the ICPB would be trying to move the risk register, at least on a quarterly basis, to the start of the agenda in future meetings. MR raised that there may be an emerging risk around the offer to Afghan refugees, who had been settled in hotels in the City and what the longer term accommodation and support package may look like and the timetable in place. MR noted that a substantive item may come to a future meeting of the ICPB on this matter and risks may be explored in that work. RA thanked MR for this update, noting that the NHS support in place to get these refugees registered with primary care and seen by GPs had been positive, with cultural challenges recognised. RA raised that living in a hotel was not a sustainable position and that the risks around this needed to be monitored.
	Any Other Business and Reflections HR raised that she had asked for an update on the conversation that had taken place in a previous meeting around how the working groups and Boards that sit under the ICPB. A discussion had since taken place at the People and Places Group about their relationship with the ICPB, and similar ground needed to be explored with the Neighbourhoods Health and Care Board (NHCB). HR asked if a regular reporting schedule could be explored and presented to the ICPB to support governance in the ICPB and provide assurance for members on the work underway across the system through this time of change. Stella Okonkwo (SO) raised that this would be Alex Harris's (AH) last meeting supporting the ICPB and thanked him for his work over the previous years. RA and ICPB members also expressed their appreciation. Sandra Husbands (SH) flagged that the running time for the Outbreak Board and the balance of the total running time between the two meetings may benefit from being reviewed.
	Next meeting: Thursday 11 November 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.
LOBSep-1	Nina Griffith to update the Local Outbreak Board on further outreach work and pop-ups to address the low level of uptake in Local Vaccination Centers (LVS).	Nina Griffith	Sep-21	Oct-21	In progress.	
LOBSep-2	Nina Griffith to respond to Marianne Fredericks on the status of the Mantle St. Estate pop-up.	Nina Griffith	Sep-21	Oct-21	In progress.	
ICPBSep-1	Item on service transition and design to be brought back to a future ICPB.	Siobhan Harper	Sep-21	Dec-21	Closed	02/11/2021 update: placed on forward plan for December 2021.
ICPBSep-2	Update on NHCB to be provided at December 2021 ICPB meeting.	Tracey Fletcher	Sep-21	Dec-21	Closed	02/11/2021 update: placed on forward plan for December 2021.
ICPBOct-1	ICPB members to hold time in diaries to extend the ICPB's on Thursday 11 November 2021 and Thursday 13 January 2022 by one hour to end at 1300 if at all possible.	ICPB members	Oct-21	Nov-21	Closed	02/11/2021 update: electronic invitation sent for November 2021 session to ICPB members.

Title of report:	**Neighbourhoods - Progress in 2021/22 and Future Plans**
Date of meeting:	11th November 2021
Lead Officer:	Nina Griffith
Author:	Nina Grifith
Committee(s):	Alongside extensive informal engagement, the enclosed proposals have been taken to the following committees ● Neighbourhoods Provider Alliance Group - October ● System Operational Command Group - for agreement – October ● Neighbourhoods Health and Care Board - October ● Finance and Performance Subcommittee - for agreement - October
Public / Non-public	*[The partner organisations are committed to being as open as possible about all the decisions and actions they take, and reports will be considered to be in the public domain as standard. If there is a reason the contents of the report should not be made public please state below.]* None

Executive Summary:

We have reached an exciting juncture in our Neighbourhoods programme whereby a number of the different service models that we have been testing over the past few years have moved or can move from transformation into business as usual. As more project areas move to business as usual, we will reduce the need for ongoing non-recurrent programme resources to drive the programme. Therefore, this year, we are presenting a proposal for a reduced amount of non-recurrent programme costs to continue to progress Neighbourhoods in 2022/23.

In most cases, the new models of care are transformations within existing services with existing recurrent funding streams. However, in some cases, the new models are novel approaches or services that have not been in place in the borough before. Where this is the case, we will need to approve a recurrent funding stream for them.

Therefore, this year, alongside the case for continued funding for the programme in 2022/23. We are also presenting proposals to agree models and funding for three elements of Neighbourhoods that have been tested and refined through the programme over the last few years. These are for new services or approaches that do not currently have recurrent funding streams in place. One of these proposals is being presented today, a further two proposals will come to the December meeting:

-Investment in community pharmacy to deliver the model for Community Pharmacy

Hackney

CITY OF LONDON

NHS North East London Clinical Commissioning Group

within each Neighbourhood (this is being presented today)

-Investment in the Community and Voluntary Sector to implement the model for engagement and work with the voluntary sector at a Neighbourhood level

-Investment in Healthwatch, to support and enable resident engagement in the Neighbourhood.

[These two proposals will be presented in December. They reflect the work that has been tested in a number of Neighbourhoods to deliver inclusive Neighbourhoods partnerships that bring together statutory and non-statutory partners with local residents to identify and deliver local priorities and tackle hyper local health inequalities.]

The totality of the asks across all of the proposals is within the total envelope of spend that has gone into the Neighbourhoods programme each year to date, and within the overall envelope of the Better Care Fund. Therefore the total ask does not represent a cost pressure to the system.

Recommendations:

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

- Approve the proposal for funding for the Neighbourhoods programme in 2022/23
- Approve the Sustainability proposal for the Neighbourhood model for community pharmacy
- Note that Sustainability proposals will be presented to the December meeting for the Neighbourhood model for resident involvement and community and voluntary sector engagement

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

- Approve the proposal for funding for the Neighbourhoods programme in 2022/23
- Approve the Sustainability proposal for the Neighbourhood model for community pharmacy
- Note that Sustainability proposals will be presented to the December meeting for the Neighbourhood model for resident involvement and community and voluntary sector engagement

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

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	X	A key part of our approach to Neighbourhoods is enabling a greater focus on prevention and addressing local health inequalities. This includes putting a greater emphasis on community navigation (non-medical support). There is work that primary care with system partners will need to deliver this year on health inequalities.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	X	Neighbourhoods is bringing together proactive models of care and support that are wrapped around each Neighbourhood. This will enhance multi-agency working and support from residents and deliver care closer to home.
Ensure we maintain financial balance as a system and achieve our financial plans	X	As we see more resources come into the community whether through recruitment to new roles, through links with voluntary sector provision or a closer link from specialist services with community-based teams we would like to see this delivering more effective community based care.
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	X	Neighbourhoods is focused on delivering integrated and coordinated care and support for residents. This includes but extends beyond just physical health. The wider engagement of both voluntary sector organisations as well as wider council services remains key to achieving the overall vision.
Empower patients and residents	X	Healthwatch have led work across Neighbourhoods and with the Neighbourhoods Resident Involvement Group to develop a charter for co-production and community involvement. Programme leads involved in Neighbourhoods have been undertaking sessions jointly with residents on how to embed this way of working in redesign work.

Specific implications for City

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

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

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

Specific implications for Hackney

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

Patient and Public Involvement and Impact:

The Neighbourhoods Resident Involvement Group continues to play an important role within the overall programme. This group brings together residents and is supported by Healthwatch. This group were fundamental in shaping the direction and strategy for Neighbourhoods.

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

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

Clinical/practitioner input and engagement:

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

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

Communications and engagement:

We have a communications plan which we developed with system partners. Our previous update to the October committee paper outlined these plans which included both resident and practitioner communications.

We are planning to deliver a series of outputs both for residents and for those people that work in City and Hackney which explains the work underway and the difference we hope

that this new way of working will have.

Equalities implications and impact on priority groups:

Helping to address inequalities (both of access to services and of outcomes) is a key purpose for Neighbourhoods. Neighbourhoods are about bringing together services (including voluntary and community sector) to work with residents to improve outcomes for populations of 30-50,000 people. Specific work will be taken forward by Primary Care (PCNs) with their system partners over the course of this year to identify and address specific identified health inequalities. This will draw on intelligence and insight already gathered.

Safeguarding implications:

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

Impact on / Overlap with Existing Services:

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

Main Report

Please see accompanying paper

Supporting Papers and Evidence:

None - see supporting paper.

Sign-off:

See Committee's identified above.

Contents

Covering Note

We have reached an exciting juncture in our Neighbourhoods programme whereby a number of the different service models that we have been testing over the past few years have moved or can move from transformation into business as usual. As more project areas move to business as usual, we will reduce the need for ongoing non-recurrent programme resources to drive the programme. Therefore, this year, we are presenting a proposal for a reduced amount of non-recurrent programme costs to continue to progress Neighbourhoods in 2022/23.

In most cases, the new models of care are transformations within existing services with existing recurrent funding streams. However, in some cases, the new models are novel approaches or services that have not been in place in the borough before. Where this is the case, we will need to approve a recurrent funding stream for them.

Therefore, alongside the case for continued funding for the programme in 2022/23. We are also presenting proposals to agree models and funding for three elements of Neighbourhoods that have been tested and refined through the programme over the last few years. These are for new services or approaches that do not currently have recurrent funding streams in place:

-Investment in the Community and Voluntary Sector to implement the model for engagement and work with the voluntary sector at a Neighbourhood level

-Investment in Healthwatch, to support and enable resident engagement in the Neighbourhood.

[These two proposals reflect the work that has been tested in a number of Neighbourhoods to deliver inclusive Neighbourhoods partnerships that bring together statutory and non-statutory partners with local residents to identify and deliver local priorities and tackle hyper local health inequalities.]

-Investment in community pharmacy to deliver the model for Community Pharmacy within each Neighbourhood.

The totality of the asks across all of the proposals is within the total envelope of spend that has gone into the Neighbourhoods programme each year to date, and within the overall envelope of the Better Care Fund. Therefore the total ask does not represent a cost pressure to the system.

1. Introduction and Context

1a. Our City and Hackney Neighbourhoods Approach

City & Hackney continues to demonstrate an ongoing commitment to place-based integration. We have made great progress in bringing services together so they are organised around each of our eight Neighbourhoods; adopting more of an asset based approach that is focusing on what matters to residents; working more closely with local communities and taking a more proactive approach to identifying and supporting residents who have complexity in their lives. Neighbourhoods is at the heart of our response to addressing local inequalities in City and Hackney. As a local system we want 'place' rather than 'organisation, service or sector' to be the currency of integrated service provision in City and Hackney.

There has been great progress in the last year with an increasing number of services being organised around the Neighbourhood footprint and further development of multi-disciplinary pathways and services that bring them together to meet the needs of residents. This approach is already delivering more joined up care closer to people's homes. The voluntary sector is essential in enabling this approach.

The Primary Care Networks (PCNs) represent the foundation for much of this work, and the priorities we have defined will support delivery of a number of the Direct Enhanced Services (DES's) that PCNs are being asked to deliver and support PCNs delivering their wider aims around population health.

Our aspiration for Neighbourhoods extends beyond health and care. We know that health and care is only a small part of what contributes to overall health and wellbeing and this has been even more highlighted during CoVID. Neighbourhoods in City and Hackney provide a focal point for wider public service reform which sees all people as equal partners and offers us a unique opportunity to truly deliver multi-agency working locally. We continue to learn from areas outside City and Hackney such as Wigan and Frome in developing our approach.

We are at a turning point in the programme as a number of the new approaches or models of care that were developed and tested through the Neighbourhoods programme in prior

years are now in place or will soon be in place as business as usual. Therefore our request for programme funds is a reduction on the previous years' ask, as part of a journey towards sustainability for the programme.

This proposal has been developed by system partners and is therefore presented as a collaborative partner proposal. It describes what has been delivered so far in 2021/22 with the funding invested and outlines our plans for 2022/23.

