Committee: Community and Children's Services	**Dated:** 03/11/2022
Subject: Health and Social Care Integration Update	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1,2,3,4
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N**
Report of: Director of Community and Children's Services	**For information**
Report author: Kate Bygrave, Community and Children's Services	

Summary

This report updates Members on current work around local integration of health and social care.

There is a large amount of ongoing work across the City and Hackney place-based partnership. This is framed within a number of work streams and is designed to promote a more joined-up approach to health and social care services, ensure access to a wider range of services, and focus on prevention.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. Members have previously received reports regarding integrated health and social care across the City of London and Hackney. A separate report on some of the structures and governance around integrated care is included on the agenda for this committee.

2. Within each Integrated Care System (ICS), place-based partnerships lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in

supporting the health and wellbeing of the population. There is a City and Hackney place-based partnership.

3. This report updates Members on some of the work taking place at the place-based partnership.

Current Position

4. The principle of the ICS is to devolve as much activity and finance to place but the exact nature of this is still to be set. This provides an opportunity for Members who sit on the local Health and Care Board to have greater influence on health spend to ensure City of London needs are met.

5. There is a local delivery plan with key priorities and outcomes and in relation to this, the City Corporation has developed some key outcomes it wants to see from integrated work in order to meet specific needs. These include (but are not limited to):

   - Meeting the health needs of rough sleepers effectively
   - Better integration and streamlining of services where residents are registered with health services in Tower Hamlets
   - Services redesigned through integration specifically meet the needs of City residents

6. There has been a significant amount of work undertaken in the placed based partnership locally.

Cost of Living

7. Partners in the local place-based partnership have been working together to identify joint work and information sharing to address some of the issues arising from the cost of living crisis.

8. The City of London Corporation has secured £50,000 from health funding to address cost of living pressures and will be using it to implement a Green Doctor Scheme which advises residents and carries out low level work in people's homes to improve energy efficiency.

Neighbourhoods

9. There are eight neighbourhoods across the City and Hackney place-based partnership, and City of London is part of the Shoreditch Park and City neighbourhood. Neighbourhoods bring together community services such as adult social care, adult community nursing, community pharmacy, mental health, and the voluntary and community sectors. Bringing services together in this way delivers more co-ordinated support and improves outcomes for residents. An evaluation will be conducted to see how these are working for City of London residents.

10. The focus of the last few years has been on redesigning community based services that are part of the neighbourhood.

11. Community Pharmacies across the neighbourhoods have been instrumental in the delivery of some community healthcare services as a result of the pandemic, including administering vaccine distribution, for both covid vaccinations and flu vaccines to increase uptake within local communities, including City residents. The community pharmacies teams were also instrumental in resolving medicine shortages as a result of the pandemic. Triaging into community pharmacies has also reduced some of the time constraints in Primary care.

12. Adult Community Nursing (ACN) moving to a neighbourhood's footprint has increased the capacity of the team to deliver more responsive services to residents, whilst still remaining in the same site, Rushden Street for the City, has maintained continuity of care, improving patient experience. Successful end of life and palliative care structures developed during the pandemic have remained in place. ACN are planning an evaluation of the move to neighbourhoods working and it's impact on patient experience that will include the experience of City residents.

13. Adult Community Nursing Teams from Tower Hamlets attended a peer review of the restructure of ACN in the City and Hackney, and provided very positive feedback on the activities of ACN across all of the Neighbourhoods.

14. The next phase of work is for community therapies to move to a neighbourhood's footprint to allow City of London residents wider access to community therapies from across the Shoreditch Park and City neighbourhood and improve the reach of community therapies to residents.

15. Planning is also underway to move some children's services to a neighbourhood model and City of London officers are part of these discussions to ensure that all City of London children have access to the joined-up services they need,

16. Adult Social Care services are linked in with neighbourhood ways of working and are part of multi-disciplinary meetings with a wider range of professionals. Here, complex cases are discussed with a joined-up plan, and ownership of cases by different professionals agreed. Adult Social Care have noted the benefits of this approach.

17. Neighbourhood forums have recently restarted in-person to allow residents and organisations from each neighbourhood to meet to discuss and agree the priorities for neighbourhood work. A new co-ordinator for the Shoreditch Park and City forum is considering different approaches to ensure that the voices of City residents and organisations are heard – this has been lacking in previous forums. A wider review of resident engagement in the system has been undertaken looking at how to include more people. Proposals from this are due to be presented shortly.

18. Evaluation of the neighbourhood's programme is in the early stages of commissioning, but will include a subset of analysis of impacts of the neighbourhoods work for the City of London.

19. Tower Hamlets has a different model for integrated care - it is not based on neighbourhoods in the same way, but there are links with the relevant colleagues and Adult Social Care are also linked in with health services.

Primary Care Networks

20. A Primary Care Network (PCN) is a collective of GPs working together to meet the needs of registered populations of between 30,000 and 50,000 patients. Locally, PCNs are based on the eight neighbourhood footprints and are responsible for providing primary care services within the neighbourhoods. The PCN's are working with local statutory partners and residents with a population health management approach. The Neaman Practice is part of the Shoreditch Park and City neighbourhood.

21. Certain funding streams are directed through the PCNs, mainly for staffing, such as physicians associates and practice-based physiotherapy. This is something that has been put in place in the Neaman Practice.

22. A pilot supporting people with long-term conditions through Community Gynaecology is being rolled out across all of the neighbourhoods, and funding through the neighbourhoods has provided a virtual menopause clinic. Plans are being developed to expand this program out to cover other conditions, starting with nephrology.

23. Another key requirement of each PCN is that they specifically reduce identified health inequalities. Work in the Shoreditch Park and City neighbourhood is focused on obesity, drug and alcohol use and smoking cessation.