The programme is requesting to draw down £738,496 from the Better Care Fund in order to continue to facilitate this change across City and Hackney.

1b. The Strategic Case for Neighbourhoods

National Context

Whilst there is significant structural change underway in the NHS with the introduction of Integrated Care Systems and dissolution of CCGs, Neighbourhoods continue to be the prescribed model for delivery of services at the hyper-local level.

NHS England describe: "*delivery being through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in Neighbourhoods*" in their publication 'Integrating Care' published in November 2020, and more recent NHSE guidance on forming place based partnerships within ICS's see neighbourhoods as the fundamental building blocks for care delivery and community engagement ICS-implementation-guidance-on-thriving (england.nhs.uk).

The NHSE Ageing Well programme emerged from the NHS Long Term Plan, and defines priorities for services to better support people in the community. This includes an ambitious new model called Anticipatory Care to identify and support people with rising and complex needs. PCNs will be mandated to deliver this through a national contract expected in 2022. This approach fully aligns with the work already underway in Neighbourhoods to develop new multi-disciplinary models of care. We are now labelling this model Anticipatory Care to align with the NHSE language, and this is a key deliverable for the programme this year and next.

Local Context

As a system we agreed our vision for Neighbourhoods in February 2020 in the Neighbourhoods Operating Model. This Operating Model remains key to our overall direction of travel for Neighbourhoods, and represents our strategic approach to place based care in City and Hackney. In that Operating Model we described:

- The commitment to place based working and seeing all system partners as equals in this approach
- The teams that we envisaged would wrap around each Neighbourhood and the specialist teams that would support them
- The culture, values and behaviours that are critical to deliver on our vision for Neighbourhoods

- The need to take a population health management approach which supports people during their life course as well as according to their complexity of need
- The need to develop broad partnerships within each Neighbourhood which include but also extend beyond health and care
- The importance of Neighbourhoods in terms of safeguarding vulnerable people in City and Hackney
- And the enablers that need to be in place to deliver our overall aspirations for Neighbourhoods

Our high level delivery plan for Neighbourhoods was set out in the Operating Model and developed further during the course of 2020. We are continuing to progress the programme in line with this delivery plan.

Whilst the programme was conceived in a pre-pandemic world, the experience of and learning from the pandemic further justify the Neighbourhoods approach. The pandemic demonstrated the strength and value in delivering joined up, responsive community services that promote good health to the whole population and meet the specific needs of the more vulnerable. It also showed the extent of existing health inequalities whilst showcasing the wealth and strength that we hold in our local communities and across our statutory and non-statutory services. The programme was also able to demonstrate that it could re-prioritise and rapidly mobilise responses to the pandemic, as seen in the delivery of Neighbourhood Multi-disciplinary meetings (MDMs), the Neighbourhoods Conversations and the Single Point of Access into community navigation.

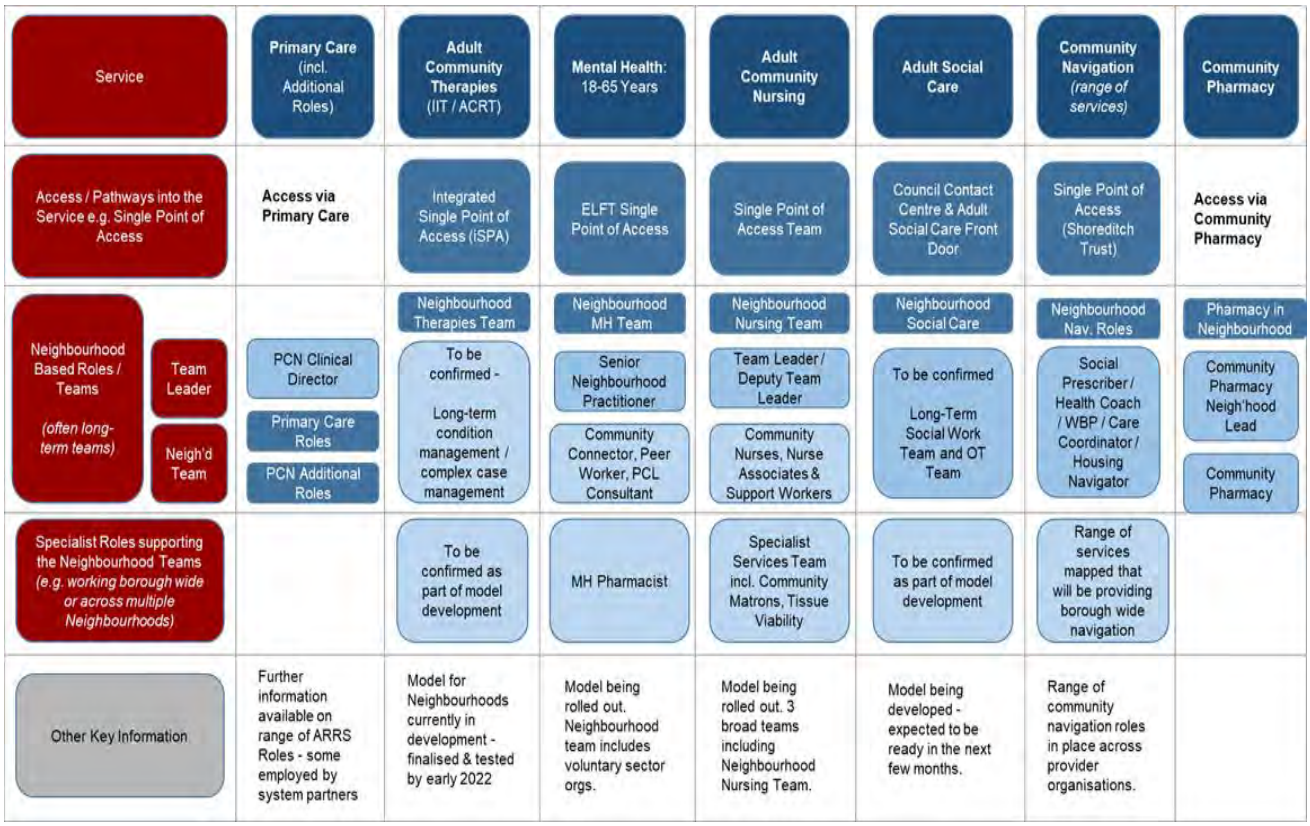
Neighbourhoods are the foundation for strong and thriving community services, working together and with local communities which will be vital to support the impact of the ongoing pandemic and recovery from the pandemic over years to come.

The strategic case for Neighbourhoods is still strong. Therefore whilst we are still forming our North East London ICS and our City and Hackney place based partnerships it is important that we do maintain the momentum of the Neighbourhoods programme to continue to progress new ways of working at the Neighbourhood level.

2. What has been achieved in 2021/22

This year we have really started to establish multi-disciplinary teams in each Neighbourhood, enabled by the successful reconfiguration of Adult Community Nursing, Adult Social Care, Community Mental Health and Community Navigation. In practice this means an increasing number of practitioners working with residents within an individual Neighbourhood, delivering services closer to home and providing the opportunity for better coordination of care and support.

The following diagram shows how services have been designed around the principle of a strong and responsive front door team with Neighbourhood based teams to support people with ongoing needs as part of a wider multi-agency Neighbourhoods approach.

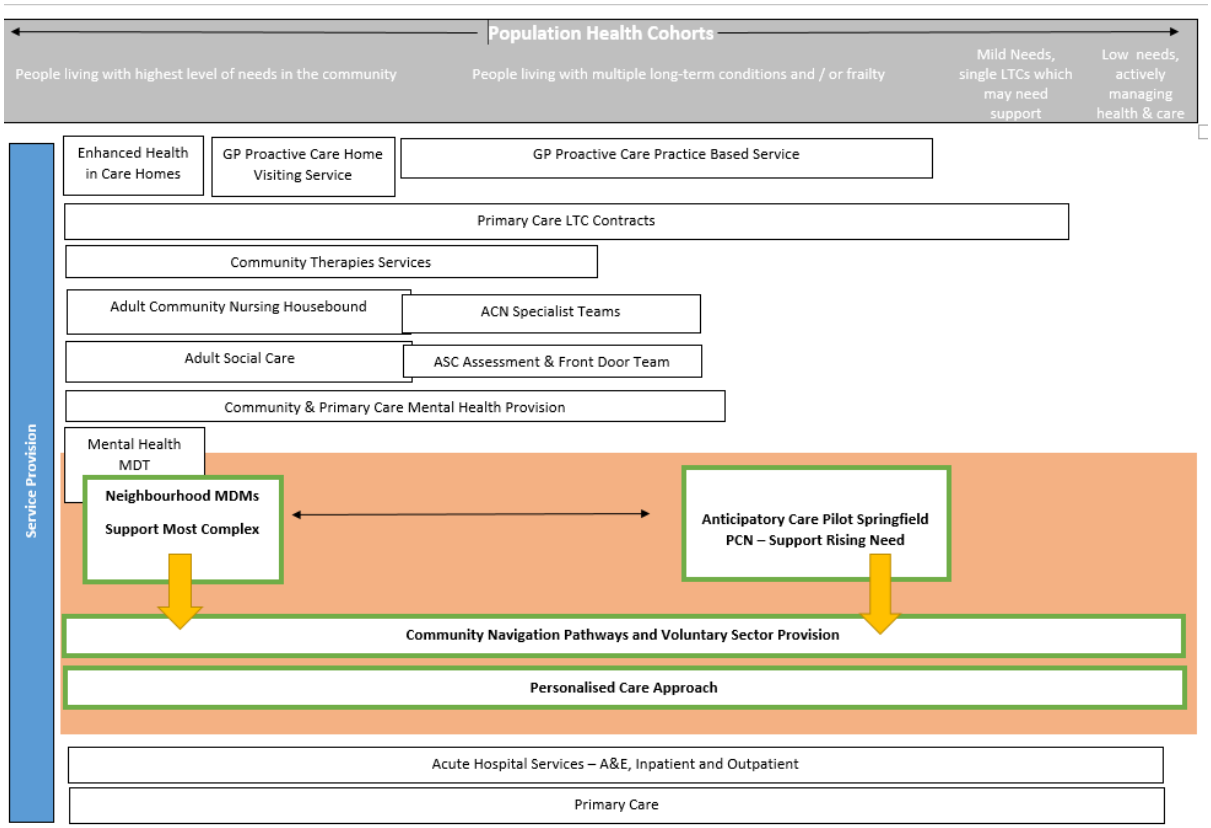


Alongside the re-design of services, we have made great progress developing the models of multi-agency working that bring partners together within each Neighbourhood, and are designed around different levels of population need. These are as follows:

- Neighbourhood MDMs for people with the most complex needs who require a multi-agency approach (in place)

- Anticipatory care for identifying and supporting people with rising needs (being piloted in Springfield Park)
- A model of community navigation to support all residents who require wider support from community and voluntary sector and to meet their non-medical needs in a holistic way. There will be a clear link from the MDMs and anticipatory care into these services, which comprise a combination of Neighbourhood based services and more specialist borough wide services (in place, currently piloting a Single Point of Access).

The following diagram shows how the different community and Neighbourhood service models fit together around different cohorts of the population.



The programme has always set a strong ambition to think more broadly than just health and social care services, and to consider how we can address the wider determinants of health through a clearer join up between health, social care, wider local authority services and the voluntary and community sector. The following describes the areas where this has been achieved to date:

- The Neighbourhood MDMs take a completely holistic view of the individuals and involve housing, debt, welfare and community / voluntary sector agencies as required to support the individuals' needs. This has resulted in improved co-ordination and outcomes for those individuals discussed in the MDMs, and has also enabled Neighbourhood teams to build relationships with these teams and to better understand each others' roles more broadly. As we develop our model of

anticipatory care we will take a similarly broad approach and consider the role of, or link into a wide range of services to meet peoples' holistic needs.

- The transformation in adult social care in LBH focused initially on re-organising their long term social work around each Neighbourhood. This has continued, but within the last year there has also been a focus on supporting individuals who need some assistance but do not necessarily require ongoing long term social care. The adult social care front door team has been merged with the council's contact centre. There has also been a cultural shift to bring in strength based approach that works to understand and meets people's wider needs. This means that the front door team work to solve people's problems and there is easy access into a broad range of services and individuals will be supported to access what they need such as debt, welfare, housing advice, and in some cases, long term social care via the Neighbourhood teams. We have also started to develop a clear pathway from the contact centre/front door team into our community navigation services.

- Community navigation is a key element of the Neighbourhoods model. We have a range of Navigation services that deliver non-medical, person centred support to residents, and develop strength based support plans with residents. These services also have strong understanding of what is in place within our Neighbourhoods and can sign post and support people to access a wide range of statutory and voluntary sector services. Through the Neighbourhoods programme we have set up a clearer structure for navigation services across the borough to ensure that they meet a wide range of identified needs. This has included establishing a number of new Neighbourhood based navigation roles as well as re-organising some existing roles around Neighbourhoods. We have also established clearer routes into community navigation services and are currently piloting a single point of access model.

- We have used the Neighbourhoods structure to bring together local community partners with statutory services and with residents to understand and address local health inequalities and build on local assets. The Well Street Common Partnership has been the pilot site for this approach, which has been replicated with a more 'light touch' model via the Neighbourhoods Conversations across the rest of the borough. Following the pilot period over the last two years we are now ready to make the partnership model business as usual across all of our Neighbourhoods, facilitated by Healthwatch and HCVS. This will provide significant insight into local communities and enable local partners to solve problems using their joint assets.

Appendix A provides more detail on progress against each of the priorities defined for the current year (21/22).

2b. What this means for residents and professionals

From all of the Neighbourhood projects we are starting to see improved outcomes being delivered across the programme - both for practitioners and for residents. The following case studies have been collected to reflect the benefit from a range of project areas:

The impact of the Neighbourhood MDMs

Example of the MDMs supporting complex medical needs

- L is a 60 years old, female patient in Hackney Downs
- Her GP had discussions with her, focused on what was most important - managing pain was L's top priority
- L suffers with chronic pain, has osteoarthritis, type 2 diabetes, obesity, pressure ulcers and chronic constipation and has a catheter in situ. She is living with family members the youngest has significant learning disabilities
- She recently moved to a new flat and has had some recent falls
- Her GP brought L to a Neighbourhood MDM to create a coordinated approach to managing her chronic pain as well as her broader health and wellbeing needs

Impact of approach and benefits for L

- All those supporting L have a joint view of what is important to her
- L is aware that professionals are coming together to consider her priorities and is kept informed of what is agreed
- Pain service, GP and community therapies team have a joint approach to managing L's pain.
- Joint visits arranged with pain service, GP and community therapies to review medicine, rehab and psychological support for L
- Preventative approach taken to avoid further falls
- Whole family approach taken, comprehensive housing review of family undertaken.

Example of the MDMs addressing a potential safeguarding issue

- M is a 65 year old man who lives alone in Hackney Marshes Neighbourhood
- He has a history of alcohol dependency and aggressive behaviours towards healthcare professionals.
- He has recently been experiencing seizures
- He has an appointee responsible for his finances, as previous assessments had shown that he lacked capacity to manage them himself.
- The Neighbourhood Wellbeing Practitioner had spoken to him about what was important. He wanted to increase his mobility and is also very concerned about his finances.
- M was well known to a number of different agencies, including primary care, district nursing, adult social care, mental health and the Financial Affairs team at the local authority

Impact of approach and benefits for M

- By joining together the knowledge of a range of people who had all worked with M, colleagues realised that there was a potential safeguarding concern regarding potential finance abuse by a friend. A safeguarding alert was raised and this is being investigated
- All colleagues were made aware of the potential abuse and can work together to minimise the risk of this
- The GP confirmed the medical management for M's seizures both with M and the wdier team, they also dispelled the myths around medication and alcohol
- The OT worked with M to support his financial situation, this included completing paperwork with him to get him the correct benefits, and explaining to him that he should only access

money from his assigned carer (who had been acting as a financial appointee) and not from his friend.
- The GP, therapies and the Wellbeing practitioner established a joint plan to support M's improved mobility

The Impact of Community Navigation

The following two case studies are taken from the Health and well bring coaches who are one of the Neighbourhood based navigation services, provided by Shoreditch Trust.

Example of navigation services supporting a resident to improve diet and increase activity

H is 60 years old, he was referred to the Health & Wellbeing Coaching service by his GP.
H is at risk of developing diabetes and is keen to prevent this and particularly concerned about preventing the need to take medication.
The coach supported H to talk through his concerns, set goals and take actions towards 'getting fitter, eating well and losing weight'.
H & the coach explored his current lifestyle - H does not exercise. He enjoys walking but feels he rarely has the time to do so. He works a lot, defining himself as 'workaholic'. He eats meals when he 'has time' and snacks between meals on crisps and biscuits.
After helping H to define is goals, the coach supported H to decide on actions and find information and activities such as beginning to swimming at a pool that runs men only sessions, establishing a regular pattern of meals with attention to portion size, increasing foods with low glycaemic index, preparing healthy snacks.
H was motivated to make changes but felt discouraged by the slow pace of losing weight. The coach supported H to manage expectations make sustainable changes in lifestyle that would impact on weight.
H noticed that he felt better keeping to regular meals and reducing portion size. He progressively moved from 0 hours of activity to 2 hours walking a week and swimming once a week. The coach also explored mindful walking and mindful eating with H to begin to develop more skills for reducing stress and eating well.
At session 5 of 8 H reported feeling much better within himself, 'body and mind' and sessions began to focus more on how to sustain the changes moving forward.

Example of navigation services supporting a resident to manage mental health issues

M is 45 years old, he was referred to a Health and Wellbeing Coach by his GP for support with sleep problems, low mood and anxiety. M is a refugee living in a hostel and currently living apart from family, who have been placed in another city.
The coach supported M to decide on what he would like to achieve based on his current situation. M was keen to focus on managing his low moods, anxiety about taking sleep medication, and described wanting to feel 'useful' through volunteering. The coach supported with clarifying concerns and questions about sleep medication to discuss with clinicians. He made goals to walk daily in local park, and also learn some ways to manage his low mood and anxiety. Each week, the coach guided M through breathing exercises, five senses method, and progressive muscle relaxation techniques to enable him to build a

toolkit for managing stress. M was signposted to volunteering opportunities.
Over time, he adapted stress management tools in ways that would work for him and fed back how useful he found them. Within a week of his initial meeting M had been invited to interviews and has now started in a volunteering role. He reports feeling that his day is more structured and describes feeling more able to manage difficult feelings and feels that he has been able to influence and change his current situation where change has been possible.

The Benefit of Well Street Common Partnership for professionals

Well Street Common Neighbourhood has a Core Partnership Group in place,consisting of staff, volunteers and community leaders from: Our Place, Alzheimer's UK, Gascoyne & Morningside Youth Club, the Primary Care Network (social prescriber), a Victoria Ward councillor, Vietnamese Mental Health Services, East End Citizens Advice Bureau, Older Peoples Reference Group, Wick Award, Frampton Park Baptist Church, Shoreditch Trust Community Connections and Hackney People First.
The group will support and help organise larger quarterly forums which bring together a range of stakeholders who live, work or provide services in the Neighbourhood.

The development of the Well Street Common Partnership was co-produced and supported by in-depth mapping and capacity building. It has facilitated integrated working between VCSE and statutory sector partners. It proved its value during the pandemic when it enabled a and enabled a more coordinated local response to Covid-19. More recently, the partnership have focused on improving health and wellbeing for local residents.

"Being part of this Partnership meant that I had connected with lots of organisations and people before Covid-19, which really helped with the response work. This shows the value of the partnership; being able to work better with others in the ward I cover."
Councillor Penny Wrout

"Too often we work 'top down' rather than really listen to local communities. I want to work with the Partnership to find out what the local priorities are in our Neighbourhood, to reach those furthest away from healthcare services and for us to pull together to address upcoming health issues like flu."
Dr Kathleen Wenaden, Clinical Director of PCN

"There is great potential for the Well Street Common Neighbourhood Partnership to shine a light on health inequalities and what this means for groups and individuals in our community, and offer an alternative way of addressing these. The Partnership will be an effective way for service providers to hear the voices of groups that have not been heard."
Polly Mann, Community Development – Wick Award

2c. Evaluation

We are developing a full evaluation of the Neighbourhoods programme and its impact on population health and outcomes. This is a long-term change programme therefore we do not expect to see the impact quickly. Cordis Bright, our system evaluation partner is

supporting this, and it is being overseen by the City and Hackney Evaluation Steering Group (as well as the Neighbourhoods Provider Alliance Group). The focus of the work is three-fold:

- **To develop a theory of change and evaluation framework for** anticipatory care. This work is now completed and is informing our evolving model of anticipatory care.

- **To undertake a stock-take of Neighbourhoods and produce a set of recommendations to help shape the future direction.** We have received a first draft of the report. It incorporated feedback and insight from a wide range of partners via four focus groups with staff and residents, 25 one to one interviews and an e-survey across practitioners which brought 140 responses. The recommendations will inform plans for 2022/23.

- **To develop an overall theory of change and evaluation framework for Neighbourhoods**. This work is scheduled to take place after the stock-take report (above) is completed and due to be completed by January 2022. This will give us a clear framework that we can use to evaluate the programme as a whole.

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

3. Looking back across the programme and defining our priorities for 2022/23

3a. Programme Review and value for money

Given we are starting to move to sustainability for Neighbourhoods, it is helpful to review the progress to date since 2018 against the ambitious, multi-year objectives defined in the original Neighbourhoods Operating Model. A significant amount of money has been invested in the programme to date, and reviewing the achievements of the programme to date demonstrates the breadth of the programme and the achievements over its life to date. This section is informed by the Cordis Bright review, and has supported us in setting objectives for the coming year.

The diagram in Appendix A shows, at a high level, the areas of focus for the programme each year to date, as well as out expected areas of focus going forwards into next year and the year after. These have been mapped against the phases of the programme that we defined in our Operating Plan in 2019. This shows how the programme has developed and progressed each year, and therefore how the focus and scope has transitioned over the period. We have also included the planned focus of the programme over the next two years.

The following describes the different phases of the programme and the key achievements over the years:

Phase 1: 18/19: Developing the vision,

- We defined what Neighbourhoods meant for City and Hackney staff and residents and agreed the vision for Neighbourhoods.
- There was a significant amount of formal and informal engagement with residents and staff.
- We started early scoping work for the phase 1 services that form the core of the Neighbourhoods team (primary care, adult community nursing, adult social care, mental health).