24. PCN Directors have been invited to attend Neighbourhoods Providers meetings so that local Primary Care, including the Neaman Practice are informed on the work in the neighbourhoods

25. PCNs also exist in Tower Hamlets (they are a statutory requirement) but, as noted above, they do not follow the same model of neighbourhoods as in City and Hackney.

Organisational development

26. The workforce and organisational development workstream has been designed to facilitate stronger partnership working across the system, and support the joined-up approach to health and care. This workstream is being piloted in Anticipatory Care. A programme of workforce training opportunities was launched in September 2022, with sessions including working through change, making meetings work and navigating power dynamics. These

training sessions are attended by the City of London's Adult Social Care team, and team leaders also regularly attend system-wide reflection sessions.

Community navigators

27. Community navigators support residents to improve their health and wellbeing by working with them to identify their needs and interests and signpost to non-medical community-based activities. The aim is for community navigators to support residents to find their own personalised solutions and ensure that the wider determinants of health are addressed.

28. Community navigation encompasses a broad variety of navigation roles, including social prescribing, health and wellbeing coaches, dementia navigators, community connectors and, in the City of London, the City Connections Service for City of London residents provided by Age UK.

29. A framework for measuring the common core outcome measures has been developed to be used across the variety of Community Navigation roles and evaluation of this framework will look at the measurement of meaningful impacts for residents

30. Current work is focussed on understanding the role of community navigation in addressing financial hardship and ensuring that people in these roles feel confident supporting people around financial hardship.

Social Prescribing

31. Social prescribers support residents to access activities, social groups and advice services based on an individual's needs and interests. The aim is to improve wellbeing and ultimately improve overall. A new Social Prescribing contract has recently been awarded and, as before, will include the Neaman Practice. City of London officers were involved in shaping the tender documentation to ensure that there was good alignment of social prescribing with the City Connections Service.

32. Practices in Tower Hamlets also have social prescribing services located in them and registered City of London residents are able to access them. City of London officers undertook work with social prescribers in these practices to understand what services they could refer people to in the City of London.

Anticipatory Care

33. Anticipatory care and virtual wards (also known as Hospital at Home) are key areas of work in integrated care, with anticipatory care being a requirement from the NHS Five-Year Plan.

34. Anticipatory care is a proactive approach to care for people living with complex health and care needs and/or frailty to allow them to stay

independent and healthy for as long as possible, as well as aiming to reduce the risk of an individual's condition worsening, resulting in hospitalisation.

35. A pilot for testing and delivering person-centred, personalised and proactive support for people with moderate frailty is being piloted in the Springfield Park PCN. The pilot will be rolled out to the wider neighbourhoods and PCNs. The approach and model will be implemented across the City and Hackney system from April 2023.

36. The City of London Corporation have been involved in discussions planning for anticipatory care and will be preparing for its roll out in April 2023. Tower Hamlets practices will also roll out anticipatory care, and Adult Social Care will be part of the approach for people registered with Tower Hamlets GPs.

37. Virtual wards are designed to allow patients to receive care where they live, rather than in hospital, through the use of remotely monitored equipment and wearable devices, as well as face-to-face appointments from multi-disciplinary teams for an individual at home. This is currently being explored within the City and Hackney partnership, and City of London Corporation are part of these discussions.

38. Care co-ordinators are currently being recruited by Homerton Hospital to deliver Anticipatory Care and Personalised Care programmes across City and Hackney. These care co-ordinators will be based at GP's surgeries. They will support patients to remain healthy and independent and at home for longer by supporting patients to access community-based support services designed around what matters to the patient. They work in a similar way to community navigators, but with a specific focus on supporting those patients with frailty and complex health and care needs, as well as working with professionals and frontline staff in multi-disciplinary teams and meetings. A care co-ordinator will be available to City of London residents registered with Neaman Practice to support them with personalised approaches to anticipatory care.

IT Enabler

39. The IT Enabler Group supports setting the digital strategy and the implementation of digital solutions that support the development of new models of care across the Integrated Care programme locally.

40. The East London Patient Record is a platform to share patient information across health and social care services in the North-East London ICS for the purposes of giving direct care. This is now actively being used by social workers in the City of London Corporation to use relevant health information to inform social work assessment and services.

41. Local patient record systems across London are now being joined up in a London-wide system so that patients in any hospital can be linked up with their appropriate social care services. For City of London residents, it will

mean that social care will have access to information for those residents who are or have been in University College Hospital, which sits in a different ICS.

Next Steps

42. The different work streams in the Integrated Care System in City and Hackney are now beginning to look at evaluation of the work undertaken. Officers are working with system partners to develop an approach that captures how these developments have impacted directly on City Residents

Implications

43. **Strategic implications:** Integrated care is a key deliverable of the Corporate Plan outcome 2 – that people enjoy good health and wellbeing. It also impacts on outcomes 1, 3 and 4.

44. The priorities in many of our strategies such as the Joint Health and Wellbeing Strategy and the Children and Young People's Plan also interact and align with work in the integrated care arena.

45. **Financial implications:** None

46. **Resource implications:** None

47. **Legal implications:** None

48. **Risk implications:** None

49. **Equalities implications:** Locally, tackling health inequalities is a key principle of the integrated care programme and there is a specific group looking at practical ways of tackling health inequalities. It is also a key focus at the ICS level.

50. **Climate implications:** None

51. **Security implications:** None

Conclusion

52. Integrated care is a key area of local work as part of the City and Hackney place-based partnership.

53. This report updates Members on some of the partnership's current work.

Appendices

- None

Kate Bygrave
Strategy and Projects Office
E: kate.bygrave@cityoflondon.gov.uk