Phase 2: 19/20: Developing Neighbourhoods models- test and learn,

- The system signed off the Neighbourhoods Operating Model, which set out the service model, ways of working and population health approach for Neighbourhoods, and mapped out a multi-year plan to achieve
- We started testing and refining the Neighbourhood models of care for those core services within the Neighbourhoods teams (adult community nursing, adult social care, mental health).
- We launched the work with community pharmacy,
- There was early development of the multi-disciplinary services and pathways that would bring teams together.
- The National PCN contract was launched which gave a contractual incentive for primary care to work together in networks within each of our Neighbourhoods. We were well placed

Phase 3: 20/21-21/22: Transformation in agreed priority areas and developing the Neighbourhoods team, 20/21-21/22

This is the phase that we are currently in. The focus is on completing the transformation in those core Neighbourhood services and building the Neighbourhoods team.

2020/21

- The pandemic diverted focus away from some of the intended transformation, however, it also accelerated the implementation of Neighbourhood MDMs and new models of Community Navigation.

21/22

- The transformation in most of the core Neighbourhoods services will be complete where it is not already, namely: Adult Community Nursing, Adult social care (long term team), Mental health (working age adults), Community Pharmacy and some elements of community navigation
- We progressed the work with childrens services
- We launched the work on long term conditions (specialist teams) in this phase, starting with a pilot in community gynaecology, and cardio vascular disease.
- We are about to kick off a system-wide OD project to ensure that we make the cultural shift required to realise the benefit of Neighbourhood working.

- We tested and finalised our model for community and voluntary sector partnerships, and resident involvement in each Neighbourhood involvement. This will become business as usual, subject to full system sign off
- We tested our broader model for addressing health inequalities on a Neighbourhood footprint, which brings together the voluntary and community partnership with a smaller delivery group. This also enables delivery of the PCN Inequalities DES.
- We developed a Neighbourhoods communications plan to support staff and resident understanding and involvement. This should supplement and systematise the range of more informal communications across the progamme to date.
- We started working with an evaluation partner to undertake an independent review and develop and outcomes framework for the programme.

Looking forwards to Phase 4: 2022/23 – 23/24

- Phase 4 represents an exciting period for Neighbourhoods where many of the services are now configured on Neighbourhoods footprints and we will focus on rolling out and embedding the Neighbourhoods based multi-disciplinary services including Anticipatory Care and Community Navigation.
- The work with childrens services and long term conditions will also progress through 2022/23.
- The focus of this phase will be on delivering a system wide OD / cultural programme for partners to support the new approaches and models of care.
- Linked to this, we will work to embed the structures and tools required for Neighbourhoods to really address health inequalities at a local level. This will be via the services and pathways, but also via the Neighbourhoods partnership structure that will bring together communities with staff to understand and tackle health inequalities at a highly localised level.
- We will use the evaluation framework to really test that we are delivering the improvements to people's health that we had intended to see.

Looking forwards beyond 23/24:

Neighbourhoods has become the approach to place based care in City and Hackney which will continue for many years to come. The large-scale service reconfigurations needed to drive Neighbourhoods will have been achieved and Neighbourhood working will be business as usual for many of our community based services. This means that we will be able to significantly reduce or re-purpose the non-recurrent investment.

There will be a need for an ongoing resource in the system to continue to drive improvement and transformation in Neighbourhoods working and place based care. It is likely that we will continue to resource a small system team that can continue to champion, support and progress the Neighbourhoods approach going forwards. However, there will need to be further discussion around where this system team is best placed and how to ensure this becomes a core part of our system structure rather than a stand-alone discrete programme team.

3b. External Review

Cordis Bright have undertaken a deep dive review of the programme. Due to timing this has not yet been widely shared with all partners at the point of writing. The review looked over the full span of the programme to provide an objective view of what has been achieved, and to form recommendations going forwards.

They identified the following key successes for the programme:

- The common understanding and agreement of the vision for the programme
- Strong intra-organisational relationships between senior leaders.
- There is emerging evidence that New ways of working, including the Multi-disciplinary meetings (MDMs) are resulting in patient care being more holistic and person-centred, with improved integration between different services, professionals and organisations.
- They also identified the strong project management capability in the Neighbourhoods team, and the co-production approach as key enablers to date.

They have also made the following set of recommendations.

- Continue to ensure the programme has a resourced, central programme management team
- Ensure system partners, at all levels, are incentivised to work together, not just in their own organisations. The report highlights middle management as an area that we should specifically support
- Ensure there is granular data available at Neighbourhood level, alongside a structure for resident consultation, to help to tailor approaches within each Neighbourhood
- Develop a communications and engagement plan for staff and residents.
- Bring together the PCNs and the Neighbourhoods programme
- Continue to support understanding of VCSOs role in Neighbourhoods
- Continue to take a co-production approach
- Develop mechanisms for monitoring and evaluating the success of the programme
- Review success of the MDMs
- Work with workforce enabler to understand the pressures on workforce that are impacting on delivery
- Continue to progress IT solutions to support Neighbourhood working

These have informed our plans for the coming year. some areas, such as the evaluation framework and the communications plan are already being undertaken this year, all of the others are reflected in the 2022/23 priorities described in the following section.

However, there is some further work required to engage wider partners in these recommendations, and jointly prioritise them.

The full report can be shared on request.

3c. Priorities for 2022/23

2022/23 is year 2 within phase 4 of the programme. Therefore we will continue to progress the priorities that we defined this year, but with a focus on those areas that have not yet delivered, and also building on the recommendations from Cordis Bright.

The following shows how we are progressing from the six priorities in 21/22 to the 22/23 priorities

21/22 Priorities	21/22 Projects	22/23 Priorities	22/23 Projects
PRIORITY 1 To take a more proactive and joined up approach to supporting City and Hackney residents with rising needs	-Commence work on anticipatory care -Continue to pilot new models of community navigation -Establish connections between anticipatory care, MDMs, and community navigation	*Continue priority*	-Roll out anticipatory care -Continued development and finalise model of community navigation -Develop digital tool(s) to record and share Personalised Care and support plans
PRIORITY 2 To continue to redesign services that will make up Neighbourhood based blended teams to support residents identified in priority 1	-Implementation community nursing model -Finalise and agree model of adult social care -Continued testing and refinement of therapies model -Full roll out of mental health blended teams -Development of model for children -Start to pilot new models and pathways for long term conditions	*Continue priority*	-Agreement and Implementation of model for community therapies -Implementation of agreed model for adult social care -Further work with the model for older adults mental health, linking to anticipatory care. -Continue to develop and test pathways for long term conditions
PRIORITY 3 To provide coaching and OD support to Neighbourhood based blended teams that enhances trust and supports collaborative working.	-Specific coaching support for MDM chairs -Agree system wide OD plan with workforce enabler	*Priority broadens slightly to encompass a whole system cultural shift:* **To agree and deliver a system-wide OD plan to enable delivery of the Neighbourhood models**	-Delivery of system wide OD plan with workforce enabler. This will support and enable the following across all levels: • Joined up working between teams • Delivering a personalised care approach • Delivering a

			population health approach
PRIORITY 4 To establish meaningful and sustainable approaches to resident involvement. This includes developing a strong Neighbourhood culture where the VCS and residents feel connected and have influence.	-Continue Neighbourhood resident involvement group to ensure a co-production approach across the programme -Development of the model to involve residents within Neighbourhoods structures	*Recognising the inter-relationships between them, priorities 4, 5 and 6 are brought together to become:* **Development of partnership and delivery structure in each Neighbourhood to enable residents, communities and services to come together with a focus on population health**	-Continue Neighbourhood Resident Involvement Group -Roll out of the agreed CVS model for community and voluntary sector involvement in the Neighbourhood -Implementation of the agreed Healthwatch model for resident involvement in the Neighbourhoods -Working with Population Health Hub, roll out of the Neighbourhoods delivery groups, which also delivers the PCN Inequalities DES -Realise benefits from NHSE population health programme and broaden benefits to all Neighbourhoods.
PRIORITY 5 To test and begin to establish partnership arrangements (at an operational and strategic level) in each Neighbourhood drawing on work in Well Street Common	-Progress the work in Well St Common and Shoreditch Park and City Neighbourhoods to develop an agreed model for community and voluntary sector involvement in Neighbourhoods		
PRIORITY 6 To put in place arrangements to improve our knowledge of and act on health outcomes and inequalities.	-At least one PCN involved in the National Population Health programme provided by NHSE and Optum -Further develop Neighbourhood level structures to understand local health inequalities		

3d. Further detail on 22/23 deliverables, including resourcing

The following tables give further detail on each of the priorities and the associated projects. Each project is led or facilitated by one organisation who works collaboratively with partners to deliver. The table also describes the resources required for each area, to demonstrate the link between programme priorities and the requested programme resources.

22/23 Priorities	22/23 Specific focus	Facilitating organisation / resource required
PRIORITY 1 To take a more proactive and joined up approach to supporting City and Hackney residents with rising needs	-Roll out anticipatory care	Continuation of current Anticipatory Care project group, led by the Neighbourhoods central team with wide system involvement. Some programme resources will be provided through the NHSE Ageing Well funding In the coming year we will roll and embed the model across the borough
	-Continued development and finalise model of community navigation	Led by the Neighbourhoods team, supported by the Public Health team and voluntary sector provider partners. Key areas of work are: -Following the well-being practitioners pilot, agreeing the future model for more intensive navigation services -Joining up the social prescribing and community connectors services -Following the pilot, agreeing the future model for a single point of access (or similar) into voluntary sector services -Agreeing a shared set of outcomes for existing services, and developing a shared training / development plan
	-Develop digital tool(s) to record and share Personalised Care and support plans	The Neighbourhoods central team will work with the IT Enabler. This supports Anticipatory care, and the PCN Personalised care DES. We will ensure it builds on existing digital infrastructure where possible in order to minimise the number of new tools / different systems professionals need to learn to use.
	-Continue to develop and pilot pathways and services for long term conditions	The CCG Long term conditions team will facilitate, working with PCNs and specialist teams. The focus will be: -Roll out of the community gynaecology pathway that is currently being piloted, -Delivery of the CVD pathway (which is a PCN DES)

		-Development of a chronic Kidney disease pathway -Other pathways defined as priorities during the year This will require continued funding for the project manager hosted by the CCG long term conditions team.
	-Further develop and refine the model for childrens services	The local authority will facilitate, working closely with community services and primary care partners The focus will be: -Improved PCN engagement in the multi-agency team meetings for 0-5 year olds, building on the improvement work underway in Woodberry Wetlands -Better links between schools and primary care for school age children This will require the following resources: The CYPMF workstream will require project management support to co-ordinate and do a lot of the work The Homerton will require a part-time practitioner to lead the required improvement in their services.

22/23 Priorities	22/23 Specific focus	Facilitating organisation / resource required
PRIORITY 2 **To continue to redesign services that will make up Neighbourhood based blended teams to support residents identified in priority 1**	-Agreement and Implementation of model for community therapies	Homerton will continue to lead. The model is currently being developed and should be finalised and agreed within the current year. In 22/23 the focus will be on implementation. This will require continued funding for the Community Therapies project manager
	-Embed agreed model for adult social care	LBH will continue to lead. The proposed model has been agreed by system partners. This has three distinct but related elements: -Transformation of the borough wide front door team to provide a more holistic , strength based approach with better links into wider services where people to not require social care -Alignment of the long term social work

		teams and Occupational Therapy so that they are organised around Neighbourhoods and working within the Neighbourhoods team -Continue to build home care links with neighbourhoods including in multi-disciplinary meetings and that learning from pilots are embedded within homecare recommissioning plans In 2022/23 the focus will be on finalising implementation of the full model LBH will require a reduced amount of funding to deliver this.
	-Embed agreed model for mental health	ELFT will continue to lead. The roll out of mental health blended teams should be complete by end of the current year. In the coming year the focus will be on: -Embedding the blended teams and ensuring clear join up with the rest of the system -Considering other, smaller elements of mental health provision for specific cohorts such as older adults. ELFT will require a reduced amount of funding to deliver this.

22/23 Priorities	**22/23 Specific focus**	**Facilitating organisation / resource required**
<u>PRIORITY 3</u> **To agree and deliver a system-wide OD plan to enable delivery of the Neighbourhood models**.	-Delivery of system wide OD plan with workforce enabler. This will support and enable the following across all levels: • Joined up working between teams • Delivering a personalised care approach Delivering a population health approach	The Neighbourhoods central team will deliver in partnership with the office of the PCNs and the workforce enabler Beyond the input of the Neighbourhoods team We are not requesting any additional resources from the Neighbourhoods budget for this work in 2022/23. We expect that funding should come from the following routes: -Workforce enabler funds -Use of Ageing well non-recurrent monies (where the OD work pertains to Anticipatory Care as this is an Ageing Well priority) -Existing organisations committing their normal training resources

22/23 Priorities	22/23 Specific focus	Facilitating organisation / resource required
PRIORITY 4 **Development of partnership and delivery structure in each Neighbourhood to enable residents, communities and services to come together with a focus on population health**	-Roll out of the agreed CVS model for community and voluntary sector involvement in the Neighbourhood	HCVS will lead, utilising the resources (to be agreed) in their separate case No separate programme resources are required
	-Implementation of the agreed model for resident involvement in the Neighbourhoods	Healthwatch will lead, utilising the resources (to be agreed) in their separate case No separate programme resources are required
	-Working with Population Health Hub, roll out of the Neighbourhoods delivery groups, which also delivers the PCN Inequalities DES	The Office of the PCNs will lead, supported by the Neighbourhoods central team and the Population Health hub. The delivery Group model is currently being piloted in Well St Common. In 22/23 this will be rolled out. The PCNs will receive some resources via the DES. The Population Health hub does not require additional specific resource to support this. This is part of the planned work of the Neighbourhoods central team.
	-Realise benefits from NHSE population health programme and broaden benefits to all Neighbourhoods.	The Office of the PCNs will lead, supported by the population health hub. Hackney Marshes PCN are currently undertaking the national Population Health programme, provided by NHSE and Optum. The programme should deliver learning, tools and materials that can be shared. The plan is to build these into the model for the Neighbourhoods Delivery groups, and into the wider training / OD plan.

3e. Alignment with PCNs

The presence of both the Neighbourhoods Programme and PCNs in City & Hackney presents an opportunity for the identification of shared priorities across both individual Neighbourhoods and across City & Hackney as a whole. Whilst it is recognised that PCNs have their own priorities (such as the sustainability of primary care and delivery of core

primary care services such as vaccination and extended access), there are other priorities relating to the health and wellbeing of Neighbourhood populations and delivery of a number of integrated services which are shared across primary care and other system partners. To date, there has been good collaboration between the Neighbourhoods programme and the PCNs, which was recognised by Cordis Bright in their review.

Whilst there is strong collaboration, we recognise that there needs to be a more formal joining of the two programmes. This will maximise the benefits of the place based approach, ensure all resources are pulling in the same direction and prevent any confusion or duplication. We have therefore started this process between the Neighbourhoods team and the office of the PCNs, which is in part around agreed shared deliverables and in part around programme governance.

All of the work of the Neighbourhoods programme will support PCN delivery by facilitating the delivery of many borough services around Neighbourhood, and therefore PCN, footprints. Likewise, all of the work underway within each PCN will further the Neighbourhoods programme by supporting my locally led initiatives around the 30-50,000 population. A number of the Direct Enhanced services (DES's) that PCNs are contracted to deliver require a joined up system approach and will be facilitated and enabled by the Neighbourhoods programme:

- Anticipatory Care - delivery of the anticipatory care service is already in train through the Neighbourhoods team working with PCNs and wider system partners.

- Personalised care – includes social prescribing, digitally enabled personalised care and support planning, and then training on shared decision making. This work has not yet been defined within a specific project to deliver the DES, however, all of the required activities are planned through existing projects, either within the community navigation work, anticipatory care or via the planned system OD work. The Anticipatory Care project has also evidenced the strong need for a personalised care approach. There is a little more work to do to agree the best structure for taking this forwards, but it will likely draw on a number of the existing channels of work and certain elements may be tested in one PCN initially.

- Inequalities: Delivering a model to address and tackle inequalities at a hyper local level. This links directly to priority number 4 in the programme. We are currently testing an approach in Well Street Common through work being delivered by the PCN, the Neighbourhoods team and the Population Health Hub. This will be further tested this year and rolled out across all PCNs in 2022/23.

We are now working to more formally merge Neighbourhoods and PCN structures. This has already started as we appointed a joint post between the Neighbourhoods and Office of the PCNs this year. We have also merged the Neighbourhoods Steering Group with the PCN Strategic and Operational delivery group into one single Neighbourhoods Provider Alliance Group. This will oversee delivery of the Neighbourhoods and PCN priorities with wider system partners.

We have agreed with the Clinical Directors that over the coming year we will continue to explore how to further bring our programmes closer together including further joint governance, and the potential for further joint posts.

The City of London within Neighbourhoods

City of London Corporation (CoLC) have been key partners within the programme since its inception. Whilst the strategic aims of Neighbourhoods programme also apply to the City, we recognise that the City forms a distinct area within the Shoreditch Park and City Neighbourhood, and as such will require a bespoke approach in some areas.

The following are examples of where we have taken a distinct City approach within the programme:

- We have developed city specific data to show the distinct demographics and health needs of City residents as these do differ from that of the wider Neighbourhood. These are being used to plan service provision.
- We are taking a distinct approach to our Neighbourhoods partnerships in the city to ensure that they appropriately represent City leaders and partners. We are developing a separate structure and Terms of reference for the Neighbourhoods delivery group in Shoreditch Park and City
- There is already very close working between primary care and social care services in the City. One of the specific benefits to the City of Neighbourhoods working is improved provision of community services. A Neighbourhoods approach should deliver this, and the recently implemented new model of Adult community Nursing has resulted in more community nurses working in the Shoreditch Park and City Neighbourhood.
- One of the main challenges within the City is that multiple borough boundaries around the city, and the large proportion of residents (25%) that are registered with practices outside of City and Hackney. As we work more closely with North East London partners there are increasing similarities between our models of community and primary care at the Neighbourhood/PCN level. This is facilitating easier links into similar service offerings in Tower Hamlets.
- The City Connectors service, provided by Age UK, are key partners within the community navigation work. They have led and influenced much of the thinking and will benefit from the borough wide work through access to training, having a standardised outcomes framework and improved connections from statutory services and into the wider community services.

4. Funding and Governance

4a. Costs of delivering Neighbourhoods in 2022/23

The costs for delivery of the Neighbourhoods Programme in 2022/23 are outlined below. The overall requested amount from the Better Care Fund in 2022/23 is £738, 496, which will be drawn from the BCF as is prior years. We have also included the allocated investment in 21/22 to demonstrate how the programme is evolving.

Whilst this is the budgeted amount and ceiling that providers can access, they will continue to be paid based on actual expenditure in 2022/23.

	2021-22			2022-23
	BCF	**Reserves from prior year**	**Total Funding 2021/22**	**BCF**
1. Homerton University Hospital	£146,837		£146,837	£75,820
2. East London Foundation Trust	£103,049	£55,102	£158,151	£86,368
3. LB Hackney	£157,306		£157,306	£119,513
4. PCNs (via Office of PCNs)	£76,500	£18,000	£94,500	£75,060
5. City of London Corporation	£20,000		£20,000	£20,000
6. CCG Planned Care (LTCs)	£25,688	£21,619	£47,307	£60,307
7. Children and Young People	£81,406		£81,406	£89,727
8. Central Neighbourhoods Team	£187,710		£187,710	£178,523
9. Healthwatch - NRIG Coordination	£60,000		£60,000	-
10. Healthwatch - *Subject to confirmation of model*				
11. HCVS - *Subject to confirmation of model*	£229,283		£229,283	
12. Community Pharmacy - *Subject to confirmation of model*	£55,200		£55,200	
13. Programme contingency				£33,178
Total	**£1,142,979**	**£94,721**	**£1,237,700**	**£738,496**

In addition, we are asking system partners to separately consider recurrent funding to deliver the model for voluntary sector, community and resident engagement and for community pharmacy as business as usual.

The total value for these proposals and the programme resources for the Neighbourhoods programme is £1,14m, which is within the overall programme envelope within the BCF.

For further detail, the following shows how the proposed programme resources will be used, these resources link directly to the priorities defined in section 3 of this report:

Service	Category	Period of Time	WTE (if relevant)	Breakdown by Post	Summarised Budget Request
1. Homerton (Community Health)	Neighbourhood Project Lead - Band 8B CYP Services	12 months	0.50	£ 37,910.00	
	Neighbourhood Project Lead - Band 8B Therapies	12 months	0.50	£ 37,910.00	£ 75,820
2. ELFT (Mental Health)	Neighbourhood Project Lead - Band 8A Mental Health	12 months	1.00	£ 86,368.00	£ 86,368
3. LB Hackney (ASC)	Project Manager P06	12 months		£ 78,653.00	
	Senior Practitioner Social Worker	12 months	0.40	£ 40,860.00	£ 119,513
4. Office of PCNs	Partnerships and Workforce Programme Manager	12 months	1.00	£ 75,060.00	£ 75,060
5. City of London	Contribution to Programme Manager costs	12 months	0.40	£ 20,000.00	£ 20,000
6. CCG Planned Care (LTCs)	Band 8A Project Manager	12 months	0.50	£ 30,307.00	
	Consultant Specialist LTC Post			£ 30,000.00	£ 60,307
7. Children, Young People and Families	Project Manager - Band 8A (PO4)	12 months	1.00	£ 59,100.00	
	Project Support Officer (PO2)	12 months	0.60	£ 30,627.00	£ 89,727
8. Neighbourhoods Central Team	Neighbourhoods Programme Lead - B8C	1 year	1.00	£ 89,335.00	
	Neighbourhoods Project Manager - B8A	1 year	1.00	£ 66,315.00	
	Neighbourhoods Project Support Officer - LBH Employed	1 year	0.40	£ 17,873.00	
	Meetings / events	-		£ 5,000.00	£ 178,523

Funding the programme in 2023/24

As described in section 3a, We are in a phase where we are moving to business as usual for Neighbourhoods which means that programme costs will come down incrementally over the next two years.

In 2023/24 the programme will take a very different form:
We will move away from resourcing the range of individual projects within organisations as the new models of care move to business as usual.

The focus of the programme will move from implementing new models of care, to:

- Realising the benefits from new ways of working, based on the evaluation framework
- Realising the benefits from the Neighbourhoods partnership structure
- Delivering the OD / cultural shifts required to deliver Neighbourhood models of care

This is demonstrated in the table in Appendix B.

As such, the programme funding will look very different. We will likely need to maintain a system Neighbourhoods team to support overall system co-ordination and benefits realisation. However, we will need to consider where this is positioned in the system as we embed Neighbourhood working into organisations. As previously described, we will look for further alignment with PCNs.

Any further non-recurrent resources will be focused on the OD / cultural shifts required to deliver Neighbourhood models of care. There is currently resource supporting OD and workforce with PCNs that will likely need to continue. Beyond that, the totality of that requirement is hard to determine at this stage as we are still at a very early stage of planning the OD work. However, system partners will need to agree a reasonable ceiling for this work in the coming months. We may also determine that the OD work should be funded from the workforce enabler.

The following shows an indicative picture of likely costs for the programme is 2023/24, with the amount allocated to OD to be determined:

Area	Indicative costs
System Neighbourhoods programme team	178,00
Partnerships and Workforce based in PCNs post to support OD work	75,000
Small amount of funding to support residual work required across any of the project areas - will only be pulled on if absolutely required	100,000
Potential use of funds to support OD work - TBC	TBC - system partners to agree ceiling

To note, these are based on early discussions and need further consideration with all partners.

4b. Governance for the Programme in 2022/23

We will continue to monitor delivery via a formal programme structure.

The monthly Neighbourhoods Provider alliance Group will oversee progress against deliverable. Every quarter (at quarter end) we will formally review delivery of the programme against the agreed milestones. This will also include a financial review of the programme.

The Neighbourhoods Steering Group will report formally into the System Operational Command Group (which will become the System Delivery group) and the Neighbourhoods Health and Care Board.

We will also develop reporting against the Outcomes Framework once it is developed.

Conclusion

The Neighbourhoods programme is delivering a key strategy for City and Hackney and has come to define our approach to place based care. There has been significant progress since the inception of the programme and this year represents an exciting juncture in the programme as many of the service transformations and new models of care are in place. Looking forwards, we can see how the programme will transition towards business as usual over the next two to three years.

We are asking system partners to approvve £738,496 funding to continue to deliver the porgramme in 2022/23. This is vital to maintaining momentum in the programme and realising our ambitions.

Appendix A
Review of progress against the Priorities agreed for the year

We agreed six priorities for the programme in 2021/22. The following describes delivery against each of these:

Priority	Headline Achievements / Activity Underway
Priority 1: To take a more proactive and joined up approach to supporting City and Hackney residents with rising needs	● **New model of anticipatory care being piloted in Springfield Park Neighbourhood.** This offers multi-disciplinary support to people with rising needs. The model will be rolled out across all Neighbourhoods in 22/23 ● New **community navigation model** for Neighbourhoods designed and being tested. This includes stronger links between different services and a single front door for navigation via Shoreditch Trust. ● **Continued development of Neighbourhood Multi Disciplinary Meetings for vulnerable residents in all 8 Neighbourhoods.** Establishment of stronger links between the Neighbourhood MDMs, anticipatory care and ● **Improvements to Multi-Agency Team (MAT) meetings for 0-5 year olds with complex needs.** This has been piloted in Woodberry Wetlands and will be rolled out across all Neighbourhoods through 21/22 ● **Improved links between Neighbourhood teams and schools established through a series of dedicated sessions with school leaders.**
Priority 2: To continue to redesign services that will make up Neighbourhood based blended teams to support residents identified in priority 1	● **New model of Neighbourhood community nursing now in place** meaning that the community nursing team is organised around the eight neighbourhoods to provide joined up, holistic care to people with ongoing needs. They have also implemented a strengthened and responsive urgent care service to meet short term and urgent needs and a newly established specialist hub for concentrate expertise in wound care and continence. ● **New and improved adult social care model for Neighbourhoods agreed and being operationalised in 2022.** This includes re-organisation of the Long Term Team around our Neighbourhoods (furthering the link social worker model that is currently in place), an improved front door into social care that takes a strength based approach and considers peoples wider needs and re-procurement of Home Care servies around the Neighbourhoods. ● **Continued roll out of new mental health blended Neighbourhood teams.** These will be in place in all Neighbourhoods by year end. ● **Completed review of the Neighbourhood pathway for people with complex emotional needs (personality disorder)** and development of a new pathway between

	primary and secondary care psychology provision. ● **Community Pharmacy Neighbourhood leads now working within Neighbourhoods supporting health promotion** and CoVID and flu vaccination, and improving awareness of and access into wider pharmacy services. The community pharmacy model, which has been tested over the last year, has been put forward to system partners for agreement.
Priority 3: To provide coaching and OD support to Neighbourhood based blended teams that enhances trust and supports collaborative working.	● **Agreed with workforce enabler to develop a system OD plan for neighbourhoods,** to enable staff to deliver the new ways of working and cultural shift required to realise the benefits of Neighbourhoods. Initial scope agreed, strategic system buy in achieved. ● **Developed (and shortly to commission) coaching plan to assist MDT working across City and Hackney.** This includes coaching for chairs of Neighbourhood Multi-disciplinary (MDMs) meetings as well as professionals regularly involved in the meetings.
Priority 4: To establish meaningful and sustainable approaches to resident involvement. This includes developing a strong Neighbourhood culture where the VCS and residents feel connected and have influence.	● **The Neighbourhoods resident involvement group (NRIG) continue to ensure that the resident voice and co-production are at the heart of the programme.** They have influenced the update of the co-production charter across City and Hackney. ● **Healthwatch have now established the model for involving residents in each neighbourhood,** this is a core element of the work to develop Neighbourhoods partnerships (Priority 5) and is being proposed to system partners.
Priority 5: To test and begin to establish partnership arrangements (at an operational and strategic level) in each Neighbourhood drawing on work in Well Street Common	● **We have agreed, in principle, a structure for partnerships in each Neighbourhood that enables a highly localised approach to identifying and acting on variation and health inequalities.** This has been tested in Well St Common. ● **As part of this structure, CVS partners have developed a model for bringing together VCS partners with statutory partners and local residents in each Neighbourhood.** This builds on the excellent work undertaken in Well St Common and Shoreditch Park and City and links to the proposal from Healthwatch. The proposed model and has been put forward to system partners for approval ● **The Well St Common Well-Being Partnership continues to flourish,** with regular forums and a community open day which was well attended by residents and partners. ● **Shoreditch Park and City partners are developing their model** with a locally facilitated forum design session

	● **Neighbourhood Conversations have continued in the remaining 6 Neighbourhoods** and these have been used to facilitate the allocation of small grants (£1000 delivered across 11 organisations to date)
Priority 6: To put in place arrangements to improve our knowledge of and act on health outcomes and inequalities.	● **The partnership arrangements described in Priority 5 will be used to drive the approach to understanding and acting on local population data.** This will include a Neighbourhood forum (for wide engagement with VCSEs) with a smaller Neighbourhoods delivery group. This is being supported by the Population Health Hub and will also meet the requirements of the PCN Inequalities DES set by NHSE. ● **Hackney Marshes was selected to be part of the NHSE/I population health academy** which is a 20 week population health programme. ● **Refreshed Neighbourhood profiles** in collaboration with PCNs providing summarised headlines of population health outcomes.

Appendix B: Overview of Neighbourhoods Programme to date

		Phase 1: Developing the vision and securing the commitment	Phase 2. Developing neighbourhood models- test and learn	Phase 3. Transformation in agreed priority areas Developing the core Neighbourhoods team		Phase 4. Further transformation and developing the extended Neighbourhoods team	
Programme Areas	**Projects**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Over-arching structure for Neighbourhoods	**Setting up the programme**	Agreed the vision	Neighbourhoods operating model agreed				
	Neighbourhoods partnerships - incorporating resident and voluntary sector		Early scoping work	Pandemic led to rapid delivery of Neighbourhoods conversations	Testing and agreement of sustainable model for community and resident involvement	Roll out model of community and resident involvement across all neighbourhoods	
	OD / Cultural work to enable Neighbourhood working				Discovery, design and launch	Delivery of OD programme	Continued delivery of OD programme
	Programme Evaluation				External stocktake Outcomes framework developed	Monitor impact against agreed outcomes	Monitor impact against agreed outcomes
Service level transformation	**Primary care**	Formed into 8 neighbourhoods	PCNs embedded through the national contract				
	Adult community nursing	Discovery and design	Testing and refinement	Model agreed, staff consultation and implementation	New model in place		
	Adult social care	Discovery and design	Testing and refinement	Testing and refinement	New model agreed	Implementation	
	Mental health	Discovery and design	Testing and refinement	Start of roll out of new MH blended teams	Mental health blended teams in place	Implementation	
	Community pharmacy		Discovery and design	Testing and refinement	New model agreed and implemented		
	Community therapies			Discovery and design	Testing and refinement	Implementation	
Multi-disciplinary neighbourhood pathways	**Community navigation (adults)**		Early scoping work	Rapid implementation of new models during the pandemic	Testing and refinement	Implementation across all neighbourhoods, linked to MDMs and Anticipatory Care	
	MDT working (adults)		Early scoping work	Implementation of neighbourhood MDMs for complex patients	Design and pilot anticipatory care model for people with rising needs	Implementation of anticipatory care across all neighbourhoods	
	Long term conditions				Design and piloting of initial pathways	Roll out of phase 1 pathway and design and piloting of further pathways	Further roll out of pathways
	Childrens services			Early scoping work	Discovery and design	Testing and implementation	

Appendix B - Draft Business Case Template for Submissions

Updated: 11.08.2021

Community Pharmacy Neighbourhood leads programme

Pharmacy Services Partnership Ltd

24 September 2021

Version control		
Version	Date	Changes from previous version
First draft	24 Sept 21	
Final draft	4 Oct 21	Incorporated feedback from stakeholders

1.0 Executive Summary

1.1 Project Overview

[Concisely describe the key points for the audience before they read the detailed paper. This section should be written last]
A key part of the Neighbourhoods model has been the introduction of 8 Community Pharmacy leads to support involvement and collaboration with PCNs. These Pharmacy leads (funded based on allocation of days) have a role in acting as Neighbourhood Pharmacy champions and communicating with our community pharmacies in their Neighbourhood. These Community Pharmacy leads are taking a leadership role working closely with wider system partners including Primary Care Networks and PCN Clinical Directors.

1.2 The Proposal

[Briefly summarise the project and the objectives to address the issues identified in the problem statement. Set out the headline timelines and key milestones/deliverables that are required for this to be successful. Up to three key risks/dependencies and opportunities

should be identified here which are then elaborated on in the Case for Change]

The Community Pharmacy leads funding will deliver 4 key objectives with community pharmacy Neighbourhood leads taking a role in supporting this and connecting with other pharmacies in their Neighbourhood/PCN.

(1) Support the roll-out and neighbourhood engagement of GP referrals to the Community Pharmacist Consultation Service (CPCPS).
(2) Support the borough wide vaccination programmes for flu and COVID-19 including myth busting.
(3) Work with each PCN clinical director to generate an action plan for each PCN area.
(4) Work within the neighbourhoods to deliver greater population health through preventive care work.

Objective 1 Support GP CPCS implementation (Ongoing)

The NHS Community Pharmacist Consultation Service (CPCS) offers patients same day minor illness consultations with a community pharmacist. From November 2019 this service has allowed practice teams to refer low acuity patients for convenient, same-day consultations with clinical advice and, where indicated, the purchase of any over-the-counter medicine the patient may need. Pandemic and other competing PCN/GP work pressures has significantly hampered the implementation of this service to date.
To address this the Community Pharmacy PCN Leads will support their local GP to successfully implement this referral pathway for low acuity footfall. The leads will

- provide training for GP support staff on the scheme.
- Engage with residents and community groups particularly the socially vulnerable regarding the new service.
- promote the use of the new Health First minor ailments scheme for the socially vulnerable.
- Monitor number of GP CPCS referrals by neighbourhood.

Objective 2 Vaccination (Autumn 22)

Work collaboratively with Neighbourhood teams to deliver successful COVID-19/Flu vaccination programmes.
Focussing on the vaccination of the residents in care homes and residential homes. Working with neighbourhood teams and community groups to mythbust and help address vaccination related inequalities. Monitor vaccination rates in various cohorts and track refusal %.

Objective 3 Individual PCN plan development (April 22 – Ongoing)

Work with each PCN clinical director and each PCN network to generate a specific neighbourhood action plan where community pharmacy can support system partners. Neighbourhood level plans to be developed by the CP leads to meet individual neighbourhood priorities and needs.

Objective 4- Preventative health care agenda (April 22 - Ongoing)

Work with Neighbourhood team so that CP can support the preventative health care agenda. With emphasis on Blood Pressure following roll out of the national service. Also investigate the benefits of Pharmacy access to the East London health care record (eLPR). Focus also on healthy lifestyle weight management, exercise, alcohol & smoking issues, Promote self-

care advice and self-help.

1.3 Cost and Value for Money

[Brief overview of financial ask including value for money]
The annual cost of this programme is £55,200+VAT. This will fund:

- Closer working between CPs and GPs will drive system efficiencies and innovations that will enable improvements in patient care and experience.
- Implementation/integration of GPCPCS will create capacity within General Practice to see sicker patients more quickly and reduce inappropriate A&E attendances. (BCF metric 1, Reduction of non-elective admissions (General and Acute))
- Rapid implementation/Integration of the CP BP case finding service maps to BCF Metrics 1 & 3 and helps address health inequalities and the prevalence gap.
- Flu/Covid vaccination rate improvements maps to BCF Metric 1
- Enhanced uptake of the Community Pharmacy Discharge Medicines Service maps to BCF Metrics 1, 3 & 4.

Better Care Fund metrics are set out below:

- **Metric 1:** Reduction of non-elective admissions (General and Acute)
- **Metric 2:** Admissions to residential and care homes
- **Metric 3:** Effectiveness of reablement
- **Metric 4:** Delayed Transfers of Care

1.4. Recommendations

[Set out the recommendation for consideration in summary.]
To approve this proposal to fund OD and leadership for the community pharmacies within each PCN.

2.0. Background

2.1 Introduction and Strategic Case

[Describing existing ways of working and background to service/project and local, regional and national context in which the preferred option is being proposed]

This neighbourhoods workstream was developed to align with the formation of Primary Care Networks and support local collaboration leveraging existing local expertise. The programme funds 8 community pharmacy primary care network (CP PCN) leads who provide leadership to the network of community pharmacies within their respective primary care network (PCN) and provide an outward point of contact/collaboration for other PCN leads and clinical directors. It is important to note that these leads receive some Nationally resourced (c£600)/mandated discrete peripatetic obligations to fulfil and that this programme funds more wholistic engagement with the network pharmacies and system partners over and above those that are Nationally resourced with little or no duplication. Over the last three

years the leads were tasked to:

- Create links with local PCN practices, leads and Clinical Directors
- Provide Community Pharmacy network leadership at Neighbourhood level
- Facilitate collaboration and service improvement across the neighbourhood Pharmacies.
- Support/facilitate service improvement across the GP/community pharmacy interface
- Facilitate and enhance co-operation with the GP networks particularly on flu and covid vaccinations
- Support the implementation and embedding of locally/nationally commissioned community pharmacy services, eg GP Community Pharmacist Consultation Service (CPCS), Community Pharmacy Hypertension Case-finding service
- Improved uptake of eLPR and the CP Discharge Medicines Service (DMS)
- Engage with wider primary care via MDT and other meetings

All the above support resilience for system partners by supporting vaccination delivery/uptake or by channel shifting low acuity conditions footfall to community pharmacy (CPCPS/GPCPCS) or via wider engagement with PCN leads/teams to develop and adopt a quality improvement approach to the way GPs/CPs work together.

The CP PCN leads provide additional capacity to the GP PCN teams to allow greater joint working and innovation with the CP network.

2.2 Scope

[What will be covered/included. Needs to describe what was in scope / not in scope of the original re-design work.]
Continued funding of these CP PCN leads will:

- Embed them with local PCN practices, leads, and Clinical Directors
- Continue to develop the Community Pharmacy network leadership at Neighbourhood level
- Strengthen collaboration and service improvement across the neighbourhood Pharmacies.
- Support/facilitate service improvement across the GP/community pharmacy interface
- Facilitate and enhance co-operation with the GP networks particularly on flu and covid vaccinations
- Support the implementation and embedding of locally/nationally commissioned services, eg GP Community Pharmacist Consultation Service (CPCS) & CP BP Case finding service
- Engage with wider primary care via MDT and other meetings
- COVID vaccination site mobilisation support

This programme provides top-up funding to allow CP PCN leads to engage with PCN colleagues in a more wholistic manner.

2.3 Problem Statement

[What problems the proposal/approach is seeking to address]
The £600 National CP PCN Leads funding is piecemeal and only resources engagement with

PCNs for discrete task-based packets of work…eg for 21-22 only collaboration PCN flu vaccinations is resourced. Our proposed complementary programme more fully resources this closer working between community pharmacies and PCN leads/practice pharmacy teams by providing a single point of contact for the CP network. Thus, fostering system trust and will act as an enabler for joint working to deliver on the objectives articulated below.

3.0 Current State (Existing ways of working)

3.1. Current Position

[What is the current service structure/in place currently i.e. describe the position pre-Neighbourhoods]

The engagement of CP PCN leads without the complementary neighbourhoods programme funding will revert to the nationally set discrete peripatetic engagement; *21-22 funding is for the 'CP PCN lead to engage with the PCN Clinical Director to agree how community pharmacies in the PCN will collaborate with general practices to increase the uptake of flu vaccinations to patients aged 65 and over' only*.

All other engagement with the PCN will be unresourced and cease.

4.0 Case for Change and Proposed Model

4.1 Case for Change

[Please describe the case for change i.e. why is this new model required - what needs to be different from the current position identified above]

The case for funding this proposal is compelling as it allows 8 local community pharmacist leads, who are embedded in the communities they serve, to better engage/innovate with their Neighbourhood counterparts. This proposal allows the neighbourhoods to better realise the value of the community pharmacy network as a community-based health resource working closely with other local health and care partners. Leveraging this local resource to better develop local innovation, and fully integrate national initiatives, will lead to better patient care and outcomes as articulated below.

4.2 Proposed Model

[Please describe in detail the proposed model. Include the detail of changes to ways of working and new roles. Include structures e.g. diagrams.]

The 8-community pharmacy primary care network (CP PCN) leads funded by this proposal will provide leadership to the network of community pharmacies within their respective primary care network (PCN) and provide an outward point of contact/collaboration for other PCN leads and clinical directors. It is important to note that the employers of these leads receive c£600 of National funding for them to complete discrete peripatetic obligations and that this programme funds complementary more wholistic engagement with the network

pharmacies and system partners over and above the Nationally funding with little or no duplication.

NB There are no current PCN funding to specifically resource engagement, leadership/OD with the community pharmacy network. The other funding streams that resource PCNs are generally focussed on developing/supporting the GP practice team.

The proposed model adds capacity to the basic existing roles to allow:

- Community pharmacy leadership at neighbourhood level
- Community Pharmacy to engage with community and GP practices to foster closer working to help develop and share best practice.
- Closer working with partners across health, social care and the voluntary and community sector as appropriate.
- Closer working with the practice support/PCN pharmacist team
- Input into neighbourhood pathway re-design opportunities.
- Collaboration and service improvement across the neighbourhood Pharmacies.
- Rapid implementation/integration of the CP Hypertension Case finding service with PCN CVD DES and wider arrangements
- Rapid roll out of GPCPCS to shift low acuity footfall away from GP and A&E
- For the development of safe & efficient information exchange between CP, Practice teams and Practice Support Pharmacists
- Service improvement across the GP/community pharmacy interface so as to realise system efficiencies and improvement in patient care/ to streamline workflows
- Improved uptake of eLPR and the CP Discharge Medicines Service (DMS)
- Engage with wider primary care via MDT and other meetings

All the above bolster resilience for system partners by supporting vaccination delivery/uptake or by channel shifting low acuity conditions footfall to community pharmacy (CPCPS/GPCPCS) or via wider engagement with PCN leads/teams to develop and adopt a quality improvement approach to the way GPs/CPs work together.

The CP PCN leads provide additional capacity to the GP PCN teams to allow greater joint working and innovation with the CP network.

The Community Pharmacy leads funding will deliver 4 key objectives with community pharmacy Neighbourhood leads taking a role in supporting this and connecting with other pharmacies in their Neighbourhood/PCN.

(1) Support the roll-out and neighbourhood engagement of GP referrals to the Community Pharmacist Consultation Service (CPCPS).
(2) Support the borough wide vaccination programmes for flu and COVID-19 including myth busting.
(3) Work with each PCN clinical director to generate an action plan for each PCN area.
(4) Work within the neighbourhoods to deliver greater population health through preventive care work.

Objective 1 Support GP CPCS implementation (Ongoing)

The NHS Community Pharmacist Consultation Service (CPCS) offers patients same day minor illness consultations with a community pharmacist. From November 2019 this service has allowed practice teams to refer low acuity patients for convenient, same-day consultations with clinical advice and, where indicated, the purchase of any over-the-counter

medicine the patient may need. Pandemic and other competing PCN/GP work pressures have stifled the implementation of this service.
To address this the Community Pharmacy PCN Leads will support their local GP to successfully implement this referral pathway for low acuity footfall. The leads will

- provide training for GP support staff on the scheme.
- Engage with residents and community groups particularly the socially vulnerable regarding the new service.
- promote the use of the new Health First minor ailments scheme for the socially vulnerable.
- Monitor number of GP CPCS referrals by neighbourhood.

Objective 2 Vaccination (Autumn 22)
Work collaboratively with Neighbourhood teams to deliver successful COVID-19/Flu vaccination programmes.
Focussing on the vaccination of the residents in care homes and residential homes. Working with neighbourhood teams and community groups to mythbust and help address vaccination related inequalities. Monitor vaccination rates in various cohorts and track refusal %.

Objective 3 Individual PCN plan development (April 22 – Ongoing)
Work with each PCN clinical director and each PCN network to generate a specific neighbourhood action plan where community pharmacy can support system partners. Neighbourhood level plans to be developed by the CP leads to meet individual neighbourhood priorities and needs.

Objective 4- Preventative health care agenda (April 22 - Ongoing)
Work with Neighbourhood team so that CP can support the preventative health care agenda. Emphasis on Blood Pressure following roll out of national service. Also investigate benefits of Pharmacy access to the East London health care record (eLPR). Focus also on healthy lifestyle weight management, exercise, alcohol & smoking issues, Promote self-care advice and self-help.

4.3 Engagement, Feedback and Co-production

[Please detail how you have engaged stakeholders in developing the model, gained feedback and how you will continue to engage stakeholders in implementation. Please cover 1). Patients and Residents and 2). Practitioners / Organisations

We have engaged with the CP PCN leads, PCN CDs and CCG leads with regard to developing this model and have refined the Job description below on this basis.

Feedback on the CP PCN leads from both Community Pharmacy and GP PCN colleagues has been positive with many PCN CDs in particular being very supportive, especially where the leads have engaged/embedded well.

Proposed CP PCN Lead Job Description (2 days pcm)
The CP Neighbourhood/PCN lead must:

- Act in good faith, for the benefit of all NHS community pharmacy contractors in the PCN;
- Manage and declare any conflicts of interest and maintain the confidentiality of any PCN information, as appropriate;
- Provide regular and timely reports on relevant developments within the PCN to contractors in the PCN area and the LPC;
- Adhere to any general guidance on the role of the Pharmacy PCN Lead issued by PSNC and/or NHS England and NHS Improvement; and
- Only make decisions on behalf of other community pharmacy contractors in the PCN area with the agreement of all those contractors.
- Develop relationships and work closely with the PCN Clinical Director, other Pharmacy PCN Leads, clinical leaders of other primary care providers, health and social care providers, local commissioners and the LPC;
- Provide leadership for the community pharmacies in the PCN to help them develop and implement a collaborative approach to engagement with the PCN with common goal to improve patient health outcomes;
- Work closely with the key members of staff of the other pharmacies in the PCN to discuss and describe how community pharmacy can support the PCN to achieve local targets, aligned to national NHS priorities and help share best practice;
- Identify opportunities for pharmacies in the PCN area and assist the LPC with the development of community pharmacy service proposals to meet local population health needs
- Attend monthly PCN and quarterly MDT neighbourhood meetings
- Facilitate dialogue between PCN and local pharmacies to improve communication channels and ultimately patient care
- Work with PCNs and pharmacies to increase overall flu and pneumococcal vaccination rates
- Support the roll out of the GPCPCS service in order to reduce GP appointments within the PCN for minor illnesses and reduce A&E appointments.
- Support implementation/integration of the CP hypertension case-finding service
- Support Community Pharmacy with referral pathways e.g. self-care where appropriate, GP services where appropriate and community services particularly preventative services.
- Co-ordinate collaborative Pharmacy meetings across the neighbourhoods for best practice and information sharing between Pharmacies
- Provide updates to PCN on national and locally commissioned community pharmacy services

4.4 Interdependent Projects

[Detail other projects or services that relate to this proposal - mainly things already in place]

4.5 Identified and Expected Benefits

[Describe how the work undertaken has delivered benefits and/or how the benefits of the proposed model will be measured. Please include specific qualitative and quantitative measures that you will use to evaluate the ongoing success of the model. Benefits may or may not be cash releasing but are never-the-less an important consideration in the business case decision. Quantify as far as possible, in non-financial and financial terms]

The benefits of having CP PCN leads fully engaged with their respective PCNs are:

- The capacity to host regular collaborative Pharmacy meetings across the neighbourhoods for example sharing information between Pharmacies
- Close cooperation with GP practice teams in each neighbourhood.
- Better information exchange across the GP/CP interface eg East London Patient Record (eLPR) Access, Routine prescription requests, Discharge Medicines Service queries
- Enhanced flu/Covid vaccination uptake 21/22
- Expedited roll out of GPCPCS across practices to bolster system resilience
    - Scoping the addition of PGDs to allow CPs to field higher acuity conditions, eg simple UTIs, Impetigo, Infected insect bites etc
- Engagement and agreement with other Pharmacists working in the neighbourhoods on patient care issues.
- Emphasis on preventative healthcare and Pharmacy role e.g. new national BP case finding service.
- Engage with other Pharmacists working in Clinical Roles across City & Hackney.
- Enhanced patient care in areas of complex patients, socially vulnerable, difficult therapies, supply issues, vaccinations, preventative working.

4.6 Addressing Health Inequalities

[Please describe how the proposal will help to address health inequalities in City and Hackney]

This proposal will help address health inequalities by supporting

- Better integration/collaboration between Community Pharmacy and General Practice/PCN teams so they can better identify ways to address the prevalence gap
- Mythbust and promote uptake of covid vaccinations in low uptake populations
- The implementation of GPCPCS deflecting low acuity footfall away from GP & A&E allowing more appropriate use of clinician time for higher acuity conditions/patients
- Integration of the new CP Hypertension case finding service so as to case find those with undiagnosed hypertension and field routine BP checks that can't eb accommodated in practice
- Work to develop new population-based approaches to care
- Innovative approaches to care provision and adopting new technology

4.7 Value for Money & Economic Case

[Please describe how the model will deliver value for money and how you will be able to demonstrate this. Please also refer to Better Care Fund metrics included below.]

This investment will enable community pharmacy to fully integrate their services within each neighbourhood/PCN, eg CP BP Case finding, GP CPCS and allow closer working between CPs and GPs which will release system efficiencies and innovations that will enable improvements in patient care and experience.

Implementation of GP CPCS will create capacity within General Practice to see sicker patients more quickly and reduce inappropriate A&E attendances. (BCF metric 1)

Rapid implementation/Integration of the CP BP case finding service maps to BCF Metrics 1 & 3 and helps address health inequalities and the prevalence gap.

Flu/Covid vaccination rate improvements maps to BCF Metric 1
Enhanced uptake of the Community Pharmacy Discharge Medicines Service maps to BCF Metrics 1, 3 & 4.

For reference: Better Care Fund metrics are set out below:

- **Metric 1:** Reduction of non-elective admissions (General and Acute)
- **Metric 2:** Admissions to residential and care homes
- **Metric 3:** Effectiveness of reablement
- **Metric 4:** Delayed Transfers of Care

5.0 Project Implementation

5.1 Overall Model Implementation

[Please describe your proposed approach to implementation.]

This model is an iteration of the existing programme. As such implementation will be straightforward with little lead time required.

The leads will be line managed by the PSP Ltd in collaboration with PCN/CCG/Neighbourhood programme colleagues via regular 1:1s and stakeholder feedback.

5.2 Detailed Timescales for Rollout

[Please detail the milestones and dates that will be delivered as part of the rollout. Please be specific here]

The Community Pharmacy leads funding will deliver 4 key objectives with community pharmacy Neighbourhood leads taking a role in supporting this and connecting with other pharmacies in their Neighbourhood/PCN.

(1) Support the roll-out and neighbourhood engagement of GP referrals to the Community Pharmacist Consultation Service (CPCPS).
(2) Support the borough wide vaccination programmes for flu and COVID-19 including myth busting.
(3) Work with each PCN clinical director to generate an action plan for each PCN area.
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Objective 1 Support GP CPCS implementation (Ongoing)
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has allowed practice teams to refer low acuity patients for convenient, same-day consultations with clinical advice and, where indicated, the purchase of any over-the-counter medicine the patient may need. Pandemic and other competing PCN/GP work pressures have stifled the implementation of this service.
To address this the Community Pharmacy PCN Leads will support their local GP to successfully implement this referral pathway for low acuity footfall. The leads will

- provide training for GP support staff on the scheme.
- Engage with residents and community groups particularly the socially vulnerable regarding the new service.
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Objective 3 Individual PCN plan development (April 22 – Ongoing)
Work with each PCN clinical director and each PCN network to generate a specific neighbourhood action plan where community pharmacy can support system partners. Neighbourhood level plans to be developed by the CP leads to meet individual neighbourhood priorities and needs.

Objective 4- Preventative health care agenda (April 22 - Ongoing)
Work with Neighbourhood team so that CP can support the preventative health care agenda. Emphasis on Blood Pressure following roll out of national service. Also investigate benefits of Pharmacy access to the East London health care record (eLPR). Focus also on healthy lifestyle weight management, exercise, alcohol & smoking issues, Promote self-care advice and self-help.

5.2.1 Neighbourhood Roll-Out

[Include a timetable for roll out across 8 Neighbourhoods, where applicable. Please be specific here.]

This model is an iteration of the existing programme. As such implementation will be straightforward with little lead time required.

6.0 Financial Summary

[Please include a summary of costs required to deliver the proposed new model]

Total Non-Recurrent Cost	-
Total Recurrent Cost	£55,200 +VAT
Overall Project costs	£55,200 + VAT

[Include a detailed breakdown of any resource needed to deliver this (both in terms of setup and ongoing costs)]

Cp Leads	8 x 2 days per month - 8 community pharmacy leads	£450/month	£43,200 +VAT
PSP Mgt costs Mtg & training	CP Manager PSP Ltd Administration charge Contract starts April 1st, 2022 so real meetings could happen during the year.4 meetings at the Tomlinson May 22, Sep 22, Dec 22, Mar 23.		£5,000+VAT £3,000+VAT £4,000+VAT
Overall Project Costs			**£55,200**

6.1 Non-recurrent costs

Summary of Item	Detail of item	Duration of cost	Cost
Pay Costs			
Non Pay Costs			
Management Fees			
Overheads			
Total			

6.2 Recurrent costs

Summary of Item	Detail of item	Cost
Pay Costs	Cost of 8 CP PCN Leads pa	£43,200 + VAT
Non Pay Costs		
Management Fees	Project management	£8,000 + VAT
Overheads	Meeting costs	£4,000 + VAT
Total		£55,200 + VAT

7.0 Risks

[risks to the delivery and sustainability of the model - please see appendix 2]

Risk Description	Impact (rank out of 4)	Likelihood (rank out of 4)	Mitigation
Ongoing CP PCN Lead vacancies	**3**	**1**	**Recruit replacement CP PCN leads**

8.0 Equality Impact Assessment

[Complete the Equality Impact Assessment as described below and provide a summary/additional commentary here]

9.0 Business Case Approval

Board	Date To be Reviewed (Approved)

Neighbourhood Providers Alliance Group	12th October 2021
System Operational Command Group (City and Hackney Delivery Group)	21st October 2021
Neighbourhoods Health and Care Board	TBC
CCG Finance and Performance Committee	28th October 2021
Integrated Care Partnership Board *(to review)*	11th November 2021

Better Care Fund Metrics

The development of a Neighbourhood model has been supported by funding from the Better Care Fund (BCF). The BCF is committed to the aim of person-centred integrated care, with health, social care, housing and other public services working seamlessly together to provide better care.

For people who need both health and social care services, this means only having to tell their story once and getting a clear and comprehensive assessment of all their needs with plans put in place to support them. This means they get the right care, in the right place, at the right time.

Partners must ensure that the work to redesign services contributes to the achievement of the Better Care Fund metrics which are set out below:

- **Metric 1:** Reduction of non-elective admissions (General and Acute)
- **Metric 2:** Admissions to residential and care homes
- **Metric 3:** Effectiveness of reablement
- **Metric 4:** Delayed Transfers of Care

Stepping up to the Place published by the LGA, NHS Confederation, NHS Clinical Commissioners and ADASS sets out a vision for integrated care.

Risk Matrix

LIKELIHOOD	CONSEQUENCE				
	Very Low (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Very Low (1)	1	2	3	4	5
Low (2)	2	4	6	8	10
Medium (3)	3	6	9	12	15
High (4)	4	8	12	16	20
Very High (5)	5	10	15	20	25

1-3 Low Risk Low Priority	4-6 Medium Risk Moderate Priority	8-12 High Risk High Priority	15-25 Very High Risk Very High Priority

EQUALITY IMPACT ASSESSMENT TEMPLATE

Name of proposal: **Community Pharmacy PCN Leads**	**Aims and Objectives of the proposal:** To facilitate closer working between Community Pharmacies and GP practices in Hackney	
Who is responsible for the Assessment?	**Lead Officer:** **Yogendra Parmar**	**Others involved:**

What data is available? **Please list:**	**Which groups or people have you consulted?** **Please list:**
Please state the information obtained following the data/evidence gathering, and or Consultation: (what did they say?)	

Does the evidence /data suggest any group is disadvantaged? Please explain below:	
Age	**Religion or Belief**
Disability	**Gender (including Transgender)**
Race	**Dependents (caring responsibilities)**
Sexual Orientation	**Other groups**

Does the proposal promote equality and diversity? Please explain:

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	